Outcomes from a structured conflict management programme implemented at three paediatric healthcare sites: a mixed-methods evaluation

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► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/archdischild-2025-329335).

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Received 3 July 2025
Accepted 8 March 2026

To cite: Phillipson J, Menson E, Barclay S, *et al*. *Arch Dis Child* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/archdischild-2025-329335

ABSTRACT

Objective Evaluation of the Medical Mediation Foundation's Conflict Management Programme (CMP)—a structured process for managing conflict.

Design Mixed-methods evaluation using Kirkpatrick's framework, a four-level model for evaluating training.

Setting Three National Health Service children's hospitals from 2021 to 2024.

Interventions 904 unique participants attended 179 tiered training sessions, totalling 2104 attendances.

Main outcome measures Quantitative data was collected via pre-training/immediate post-training surveys including the Turnover Intention Scale, and the Brief Resilience Scale. Pre-training/post-training scores were compared using the Mann-Whitney U test, with a conservative Bonferroni correction applied to each set of tests. Qualitative data were collected through semistructured interviews at one and three years analysed using Braun and Clarke's standard approach to thematic analysis.

Results 664 participants (71%) completed pre-training evaluation questionnaires, and 569 (63%) immediate post-training, reflecting immediate benefits of training. 26 interviews were conducted, demonstrating sustained behaviour change over three-year follow-up. Knowledge scores increased significantly (all $p<0.002$), and staff reported improved confidence and empathy. Behavioural changes included early conflict recognition and improved team communication. Self-reported scoring of conflict management skills improved significantly across all measured domains (all $p<0.004$). Organisational impact included improved staff-family relationships, improved workplace culture and perceived time-savings. There were subtle improvements in resilience ($p=0.038$), though no significant change in turnover intention ($p=0.434$).

Conclusions Implementation of the CMP produced individual and organisational benefits, which were sustained over time. The importance of institutional support, dedicated resources and integration into organisational structures was highlighted.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Conflict is known to cause considerable psychological and financial burden in clinical settings.
⇒ Most evaluation of conflict management training in healthcare is limited to short-term, self-reported outcomes and acquiring intended learning (Kirkpatrick Level 2).

WHAT THIS STUDY ADDS

⇒ This Conflict Management Programme was independently evaluated.
⇒ The evaluation demonstrated individual and organisational change, including impact at Kirkpatrick Level 3 (behaviour) and Level 4 (results).
⇒ There were sustained improvements in conflict management skills, team communication and culture.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Embedding this programme has the potential to reduce the burden of healthcare conflict on organisations and clinical teams.
⇒ Programme effectiveness depended on leadership engagement, protected time and integration into local systems.

INTRODUCTION

Paediatric healthcare is susceptible to conflict between clinicians and families[1] due to high-stress clinical environments, communication difficulties and resource and workload demands.[2–6] If not managed effectively, conflict can have serious consequences across multiple levels. For organisations, this includes high legal costs, staff turnover and reduced productivity. For staff, it can contribute to burnout, poor team cohesion and diminished well-being. For patients and families, unresolved conflict strains therapeutic relationships and contributes to medical errors and poorer health outcomes.[4 7–12]

There have been calls to develop and assess structured conflict management processes.[4 13–15] While training has been shown to reduce the negative consequences of conflict,[2–4 7 10 12 16] few structured programmes have been implemented.[4 13–15 17] The Medical Mediation Foundation's (MMF) Conflict Management Programme (CMP)[18] is one of the few formalised approaches to managing conflict in paediatric healthcare and shows promise in reducing both the incidence of conflict and related staff burnout.[12 15 19 20]

MMF designed the CMP to embed conflict management principles into everyday practice. It involves tiered training, a structured process for managing conflict of differing severity and training in-house trainers for sustainability.

This project involved delivering and evaluating the impact of the CMP within three paediatric

services outside London (as requested by the funders), over 3 years (2021–2024).

METHODS

Educational methods

The funders approached MMF to deliver and evaluate the CMP based on its experience in healthcare mediation and conflict management training.

The CMP was delivered to multidisciplinary staff in 3–5 clinical areas at each site, selected by each project lead.

Tiered training comprised:

- Level 1A and 1B: foundation; two half-day sessions at least 1 month apart.
- Level 2: training senior staff; one full day.
- Level 3: 'Train the Trainer', two full days.

Originally designed for in-person delivery, the CMP was adapted due to the COVID-19 pandemic and was delivered predominantly online (via Zoom), supported by interactive presentation software (Mentimeter).

In year 2, MMF developed an e-learning version of Level 1 in partnership with National Health Service (NHS) England (endorsed by the Royal College of Paediatrics and Child Health and accredited by the Royal College of Nursing). This was integrated into the CMP training structure[21] and in year 3, shortened (45–90 min) interactive sessions were delivered to complement it, maintaining overall content.

Due to pandemic-related clinical pressures and attendant challenges in releasing staff, site A withdrew from the project after year 1. The residual project funds were reallocated to sites B and C.

Over the project span, 179 training sessions were delivered to 904 participants, resulting in a total of 2104 attendances (table 1). At each of the sites B and C, 12 staff were trained as trainers (Level 3) to co-deliver sessions with MMF trainers in years 2 and 3.

Evaluation methods

Independent evaluation of the project was embedded into training design[22 23] in line with best practice.[24] An evaluation steering group included each site's project lead, patient experience representatives, the project funders, the project directors and the independent evaluation lead. The evaluation was designed by OL and approved by the project funders. The evaluation design was also informed by an evaluation planning study[25] grounded in the principles of utilisation-focused evaluation.[26] Stakeholder interviews (including patient/family) informed the areas of focus for evaluation and the optimal data sources to include. Four key areas emerged:

- Experience of training sessions.
- Staff competency and wellbeing.
- Patient/family experiences of conflict.
- Impact on staff time and clinical resources.

Table 1 Attendance at CMP sessions over 3 years. Site A withdrew after year. Level 1 shortened sessions of 45–90 min duration were offered to complement e-learning in year 3

		Number of sessions (number of attendances)			
		Year 1	Year 2	Year 3	Total
Level	Level 1A	36 (480)	24 (337)	6 (53)	66 (870)
	Level 1B	34 (411)	24 (307)	2 (26)	60 (744)
	Level 1 (shortened)	–	–	9 (79)	9 (79)
	Level 2	12 (138)	4 (34)	8 (74)	24 (246)
	Level 3	8 (64)	8 (81)	4 (20)	20 (165)
Site	A	22 (217)	–	–	22 (217)
	B	35 (469)	35 (472)	19 (146)	89 (1087)
	C	33 (407)	25 (287)	10 (106)	68 (800)
Total	Sessions (attendances)	90 (1093)	60 (759)	29 (252)	179 (2104)
	Unique participants	480	371	53	904

CMP, Conflict Management Programme.

Quantitative methods

Quantitative data were collected via anonymised questionnaires pre-Level 1 and immediately post-Level 1 training (1A and 1B). The questionnaire content is detailed in table 2, and full instruments are included as online supplemental materials 2 and 3.

Although a 1-year follow-up survey was conducted, the response rate was low (17%; n=113) despite multiple reminders. To avoid potential selection bias, these data were excluded from analysis and the planned 3-year survey was not conducted. Instead, longer-term effects were explored through qualitative methods at 1 and 3 years.

Qualitative methods

11 semistructured interviews were conducted at 1 year and 15 at 3 years after project initiation (see online supplemental material 1 for interviewee demographics). Questions were guided by identified areas from evaluation planning interviews[25] (see online supplemental material 1 for interview guides).

Interviewees were selected by snowball sampling from site leads, focused on individuals with insights into the impact and implementation of the training. Interviewees included nursing, medical and allied health professionals across all sites. Recruitment was stopped when several consecutive interviews generated no new codes, indicating thematic saturation.

Interviewees were informed that interviewers were independent of training delivery. Interviews were conducted by a single independent interviewer, in person or by video call and were audio-recorded, digitally transcribed and anonymised.

In addition to interviews, free-text comments and feedback were elicited via chat comments at the close of Level 1B training sessions.

Data analysis

Demographic data, conflict prevalence, time off work and content relevance were summarised using descriptive statistics. Responses to the question 'How likely are you to recommend this training to a friend or colleague?' were used to calculate a Net Promoter Score[27] which measures participant satisfaction by subtracting the percentage of detractors (scores 0–6) from promoters (scores 9–10). Scores range from −100 to +100, with higher values indicating stronger endorsement.[28]

Pre-training and post-training scores for the combined Brief Resilience Scale score, the combined Turnover Intention Scale-6 score, the conflict skills questions and grades for the conflict knowledge questions were compared using the Mann-Whitney U test (significance level 0.05). To adjust for multiple comparisons, a conservative Bonferroni correction was applied to each set of tests. Knowledge-question scores were analysed as separate quantitative variables using the same statistical tests as the Likert-scale items but were not combined with them.

Table 2 Quantitative outcomes measures and scoring procedures

Domain	Measure/item	Timing	Scale/scoring	Notes on scoring and analysis
Conflict management skills	Self-rated ability across four key skills	Pre-training and post-training	7-point Likert scale (1=strongly agree, 2=agree, 3=slightly agree, 4=neither agree/disagree, 5=slightly disagree, 6=disagree, 7=strongly disagree)	Analysed as ordinal quantitative variables
Knowledge of conflict management principles	Two free-text questions	Pre-training and post-training	Scored 0–10 by faculty	Two scorers agreed criteria, co-scored 10 samples to ensure consistency, then scored independently; discrepancies >2 points resolved by consensus.*
Conflict exposure	Number of conflict episodes with patients/families in preceding 2 weeks	Pre-training and post-training	Numeric count	Descriptive analysis
Staff resilience	Brief Resilience Scale (BRS)	Pre-training and post-training	6-item validated self-report scale	Measures ability to recover from stress, self-rated on a 5-point Likert scale; tested for construct, convergent, discriminant and predictive validity.[33]
Staff turnover intention	Turnover Intention Scale (TIS-6)	Pre-training and post-training	6-item validated self-report scale	Measures intention to leave current employment; tested for construct, criterion-predictive and differential validity and high reliability demonstrated (Cronbach alpha coefficient of 0.80)[34]
Training relevance	Perceived relevance of training	Post-training	3-point scale (1=not relevant, 2=relevant, 3=very relevant)	Acceptability measure
Programme advocacy	Likelihood of recommending the CMP to a colleague	Post-training	10-point scale (1=not at all likely; 10=extremely likely)	Satisfaction measure used to calculate the Net Promoter Score.

CMP, Conflict Management Programme.

Theme development from qualitative data was inductive based on Braun and Clarke's standard approach,[29] with steps: (1) familiarisation with data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes and (6) producing the report. Primary coding was undertaken by Juliette Phillipson and coding decisions and theme development were peer-debriefed with Oscar Lyons. Data were managed and coded in Nvivo. The themes were: (1) developing interpersonal and reflective communication skills; (2) applying proactive and structured approaches to conflict; (3) experiences of training delivery and implementation challenges and (4) evolving organisational culture and perceived outcomes (detailed in online supplemental material 1). These themes were subsequently mapped onto the Kirkpatrick framework (reaction, learning, behaviour, results) to integrate qualitative and quantitative findings.[22 23]

Reflexivity

The primary evaluator (JP) is a female doctor with a Master's in Public Health and experience in mixed-methods project evaluation. The supervising evaluator (OL) is a male doctor and researcher with a PhD in healthcare leadership and experience in the design and evaluation of healthcare education programmes. JP and OL were academic researchers contracted to conduct the evaluation. EM and SB co-developed and delivered the CMP, contributed to the initial evaluation design and provided input through review of the final manuscript but were not involved in data collection, coding or interpretation. To maintain independence and reflexive awareness, JP conducted the qualitative interviews and analysis independently. The project directors were interviewed to provide contextual understanding of Project implementation and evaluation challenges, but their data were not included in the analysis. Their involvement in project delivery may nonetheless have influenced interpretation of findings, and this potential influence is acknowledged.

RESULTS

Participant demographics

644/904 participants completed the pre-training survey (71% response rate), and 569 completed the post-training survey (63% response rate). Around half the respondents (52%) were from site B, a third from site C (35%), and the remainder were from site A (13%). Most (91%) were women, 7% men and 2% did not specify gender.

Role distributions are presented in figure 1.

Kirkpatrick level 1: reaction

92% of participants rated the CMP training as 'very relevant' to their work and the remaining 8% rated it as 'relevant'.

The Net Promoter Score was 64, indicating a high level of participant satisfaction.[28]

In free-text comments, content areas frequently highlighted as being particularly valuable included empathy, self-reflection and strategies for handling conflict. Participants stated that the training was both beneficial and empowering for their work.

Interviewees commented on the relevance of content to day-to-day practice. Feedback on content and course facilitation was universally positive. Participants appreciated the interactive elements like role-plays and case discussions, and the multidisciplinary approach was seen as enhancing communication and team cohesion. Those who trained as trainers frequently described the experience as positive and skill-building.

Participants, particularly those at site A, reported challenges in accessing and sustaining training due to clinical workload, rostering difficulties and the length and structure of sessions.

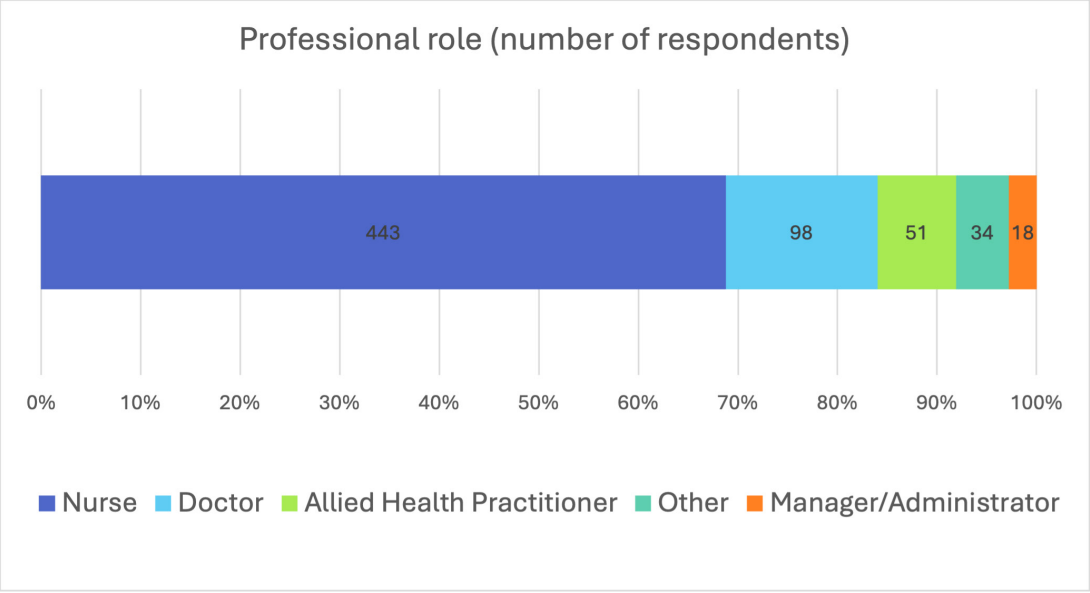

Figure 1 Professional role of questionnaire respondents. 'Allied Health Practitioner' is inclusive of speech language therapist, dietitian, occupational therapist, social worker, clinical psychologist and therapist. 'Other' is inclusive of chaplain, assistant practitioner, ward clerk, clerical officer, sibling support worker, patient service coordinator, healthcare assistant, clinical support worker, security, youth support coordinator, associate director.

Online delivery increased accessibility to training, particularly for shift-based staff, but some felt that it limited group connection and interaction.

Kirkpatrick level 2: learning

There were significant improvements in both the self-reported (subjective) and the graded (objective) questions related to conflict management knowledge (see table 3).

Participants described notable improvements in their understanding of conflict management and their communication skills. Reported learning points reported frequently included increased awareness of early conflict warning signs, understanding of empathetic communication and greater confidence in handling difficult conversations. Specific skills reported included active listening, open-ended questioning, planning for challenging discussions and interpreting non-verbal cues.

Participants reported focusing on understanding and exploring families' underlying concerns, as opposed to giving premature reassurance. Many also reported greater awareness of early signs of conflict and feeling better equipped to respond with empathy and clarity.

Interviewees noted that the training also promoted self-reflection. They reported mentally reframing previous difficult interactions and better understanding the emotions driving patient and family behaviour. Participants described a reduction in anxiety and avoidance when facing challenging conversations, leading to improvements in their confidence and wellbeing.

Kirkpatrick level 3: behaviour

In both 1-year and 3-year interviews, participants consistently reported improvements in their approach to conflict, indicating long-term behavioural impact. Specifically, interviewees

Table 3 Conflict management skills and knowledge questions in pre-training and post-training questionnaires are presented

		Median pre-training	Median post-training	P value
Skills questions	Q1. I know the main warning signs for conflict.	5	6	<0.004*
	Q2. I feel confident in my ability to start a conversation with a patient or family member when conflict has been identified.	5	6	<0.004*
	Q3. I know who to go to if I want to discuss a conflict case.	6	6	<0.004*
	Q4. Staff on my ward have a shared understanding of how to recognise and manage conflict.	5	6	<0.004*
Knowledge questions	Q1. What are the three factors which define conflict in paediatric healthcare?	0/10	3/10	<0.002*
	Q2. What are the four most commonly cited causes of conflict in paediatric healthcare?	1/10	2/10	<0.002*
Validated tools	BRS combined score (mean)	3.3	3.3	0.038
	TIS-6 combined score (sum)	16	16	0.434

Respondents answered skills questions on a Likert scale using 1 (strongly disagree), 7 (strongly agree). Free-text answers to knowledge questions were graded from 0 (lowest score) to 10 (highest score) by Project faculty. Pre-training and post-training responses to the Brief Resilience Scale and the Turnover Intention Scale-6 are also presented. All pre-/post comparisons used the Mann-Whitney U test.
*P values adjusted using the Bonferonni correction for multiple comparisons.
BRS, Brief Resilience Scale; TIS-6, Turnover Intention Scale-6.

described shifting from reactive to proactive and structured responses, using techniques such as active listening, open-ended questions and intentional de-escalation strategies. Practical examples included planning conversations more carefully, being mindful of body language and creating the right conditions for difficult discussions.

Participants also reported that skills gained were widely adopted and shared within teams. Many reported applying the techniques themselves and observing others doing so. Developing a shared language and consistent framework helped unify team responses to conflict and supported a culture shift away from labelling families as 'difficult'.

Several participants said they used training techniques when supervising, coaching or mediating conflict between colleagues.

Kirkpatrick level 4: results

There was no significant change in TIS-6 pre-training and post-training (table 3). Although the median BRS combined score remained unchanged, the Mann-Whitney U test indicated a statistically significant change in resilience scores due to an improvement in the distribution of scores.

In the pre-training questionnaire, respondents identified a mean of 1.1 episodes of conflict in the preceding 2 weeks, with 51% of respondents reporting at least one episode of conflict in the preceding 2 weeks. Post-training, episodes of conflict identified by respondents increased to a mean of 1.5 identified episodes in the preceding 2 weeks, with 58% of respondents reporting at least one episode.

Participants reported that the CMP improved team dynamics, promoted collaboration and strengthened relationships with patients and families. They described greater openness in discussing conflict and applying consistent approaches across teams, contributing to a shift toward a more reflective, communicative workplace culture.

While interviewees noted that applying these skills could be time-intensive in the early stages, they also noted that using these skills often prevented escalation, ultimately saving time. Interviewees struggled when asked to quantify these savings, meaning that calculation of return on investment was not possible.

Interviewees felt that the training reduced both the frequency and the severity of conflicts. Specific examples demonstrated positive impacts on family relations by fostering trust and reducing hostility. Many interviewees gave specific examples of situations in which the training had resulted in improved relationships with families. Interviewees also described specific situations where the training helped avoid legal escalation.

Interviewees gave multiple examples where the CMP not only improved individual practice but also contributed to a culture change, with early, empathetic and proactive conflict resolution becoming a shared norm across teams.

Organisational uptake

Organisational differences between the three sites were noted. At site A, heightened clinical pressures and associated difficulty releasing staff to attend training prevented their continuation beyond year 1.

Site B delivered the full CMP. They had a dedicated, Trust-funded Project lead (1 day/week) for the Project duration. After year 1, Level 1 training was mandated for new nursing staff. By the end of the project, 12 in-house staff had been trained to deliver Level 1 training alongside MMF faculty. At this site in particular, participant feedback linked the training to a change in workplace culture and improved patient outcomes. The success was attributed to clear leadership, CMP integration into Trust policy and adaptation to e-learning platforms.

Site C also delivered the full CMP. However, the site project lead was promoted to another role in year 2 and was not replaced, which impacted implementation thereafter. Site C participants expressed frustration at trying to embed an externally developed programme without protected time or organisational commitment (see box 1).

Across all sites, participants expressed the need for strong organisational commitment and practical strategies in order to ensure sustainability. Suggestions included mandating the CMP training, providing regular refreshers and embedding training sessions into daily workflows. Involving senior leadership in training sessions was also identified as a critical strategy for securing organisational support. Feedback prompted the introduction of hybrid delivery in year 3, combining e-learning with shortened sessions.

Quotes from qualitative interviews

See box 1.

DISCUSSION

This mixed-methods evaluation of the CMP demonstrates positive outcomes at individual, team and organisational levels within three paediatric services. Quantitative findings identified immediate self-reported improvements in knowledge, conflict management skills and resilience. While there was an observed rise in self-reported conflict episodes, this likely reflects improved recognition rather than increased incidence. Participants reported sustained increases in confidence and competence in managing conflict, strengthened communication skills and improved relationships with patients, families and colleagues. Qualitative evidence of sustained behavioural change and improvements in team culture suggests that when supported by leadership engagement, protected time and integration into local systems, the CMP can become embedded in clinical practice.

The observed improvements in empathy, listening and early recognition of conflict have particular relevance to paediatrics, where the quality of clinician-family communication directly influences trust, care satisfaction and patient outcomes.[4 7 30] Embedding a structured CMP within paediatric services may contribute to healthier staff relationships as well as to improved family experiences of care. Although qualitative data suggested improvements in workplace culture, staff-family relationships and time efficiency, these outcomes could not be quantified objectively. This reflects a methodological limitation of training evaluations: the challenge of systematically measuring patient-reported or family-reported outcomes. When measuring conflict, ethical considerations of patient involvement become particularly pertinent, as gathering feedback directly from families requires consent processes and safeguards for children and parents experiencing distress or conflict. Nonetheless, recent high-level evidence indicates that improved teamwork, communication and reduced burnout among staff are associated with better patient safety and satisfaction outcomes.[30]

Implementation success varied across sites due to differences in infrastructure, leadership continuity and organisational priorities. Site B benefited from stable Project leadership, senior management endorsement and integration of conflict management principles into existing governance and staff-support structures, which supported sustainability. In contrast, Sites A and C faced operational pressures, staff turnover and limited

Box 1 Participants' quotes from semistructured interviews, organised by Kirkpatrick Level. Illustrative quotations were selected to reflect diversity of site, profession and timeframe, rather than proportional representation.

Kirkpatrick level 1: reaction

"[(The time required]) was quite a big commitment, which was very tricky to sustain within not only the current climate, but also from a financial position"—Site A, Nursing role (Year 1)

"The online nature for some people didn't work so well… You can see each other, but you can't really contribute. And I think it was easy for us to switch off during the day."—Site B, Medical role (Year 1)

"I personally felt the training was fantastic… it was superb. I thought it was pitched right. I thought it was helpful. I think particularly [(course facilitators]) have a certain way of [(teaching]), I don't know how they do it, but it seems to stick a bit better. I thought it could not offer anything else."—Site B, Nursing role (Year 3)

"[(Being a trainer]) has been really good in increasing or consolidating my communication skill set but enabling me to ensure that we can really embed it across our organisation."—Site C, Nursing role (Year 1)

Kirkpatrick level 2: learning

"The listening skills and recognition of the really small things can make a massive difference early on in a conflict. So listening, the language, allowing them to speak and not the premature reassurance…"—Site B, Nursing role (Year 1)

"[(I learned to]) think about 'why is he communicating in that way? Why is he saying all these nasty things? It's taking a step back… being able to reflect on why he's communicating that way."—Site B, Physiotherapist (Year 3)

"It makes me feel less apprehensive about going into conversations than I had felt before I had the training… it has helped to lessen the anxiety."—Site C, Medical role (Year 3)

Kirkpatrick level 3: behaviour

"If you recognise [(conflict]) and you can talk quite openly with families about it, then actually that improves the relationship."—Site B, Medical role (Year 3)

"If I'm teaching and coaching, I think I just use lots of the things I've learnt, lots of domains for teaching about communication and leadership and management actually… Lots of the skills actually overlap as a supervisor as well."—Site C, Nursing role (Year 3)

"I'm seeing people applying the techniques or trying to apply the techniques, vocalising that that's what they're doing. So I do see a difference… There's an intentionality in engaging with parents that I think is different."—Site B, Nursing role (Year 1)

"I only booked to do the training because I've started to see a difference in the girls. And in the doctors too, those who had done it. They seemed calmer, less defensive. I do see that they talk less and listen to parents more. They ask the parents more questions about what they thought or what was worrying them."—Site C, Nursing role (Year 3)

Kirkpatrick level 4: organisational impact

"We talk about conflict much more, instead of it being a hidden thing, instead of it being something that was kind of like too difficult to deal with, people just call it out for what it is, and then you can start a conversation both with the family and also within your team about how to move things forward. So it's been a really positive impact."—Site B, Medical role (Year 3)

"One of the really positive things is to have built up relationships across our service…"—Site C, Nursing role (Year 1)

"We could have ended up in court with this family and actually we didn't. And I see that as a success because of the conflict management training."—Site B, Physiotherapist (Year 3)

"The conversations I've had, having that space for them to really kind of say what they're feeling and what their concerns or worries are, I think then they felt kind of that actually they are really being listened to. Which then obviously helps them feel that whatever's really underlying their behaviours is then being addressed or at least acknowledged."—Site C, Medical role (Year 3)

protected time for training. Site A's withdrawal was primarily due to competing organisational demands and the absence of a dedicated site lead. Site C's engagement was constrained by workforce shortages and changing organisational priorities. This highlights the influence of organisational readiness, resource allocation and leadership stability on the feasibility and sustainability of conflict management initiatives.

Turnover intention did not change significantly following participation in the CMP. This may reflect the timing of data collection, as only immediate-post training data was obtained, without the additional year 1 and 3 data intended. Broader organisational factors such as workload, staffing pressures and career satisfaction could also exert a stronger influence on turnover intention than interpersonal or communication skills. Future evaluations with longer follow-up and linkage to workforce data would help address these questions.

The majority of conflict management training evaluations in healthcare fail to assess impact beyond Kirkpatrick Level 2.[31 32] In contrast, this evaluation incorporates mixed-methods, longitudinal qualitative data and captures Kirkpatrick Level 3 and 4 outcomes, strengthening the validity of the findings and demonstrating a more methodologically sound approach than is typical in the conflict management training literature.

Limitations

This evaluation had several limitations. While patient-reported outcomes and a return-on-investment analysis were identified as priorities during the planning phase, they were not achieved due to time, infrastructure and funding limitations.

While quantitative and qualitative data were integrated using the Kirkpatrick framework, the qualitative data contributed greater depth to interpretation. A fully convergent mixed-methods design was beyond the scope of this evaluation. Long-term quantitative follow-up was planned via a 1-year survey and a 3-year survey, but was abandoned due to the low response rate at 1 year and these data were excluded given the risk of selection bias. Consequently, sustained quantitative impact could not be assessed. The majority of qualitative data originated from Site B, which demonstrated higher engagement and completion rates. While this likely reflects genuine variation in implementation success, it may limit the representativeness of findings. The sample size for higher-tier training groups was small and uneven across sites, precluding meaningful subgroup analysis.

CONCLUSION

This evaluation of MMF's CMP, implemented in selected sites at three NHS children's hospitals, indicated strong individual and organisational benefits, with sustained impacts on conflict management skills, resilience and team communication. Uptake and engagement with the training varied by site, highlighting the importance of embedding conflict management training within paediatric services' infrastructure for success. Future programmes should prioritise institutional commitment, protected training time and blended learning approaches to ensure sustainability, accessibility and impact. Embedding CMPs within paediatric services has the potential to transform organisational culture and improve patient-family relationships.

Acknowledgements Funding for this work was provided by the True Colours Charitable Trust. Thank you to Jordan Gorenberg and Arisha Khan for their contributions to the interview process and to Charis Clements for her assistance in grading the pre-training and post-training questionnaires. We thank all the participants who gave their time for the interviews, and who engaged in the CMP. We gratefully acknowledge the staff and leadership teams at the three participating children's hospitals for their engagement, collaboration and commitment to improving conflict management in paediatric care.

Contributors Training design and securing of charitable funding for the CMP was undertaken by SB and EM. SB and EM co-directed delivery of the training, staff support and supervision sessions. The intellectual property of the CMP resides with the MMF. OL led the design of the evaluation, developed and distributed the quantitative data collection tools. Interviews were conducted by JP, Jordan Gorenberg and Arisha Khan. JP conducted all data analysis, wrote and edited the manuscript, with support from OL. EM and SB reviewed the manuscript for accuracy and clarity but were not involved in data analysis or interpretation. All authors are responsible for the content of the paper. OL is the guarantor.

Funding Delivery and evaluation of the Project was funded by the True Colours Charitable Trust (Grant 1 (Project): TCT16450, Grant 2 (Evaluation): TCT1646). NHS England commissioned and funded MMF to create and develop the associated eLearning course.

Competing interests MMF commissioned the independent evaluation presented in this paper. Two authors (SB and EM) are affiliated with MMF and were involved in the design and delivery of the CMP. The evaluation was conducted independently by JP and OL, who were contracted to design, collect and analyse the data and to prepare the manuscript. This role separation was established to ensure independence of the evaluation and transparency in reporting.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants. This study was approved for an ethics exemption by the Oxford University Clinical Trials and Research Governance Group. The study was also registered with governance committees at each of the study sites. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Anonymised data are available upon reasonable request.

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