

**January 2017**

**Elizabeth Garrett Anderson
Programme
Evaluation of Intake One and Two – DRAFT REPORT**

**Ipsos MORI report prepared for the NHS Leadership Academy**



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# Executive Summary

The Elizabeth Garett Anderson (EGA) Programme (‘the Programme’) is a unique healthcare leadership programme. Launched in October 2013, the EGA Programme forms a part of the NHS Leadership Academy’s portfolio of Leadership Development Programmes. Falling between the Mary Seacole and Nye Bevan programmes, it was originally aimed at developing NHS staff looking to take on a **senior leadership role**: leading teams in which members themselves lead their own teams, or a role with significant responsibility such as coordinating national projects. The programme is fully accredited, leading to a Masters in Healthcare Leadership and an NHS Leadership Academy Award in Senior Healthcare Leadership.

In total, the Programme is made up of **eight separate modules** with a focus on three levels: individual, staff and organisation, and is delivered across three core learning methods: 1) work-based application (around 50% of the content); 2) online learning (35%) and 3) Face-to-face residential behavioural experimental workshops (15%). In addition, there are Action Learning Sets, taking place eleven times during the Programme’s duration for full-day working sessions, and a face-to-face final event. The Programme, as with all of the NHS Leadership Academy’s suite of Leadership Development Programmes, is closely related to the nine domains of the Healthcare Leadership Model (as detailed further in Chapter One.

The programme, has changed in many ways since its inception. The early teething problems were reported by delivery partners to now have been ironed out, and the course is being smoothly delivered. Programme places for Intakes One and Two were fully funded, however now, and with the exception of **a limited number of bursaries available**, organisations are required to part fund the course for members of their staff who apply to the Programme.

With the overall aim to explore the extent to which the Programme has led to the achievement of the desired outcomes for participants, Ipsos MORI was commissioned by the NHS Leadership Academy in early 2016 to conduct an evaluation of the Programme) for Intakes One and Two. This report presents the findings from the evaluation; focussing on an assessment of how far the Programme has gone in generating the desired outcomes for participants completing the Programme as part of these first two intakes.

After the initial evaluation scoping stage, a Theory of Change was developed by Ipsos MORI in collaboration with the NHS Leadership Academy and the Programme’s key stakeholders. The evaluation was designed around this Theory of Change, and was restricted to exploring, as far as was possible, the realisation of a number of **short and medium term outcomes**.

Evaluation methodology and limitations

The evaluation comprised four strands, as follows:

1. **Inception and scoping:** This strand included a review of the relevant background documentation to the Programme, and consultations with key stakeholders. The output of this strand was an Evaluation Design Document which outlined the agreed scope of the evaluation, and the approach for undertaking the main evaluation phases.
2. **Survey of participants:** An online, quantitative, census survey of Programme participants in Intakes One and Two was undertaken to gather self-reported measures of experience and perceived outcomes from participation in the Programme.
3. **Case studies:** A series of participant-centred case studies (13) involving in-depth qualitative interviews with participants, line managers, direct reports and peers was conducted.
4. **Interviews with Programme tutors:** Finally, in-depth qualitative interviews were conducted with five tutors responsible for leading the learning of participants in Intakes One and Two[[1]](#footnote-2).

As discussed in the main body of this report, there are a number of notable limitations with the evidence collated that forms this evaluation. 1) The absence of a counterfactual or comparison group means that it is not possible to be certain whether, or to what extent, any of the changes measured would have happened in the absence of an individual participating in the Programme. 2) A lack of management information, to objectively measure outcomes at the overall level, means that much of the evidence sought is self-reported by participants, their line managers/colleagues and course tutors which forms a more subjective assessment of outcome. 3) Due to the timing of this evaluation, which happened sometime after the completion of the programme for Intakes One and Two, a baseline survey was not feasible hence the evaluation lacks a true measure of participants’ perceptions around their own leadership practices before they started the programme, which would have been preference without a counterfactual / comparison group. 4) The online survey that was carried out, whilst achieving a reasonable response rate, contains small base sizes thus the findings should be treated as representative of the views of those who took part, and not participants from Intakes One and Two overall.

These limitations mean that it is not possible to firmly conclude what the impact of participation in the Programme has been for participants in Intakes One and Two, but this does not reduce the usefulness of the evaluation in identifying the areas in which it is likely the Programme has delivered the desired outcomes based on the evidence presented within this report.

Programme application process and delivery

The evaluation explored participant’s views on the application process (including the time involved and the time it took to be notified on the outcome), which revealed few problems overall. More of an issue for those who participated was the support, or lack thereof, they received from their line mangers, departments and organisations more generally when applying. Some participants’ organisations had also been concerned about the financial implications of their employees dropping out of the Programme (i.e. whether they would be required to cover the cost of the place if their employee dropped-out).

The information provided by the NHS Leadership Academy before applying was assessed. Participants surveyed were split, with some saying it was about right, and others saying it too little at the time. The case studies further revealed that the clarity of the information about the Programme’s aims, detailed content, timeframes and required time was somewhat lacking. These are issues which are known to the Leadership Academy, and could be tied to the fact that the Programme was in ongoing development during these first intakes, and it would be expected that these have been resolved by now, however.

The theme of a lack of support, in some cases, from peers, line managers, and organisations followed through when participants were asked about the support received during completion of the Programme. Tutors, on the other hand, were almost universally supportive according to those we spoke to, which corresponded with tutor’s own views around the importance of their role in supporting participants through the Programme.

Programme outcomes

Participants in Intakes One and Two who took part in the evaluation, as well as line managers, peers and colleagues interviewed as part of the case studies, and Tutors, were very positive about the Programme from their experience of it, and would speak positively about the programme to others. In some cases, experiences exceeded initial expectations. For example, some participants were primarily motivated by the opportunity to gain a Masters-level qualification, but ended up getting much more out of the course than they had initially thought they would.

Individual level outcomes

This positive experience of participants was manifested in the increased leadership effectiveness that participants reported having gained during the course of the Programme – with positive change evident across all nine domains of the Healthcare Leadership Model. The vast majority of online survey participants reported a positive change in their effectiveness in at least one area over the duration of the Programme, with the majority of participants across all nine domains reporting a small to medium increase in effectiveness and sizable minorities reporting larger improvements.

Case studies showed that the course was seen to have strengthened existing leadership practices or confirmed that these were in line with best practice, emphasising the need for participants in the Programme to have a sufficient base-level of practice.

Key drivers of the positive improvements in individual leadership practice were identified as being related to **confidence; self-reflection,** being able to form a more **strategic view;** and being able to **ground leadership practice in theory / evidence.**

Career progression too was explored. A majority of survey participants reported that they had changed roles since they started the Programme: three quarters of these had moved into more senior roles and/or with increased responsibility. Those who had not moved roles expressed that the Programme has given them the confidence to apply for new roles, and/or that they felt in a better position to be successful when choosing to make the next step.

While the Programme was seen to have had at least some role in developing leadership practices or on career progression, participants in the evaluation were unable or unwilling to attribute change to their participation in the Programme wholesale.

Team / service-level outcomes

Reported measures at the team and service-level also demonstrated perceived positive outcomes from the Programme. Participants in the survey identified a positive outcome across a range of prompted areas. The most positive outcome was identified in relation to **team morale**, **communication between teams**, and **connection between organisations**. Participants were less likely to report that the Programme had a positive impact on the **financial performance of their team and / or organisation.**

Positive team and service level outcomes were further supported during the case studies. Participants were able to state that better **self-awareness** and **improved communication skills** (both as a result of the Programme), had led to positive changes in the functioning of their teams more generally. A number of participants in the case studies were able to articulate clear examples of how they had been able to deploy skills and / or tools gained through their participation in the Programme to deliver a positive outcome on the **team’s morale**, **sense of shared vision, conflict resolution and engagement**. This was echoed in interviews with those working with and around them.

In turn, positive changes at the team-level were also seen to have knock-on impacts for service delivery, as teams that have greater morale, and are better engaged, were seen as being more likely to be productive and efficient.

There was also evidence, during case studies, that participants from Intakes One and Two of the Programme have been able to join-up services within their organisations, thus bringing about improved communication channels and closer working relationships between otherwise less connected areas.

In addition, participants also provided examples of ways in which they had delivered positive outcomes for service delivery, viewed as being both directly and indirectly resulting from their participation in the Programme.

Organisational outcomes

Evidence of wider impacts on the participants’ organisations was more limited, due to the longer timescale needed to realise these, and the level of seniority at which participants were operating. However, some positive examples, building on the same themes identified within the team and service-level outcomes were realised.

There were participants, during case studies, who were able to identify ways in which they might actively share learnings from the Programme with others, initially within the team, but also more widely across the organisations they worked in. This took the form in both informal and formal information sharing.

Some key factors that could further facilitate the embedding of learnings from the Programme across organisations were identified, in particular continued access to materials (e.g. those contained within the Virtual Campus).

System-level outcomes

Although beyond the scope of this evaluation to draw conclusions as to the realisation of system-level impacts, the positive evidence as to the realisation of most of the short and medium-term outcomes should be viewed as a positive sign. However, realisation of system-level impacts is dependent on a number of external factors beyond the control of the NHS Leadership Academy.

1. Introduction and background
2. Ipsos MORI was commissioned by the NHS Leadership Academy (‘the Academy’) in early 2016 to conduct an evaluation of the Elizabeth Garrett Anderson (EGA)\_Programme (‘the Programme’) for Intakes One and Two. This report presents the findings from the evaluation; focussing on an assessment of how far the Programme has gone in generating the desired outcomes for participants completing the Programme as part these intakes.
	1. Background and context

Several key changes or events in the health and social care sector provided the wider context or impetus for the development of the Programme. For example, the ‘Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[[2]](#footnote-3), by Sir Robert Francis QC, was seen as a turning point in how leadership in the NHS was perceived. Along with the Morecambe Bay investigation[[3]](#footnote-4), the Francis report highlighted a relationship between inadequate leadership, or certain models of leadership, and poor patient care.

Other evidence suggested that it is not simply that bad leadership leads to bad care, but that the converse is also true; high quality care can stem from good leadership. Indeed, the Care Quality Commission highlighted that 94% of services rated as good or outstanding overall by them were also rated highly in terms of leadership. [[4]](#footnote-5) As such, several reports across the health sector indicated that without better leaders, the NHS might not deliver fully on the three aspects of quality, as defined by Lord Darzi in 2008: patient safety, clinical effectiveness and the experience of patients[[5]](#footnote-6).

The NHS Leadership Review (2015)[[6]](#footnote-7) also further put leadership at the heart of not only making change happen, but embedding them in the long-term, reporting that while clinical innovation was important, *‘leadership is the key to making changes stick’*. This is particularly relevant in the context of the significant ongoing challenges being faced across the health and social care system at the moment. Including, the ‘efficiency challenge, through which the NHS has been tasked with finding £22bn of efficiency savings[[7]](#footnote-8) by 2020/21 to help meet a funding gap of £30bn, while at least maintaining the standards of care received by patients. In addition, all health and social care systems in England are currently in the process of producing multi-year Sustainability and Transformation Plans (STPs) which must *‘show how local services will evolve and become sustainable over the next five years.’[[8]](#footnote-9)* This is another example of where the system could benefit from strong and high-quality leadership to help ensure that the transformations required as part of these STPs are delivered as planned without undue disruption to the services received by patients and service users.

In light of a growing body of evidence, the NHS Leadership Academy was created with a clear mission to deliver excellent leadership across the NHS, ultimately to directly impact patient care[[9]](#footnote-10). Underpinning, much of the work of the Academy, – including the Programme, is the Healthcare Leadership Model (HLM)[[10]](#footnote-11). Therefore, the suite of courses offered by the Academy are underpinned by the nine domains of the HLM. All programmes have the aim of supporting leaders in improving patient care through an understanding of themselves and their staff. It is in this context that the Anderson Programme was designed for those working in a mid-career role aiming to make the progression into senior leadership roles.

Further information on the development of the HLM is presented in **Annex A.1.**

* 1. The Elizabeth Garrett Anderson Programme

The Elizabeth Garett Anderson (EGA) Programme (‘the Programme’), launched in October 2013, forms a part of the Academy’s portfolio of Leadership Development Programmes. Falling between the Mary Seacole and Nye Bevan programmes, it was originally aimed at developing NHS staff looking to take on a senior leadership role, leading teams in which members themselves lead their own teams or a role with significant responsibility such as coordinating national projects.

On completion of the programme, participants are awarded an MSc in Senior Healthcare Leadership in addition to the NHS Leadership Academy Award in Senior Healthcare Leadership, with all cohorts within Intake One having graduated in November 2015 and the final cohort in Intake Two graduating in March 2016.

* + 1. Aims and objectives
* The Anderson Programme Handbook[[11]](#footnote-12) outlines that the Programme aims to encourage those in mid-career roles to explore and understand how they, as leaders, can:
* Ensure that patients have good quality and safe experiences;
* Make a difference to improving care quality and the patient experience;
* Enable others to give their best to improve care quality and the patient experience;
* Make person-centred co-ordinated care happen;
* Make decisions based upon the best available evidence to improve care quality and the patient experience; and,
* Create value for patients and the public.
	+ 1. Governance, roles and responsibilities

The **NHS Leadership** **Academy** commissioned a single consortium to deliver both the EGA Programme and the Nye Bevan Programme.

The consortium is made up of three organisations: **KPMG** are the prime contractors, sub-contracting elements of design and delivery to both the **University of Birmingham** and the **University of Manchester.** Further information on the other organisations and stakeholder groups involved in the governance and delivery of the Programme can be found in **Annex A.2**.

* + 1. Content

In total, the Programme is made-up of **eight** separate modules[[12]](#footnote-13) – the content of which has been slightly adapted since Intakes One and Two. Nonetheless, the focus remains on three levels – **individual**, **staff** and **organisation** – with modules mainly targeted at one aspect or link.

In addition, there are two ‘golden threads’ running through the content of the course. The golden threads were for the Programme are[[13]](#footnote-14):

1. Patient experience and care quality; and
2. Equality and diversity.

Those stakeholders consulted at the outset of the evaluation highlighted that these threads run through all aspects of the Programme, including the content of the modules.

The process for the design of the course was an iterative one between partners, using shared expertise as the basis for the content. Each module is designed to achieve specific learning outcomes as outlined in the Programme Handbook. The rationale for the exact content of each module was not evidenced during the design phase of the Programme, but discussions during the familiarisation stage suggest that it is grounded in:

* Current leadership theories; and,
* The principles of good leadership practice – including behaviours, attitudes and skills – as also outlined in or underpinning the HLM.

The module content, as outlined in the Programme handbook, is detailed in **Annex A.3**.

* + 1. Participation

For Intakes One through Three, applications were managed through Local Delivery Partners (LDP). In total, the Academy received 1,431 individual applications at this stage, from which the final participants were identified.

The Programme was designed to be able to reach as many people at the mid-career point as possible, while maintaining small cohort groups and seeking to maximise contact time with the same tutor. As such, in general, each annual intake consists of around five to six cohorts of participants. The cohorts consist of around 48 participants, and each cohort is separated into tutor groups of 16 people – each with three tutors. There are four individual and five group tutorials throughout the Programme.

Each cohort is also split into Action Learning Sets (ALS) of eight people. The ALS meets 11 times during the course and each is led either by the set or a tutor.

Tutors are predominantly faculty and associates from the two universities, and have been throughout the Programme. All tutors receive the same training and induction, which include five days intensive training, normally received in groups of three.

* + 1. Theory of Change

Figure 1.1 overleaf represents the ‘Theory of Change’[[14]](#footnote-15) for the Programme, as developed in collaboration with NHS Leadership Academy, and key stakeholders in the Programme, during the scoping stages of this evaluation. This Theory of Change focuses exclusively on the Programme as it was designed and delivered for Intakes One and Two. A detailed explanation of the Theory of Change is provided in **Annex A.4**.

* + - 1. Elizabeth Garrett Anderson Programme – Theory of Change



* 1. Evaluation Scope and Objectives
		1. Programme outcomes

The overall objective of this evaluation was to explore the extent to which the Programme has led to the achievement of the desired outcomes, as set out in the Theory of Change, for participants in Intakes One and Two. As set out in the Theory of Change, the Programme was intended to generate outcomes at several levels, from that of the individual (short-term outcomes), to the health and social care system as a whole (long-term outcomes). The scope of the evaluation was restricted to exploring, as far as was possible, the realisation of the short- and medium-term outcomes detailed below.

* + - * 1. EGA Programme – Intended outcomes

|  |  |
| --- | --- |
| Short-term outcomes |  Medium-term outcomes |
| *Participants are…* |  |
| SO1: Better able to inspire a shared purpose in their team; | MO1: Teams/organisations share values, a vision and a purpose; |
| SO2: Better able to share their vision; | MO2: Teams/organisations are held accountable and improvements implemented based on evidence; |
| SO3: Better able to evaluate information; | MO3: Team members are valued, engaged and developed. Team capability improved. |
| SO4: Better able to hold teams and individuals to account; | MO4: Service is better connected at an organisational level; |
| SO5: Better able to lead with care; | MO5: Organisational relationships are built and maintained; and. |
| SO6: Better able to engage their team; | MO6: Participants are able to achieve career progression to leadership positions;  |
| SO7; Better able to develop individual and team capability; | MO7: Teams/organisations deliver an improved quality of care; |
| SO8: Better able to connect the service; and, | MO8: Teams/organisations deliver better patient outcomes;  |
| SO9: Better able to influence for results.  | MO9: Teams/organisations deliver improved patient experiences; and, |
|  | MO10: Teams/organisations deliver services with increased efficiency.  |

In addition, the scope of this evaluation is restricted to participants in Intakes One and Two due to the fact that these are the first intakes to complete the programme, and therefore the first group for whom the short and medium-term outcomes may be observable. This evaluation will also inform potential future evaluations for later intakes, or the Programme as a whole.

* 1. Evaluation Methodology
		1. Evaluation approach

The evaluation comprised four strands, as follows:

* **Inception and scoping:** This strand included a review of the relevant background documentation to the Programme, and consultations with key stakeholders. The output of this strand was an Evaluation Design Document which outlined the agreed scope of the evaluation, and the approach for undertaking the main evaluation phases.
* **Survey of participants:** An online, quantitative, census survey of Programme participants in Intakes One and Two was undertaken to gather self-reported measures of experience and perceived outcomes from participation in the Programme. A follow-up online quantitative survey of line managers, the contact details for which would be put forward by participants during the participant survey, was planned however due to the small number of participants who volunteered their line managers’ contact details, this was not deemed practical[[15]](#footnote-16).
* **Case studies:** A series of participant-centred case studies involving in-depth qualitative interviews with participants, line managers, direct reports and peers was conducted. In total **thirteen** case studies have been completed, and two remain in progress at the time of producing this initial report.
* **Interviews with Programme tutors:** Finally, in-depth qualitative interviews were conducted with **five** tutors responsible for leading the learning of participants in Intakes One and Two[[16]](#footnote-17).

The evidence generated across the streams of data collection has been triangulated in the production of this report. Further detail on the evaluation methodology is provided in the annexes to this report.

* + 1. Limitations of the evaluation evidence

There are some limitations with the evidence collected through this study, as detailed here.

* **The absence of a counterfactual / comparison group:** Options for identifying a comparison group were explored during the scoping phase of this evaluation, however this did not prove possible. As such, it is not possible to be certain whether, or to what extent, any of the changes measured would have happened in the absence of an individual participating in the Programme.
* **A lack of management information:** It had been intended that analysis of management information may be possible to monitor changes in individuals over time, and also monitor the performance of the services they deliver. During the scoping stage it was identified that there was no available source of management information that could be mapped across participants in order to measure team / service / organisational outcomes (e.g. Friends and Family Test (FFT) scores), due to the significant range of roles that participants fulfilled. In addition, efforts were made to access the 360o assessment data for participants, but access to this data, and to the tool used (to enable replication) was not possible due to confidentiality and rights concerns. While the case studies sought to identify additional management information, much of this proved to be anecdotal / self-reported rather than providing access to actual data.
* **Lack of a ‘before and after measure’:** Due to the timing of this evaluation, in that it was commissioned and designed sometime after the completion of the programme for Intakes One and Two, no baseline survey was possible hence the evaluation lacks a true measure of participants’ perceptions around their own leadership practices **before** they started the programme. In the absence of a counterfactual / comparison group, it would have been preferable if participants could have been surveyed before and afterwards, to assess any improvements or changes. As the next best substitute, questions were built-in to the online survey (and explored in more detail in the case studies), which retrospectively asked participants about their leadership practices before they had started the programme, and then at the time of completing the survey.
* **Small base sizes for the survey data:** While the online survey achieved a reasonably high response rate, considering the time that has passed since participants completed the Programme and the mode of data collection the data have not been weighted, and as such the survey findings should not be treated as representative of the views of participants overall, but only of those who took part in the evaluation survey.[[17]](#footnote-18) Further technical details of the survey are included in **Annex C.3.**

These limitations mean that it is not possible to firmly conclude what the **impact** of participation in the Programme has been for participants in Intakes One and Two, but this does not reduce the usefulness of the evaluation in identifying the areas in which it is likely the Programme has delivered impact. It is important to bear these limitations in mind when considering the findings and conclusions presented in this report.

* 1. Report Structure

The remainder of this report is structured as follows:

* **Chapter 2: Programme delivery:** Summary of findings from the in-programme evaluation work, exploration of findings from the survey of participants, case studies and tutor interviews in relation to the **delivery** of the Programme (application process, information, support).
* **Chapter 3: Programme outcomes:** Discussion of the extent to which **outcomes** have been realised for participants in Intakes One and Two, the existence of any evidence to underpin these and the role of the Programme, drawing upon data from the survey of participants, the case studies, and interviews with tutors. Outcomes are discussed at three levels: **individual participants**; **teams / services / organisations**, and **system**.
* **Chapter 4: Conclusions and recommendations:** Discussion of the extent to which the short and **medium-term outcomes** of the Programme have been, or are being, realised for Intakes One and Two, and the extent to which it seems likely that the longer-term outcomes will be realised. Recommendations on how the Programme might be adapted or improved in order to deliver enhanced outcomes or increase the likelihood of outcomes being realised, and on how the impact of the Programme might be more robustly measured going forward.
* **Report annexes:** A separate document presents further relevant background information to the Programme and the evaluation, as well as detailed findings from the survey and case studies.
1. Programme delivery

The Programme has been subject to ongoing “in-programme” evaluations, administered by the delivery consortium since its inception. The main purpose of these evaluations has been to feed into the continuous improvement of the Programme falling its launch. As such, in order to avoid duplication of data collection, the evaluation reported upon here did not seek to explore the areas of the Programme already covered through the in-programme evaluations. However, in order to provide context and further the understanding of the impacts of the Programme, a summary of the main findings as relevant to this evaluation, is presented in this section.

* 1. Learnings from review of in-programme evaluations
		1. Participant Numbers, Deferrals/Withdrawals and Attrition
1. Review of the in-programme evaluation reports provided by the Leadership Academy shows a total of 396 participants successfully completing the programme in Intakes One and Two. The latest reported attrition rates for these two intakes, stood at 6% and 10% respectively showing that a good number of those from Intakes One and Two who started the Programme completed it.[[18]](#footnote-19)
	* + 1. Participant split, Intakes One & Two

*Source: EGA In-programme evaluation June 2016*

Although gender figures are not reported at the intake level, the overall figures provided in the evaluation reports indicate that a total of 64% of initial participants were female whilst their corresponding attrition rate was noticeably lower at 57%. Figures relating to the ethnicity of participants are also not available at the intake level but are presented at an aggregate level with White British accounting for the majority of participants at 77%. Attrition rates across ethnicities were broadly similar to overall proportions of participants.[[19]](#footnote-20)

* + 1. Academic Outcomes

Table 2.1 outlines the academic outcomes for Intake One,[[20]](#footnote-21) illustrating the distribution of MSc awards handed out in the November 2015 exam board. Of the 165 participants awarded an MSc at this time, more than half were awarded a Merit, 26% Distinction and 17% a Pass.

* + - * 1. MSc Awards as of the November 2015 Exam Board

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Award
 | 1. Cohort 1
 | 1. Cohort 2
 | 1. Cohort 3
 | 1. Cohort 4
 | 1. Cohort 5
 | 1. Cohort 6
 | 1. All
 |
| Intake One |
| 1. Pass
 | 1. 10
 | 6 | 7 | 4 | 1 | N/A | 28 |
| 1. Merit
 | 1. 12
 | 26 | 20 | 17 | 19 | N/A | 94 |
| 1. Distinction
 | 1. 2
 | 7 | 5 | 18 | 11 | N/A | 43 |
| 1. Total
 | 1. **24**
 | **39** | **32** | **39** | **31** | **N/A** | **165** |
| Intake Two |
| 1. Pass
 | 1. 8
 | 3 | 6 | 3 | 4 | 6 | **30** |
| 1. Merit
 | 1. 15
 | 25 | 24 | 13 | 12 | 11 | **100** |
| 1. Distinction
 | 1. 10
 | 10 | 7 | 16 | 11 | 2 | **56** |
| 1. Total
 | 1. **33**
 | **38** | **37** | **32** | **27** | **19** | **186** |

*Source: EGA In-programme evaluation June 2016 & programme information, NHS Leadership Academy*

* + 1. Two Golden Threads & Four Leadership Principles
1. Within the in-programme evaluations measures of self-reported outcomes were collected through surveys completed at the end of each individual module or residential workshop.
2. The areas of impact explored through these metrics relate to the four key leadership principles cutting across all Leadership Academy programmes and the two Golden Threads (Patient experience and care quality; Equality and diversity) specific to the EGA programme, as outlined earlier in this report.[[21]](#footnote-22)
3. The aggregated data evidences a consistently high self-reported[[22]](#footnote-23) rating against the two Golden Threads, however across all reports prior to the latest available, the average percentage of respondents agreeing with the first Golden Thread was greater than the proportion agreeing with the second. Additionally, lower ratings against both threads are noticeable across Intakes 1-3 for Module 7 and it is suggested that this is as a result of the module being geared toward preparation for the dissertation and therefore less applied in nature.
4. When responses against the four key Leadership Principles are examined, ratings are again shown to be consistently high with an average of 95% of respondents in the latest period *agreeing* or *strongly agreeing* that they are better able to demonstrate the relevant module learning outcomes applicable to the module they had completed in that period. Ratings against academic learning were slightly more varied over the four categories and throughout the in-programme evaluation reports, however over the four categories[[23]](#footnote-24) in the latest report, on average 87% rated them favourably.
	* 1. Tutor and Module Support & Organisation
5. Throughout all reports, the satisfaction with tutor support amongst respondents remained high across all intakes throughout the modules detailed up to and within the June 2016 report. Module support and organisation ratings were found to be slightly lower on average and were particularly lower for modules seven and eight. This was attributed to the different nature of these modules encompassing the preparation for the dissertation and the dissertation itself respectively and the demanding volume of work within the given time constraints.
	* 1. Career Development and Promotion

At the final event for intake one, 158 respondents to a short survey self-reported on their career progression, as measured by promotion, since starting the Programme and were asked whether they could attribute such progression to the programme itself. Almost half of those who responded, 47%, reported being promoted during the course of the programme whilst the vast majority of those respondents attributed this to the programme, 96%. Career progression was explored in more detail as part of the survey and case study work undertaken as part of this evaluation.

* + 1. Individual Module outcomes

Information from the in-programme evaluations pertaining to the individual module outcomes are available for several of the modules undertaken by intakes one and two. Annex B collates the available data and illustrates a consistently high proportion of respondents likely to agree with the statements provided. However, it should be noted that scores for module seven are again noticeably lower than the average across all modules by intake. These scores are also self-reported and as a result may suffer from selection bias. Response rates for module surveys were found to decline over time as participants progress through the course.

* + 1. Virtual Campus & Residential Workshop Evaluations
1. The **Virtual Campus** was evaluated in terms of its content, accessibility and the usefulness of supporting guidance with a significant proportion *agreeing* or *strongly agreeing* that the content was **accessible**, **useful** and that the **support and guidance was good**.
2. **Residential Workshops** were evaluated specifically on their delivery/facilitation and relevance to both the programme and work as opposed to the outcomes resulting from them, however ratings for relevance of the residential to the programme were generally high for Residential Three for both Intakes One and Two, whilst relevance to work received a lower rating. Ratings from Intake Two for Residential Two were higher than the ratings of Residential Three across all criteria. Information is available for Residential Four, however the unique nature of this means it has been rated differently.
	1. Application and programme delivery

Throughout the survey and case study, this evaluation, the evaluation sought to understand experiences of key aspects of the application process and of the Programme delivery. While to a large extent this had been covered as part of the in-programme evaluation, further exploration of this was deemed relevant as these areas were identified as potentially affecting the realisation of outcomes.

* + 1. Quality of the application process

Overall, both the survey and the case study work showed there to be no substantial problems with the application process – although some participants had a harder task securing the backing of their organisation before signing-up. The concerns about the financial implications of drop-out are also important given that for participants in later intakes employers have been required to contribute towards the cost of tuition.

In particular, the **clarity of the process,** was rated as *good* or *very good* by two-thirds of survey participants. However, areas where there remains substantial room for improvement were identified, as highlighted in Figure 2.2. In particular, around one-third (31%) rated the **quality of support they received from their Local Delivery Partner** as *very or fairly poor.*  In addition, just over three-in-ten (30%), reported the same for the **quality of feedback received on their application**. Across all domains, substantial proportions did not have an opinion either way.

* + - 1. Ratings of quality of application process



Equally, participants in the case studies generally did not raise any issues with their experience of the Programme’s application process. However, the amount of support they received from their line managers and their **organisations / departments more generally** varied somewhat.

In some cases, while participants found their line managers to be supportive of their application for the Programme, their wider organisations had been less sure in their support. This was linked to concerns that organisations would be required to cover the tuition fees for the Programme should the participant drop out part way through.

Given the Programme was very much in its infancy for both Intakes One and Two, it is to be expected that some organisations were reported to be unsure or even sceptical of the benefits of the Programme.

"I had a bit of a job internally to make sure I could get my employer to sponsor it… …My immediate line manager was very supportive, but corporately across the business, I'm not sure that they were."

Participant, Non-clinical, NHS Funded Care, ID 100133

* + 1. Amount of information provided about the programme

As well as the **quality of information** provided, as discussed above, participants were surveyed as to the **amount of information** they had received about the Programme before applying. Experiences here were divided. While two in five (42%) did feel that the amount of information was ‘about right’, a small majority (55%) said that they were given *‘too little information’*, significantly almost a third (32%) *‘far too little’*. A perceived lack of information prior to the start of the Programme was also highlighted in the case studies – in terms of a lack of clarity about the Programme’s aims, detailed content, timeframes and required time commitments. The first three of these are likely to be related to the fact that the Programme was developing as it was being delivered, especially for the earliest cohorts in Intake One. However, a lack of clarity over the require time commitment, which was, according to participants in the case studies, often significantly more than the 10-15 hours per week advertised, is important to note. A misunderstanding of the required level of time commitment has the potential to negatively impact experiences of the Programme, and in turn impair the realisation of outcomes. This will be discussed later in this report.

* + - 1. Ratings of information provided during application process



Timings of application process

The majority of participants surveyed were positive about the time involved in the Programme application process. Eight in ten (83%) said that it took them ‘about the right amount’ of time to complete their application, and three quarters (75%) said the same in relation to the time taken to upload additional information. However, participants were somewhat less positive about the time it took to find out that they had been successful; one in four (25%) said it was too long, with six per cent feeling that this took ‘far too much time’. The only time-related criticisms to be raised by participants in the case studies relate to the amount of time it took to find out they had been successful, and when they would be starting.

* + - 1. Timing of application process

****

* + 1. Support

The level of support received during completion of the Programme was identified as being a likely driver of positive experience and outcome.

Survey participants were broadly positive about the support received during the Programme. In particular, support from **tutors** (95% said this was *very* or *fairly good*), **others on the programme** (92%), the **team** that they were leading at the time (78%) and the **Leadership Academy** overall (75%). There was less certainty regarding support from **peers**, **line** **managers** and **employer organisations**, with significant proportions rating this as *very* or *fairly poor* or as being *neither good nor poor*. It is to be expected that individuals would have differing experiences of being supported, and that beyond the support provided by tutors and the Leadership Academy itself this is somewhat out of the control of the Leadership Academy, beyond issuing guidance to employers and line managers as to how they might support participants. Support from the Local Delivery Partners received the lowest ratings in terms of quality of support.

Case study interviews highlighted that participants generally thought that they were well supported from their line managers and organisations before starting and during the Programme, but there was undoubtedly a wide range of experience in this regard. While support from line managers and other senior colleagues may have been more pastoral in nature, participants’ discussion of support from their organisation tended to focus on the amount of study leave they were allowed to utilise to undertake the work associated with the Programme, in addition to that required for attending residential sessions. As discussed later in this report, the amount of time that participants were allowed to dedicate towards their involvement in the Programme was seen as a significant determining factor in the outcomes they experienced.

The Programme has been built with a central role for the tutor, and feedback from one participant in particular reported that the support they had received from their tutor was crucial in delivering the outcomes they experienced, therefore the high-level of satisfaction with the support received is very positive.

“The tutor was above and beyond, I suspect they put 50 times the volume of contact that was mandated in, and it made a real difference. There needs to be more [tutor – participant] contact based on speaking to people with different tutors. I feel that outcome would have been very different without [the support from the tutor].”

Participant, Clinical, NHS Funded Care, 100068

Interviews with tutors also highlighted the importance of the tutor – participant relationship, with strong relationships characterised by, and built on, bidirectional **trust, openness and honesty.** Tutors also characterised their role as being one of **supporting** participants, facilitating their learning as part of a more adult-adult or peer-to-peer relationship rather than directing them in their learning.

* 1. Summary
* Survey and case study work did not identify any substantial issues with the application process. However, some areas for improvement were identified, mainly relating to provision of information. Challenges in securing organisational support and their link to financial implications of drop-out from the Programme are of relevance given the requirement for organisations to part-fund the participation of participants in later intakes.
* Some gaps in terms of provision of information prior to the start of the Programme, and timescales for application processing and starting the Programme were identified by participants and tutors. These largely appear to have related to the emergent nature of the Programme during its early stages, and will have become lesser issues as the Programme has developed.
* Participants reported being very well supported by tutors, both in the survey and the case studies, and it is clear that tutors have a central role to play in driving the experience of the Programme – and therefore ensuring that tutors are well-suited to the unique nature of the Programme is a key part of ensuring successful delivery, and in turn delivering the desired outcomes to participants. Tutor interviews also reflect the perceived importance of this role and the relationship.
1. Programme outcomes

This chapter focuses on exploring the extent to which the short- (individual-level) and medium-term (team / service / organisational-level) outcomes of the Programme have been realised in relation to participants in Intakes One and Two of the Programme. This chapter brings together evidence collected across the survey of participants, case study interviews, and in-depth interviews with tutors.

In the absence of a counterfactual or comparison group, the case study interviews sought to understand the extent to which any positive changes in leadership practice, or outcomes for the team, service or organisation, can be attributed to an individual’s participation in the Programme (i.e. it is not possible to say with certainty whether these things would have happened if an individual had not participated). However, it is important to note that many participants involved in the case studies worked at organisations going through substantial periods of transition (e.g. service redesign, integration) which affected their ability to be able to isolate the perceived outcome resulting from their participation in the Programme. In addition, given the range of roles that participants have across the health and social care system, and within their organisations, they are not always in a position to directly influence some aspects of service delivery (e.g. quality of patient care).

* 1. Individual-level outcomes

These are the effects the Programme is expected to have in the short-term, through the input, activities and outputs. The first ‘actor’ in this linkage is the individual programme participant, and therefore the short-term outcomes are based on the expected effects for the individual. Each outcome replicates an area of the nine domains of the HLM, and assumes participants will be better able to enact each as a direct result of participation in the Programme, and the leadership practices developed.

Overall, participants surveyed were overwhelmingly positive about the Programme, with almost nine in ten (87%) saying that they **would speak highly about the Programme[[24]](#footnote-25).** However, at 8%, the proportion of participants who would speak critically about the Programme is not insignificant, and supports findings from other areas of the survey suggesting that at this stage there is still room for it to be improved to both provide a better experience for participants and maximise the positive impact it can have on them and others working with them. The case studies highlighted that in some cases the positive experience exceeded expectations at the start of the Programme, with some participants being primarily motivated by the opportunity to gain a Masters-level qualification initially.

* + 1. Individual leadership practices

Participants in the online survey and the case studies were asked to think about nine leadership practices and consider their performance in these. Survey participants rated their personal effectiveness in each area from 1 (*not at all effective*) to 10 (*very effective*) both before and after their participation in the Programme[[25]](#footnote-26). Case study interviews with participants, their line managers and colleagues were designed to allow the evaluation team to explore perceptions around improvement in leadership practice in more depth and understand how any changes had occurred, as well as specific examples of behaviours and actions illustrating the change. Both the survey and case study work consistently found evidence of reported improvements in leadership practices overall.

Across all nine leadership practices, the mean rating participants gave themselves for their performance post-Programme was higher than the mean rating for performance prior to participation. The vast majority (95%) reported a positive change in their effectiveness in at least one area over the duration of the Programme. The area of greatest perceived improvement was *influencing for results,* for which the mean rating increased by 2.25 points over the duration of the Programme, from 5.6 to 7.85. *Connecting our service* (+2.17)*, sharing the vision* (+2.14)and *holding to account* (+2.1)were also seen as areas of greatest improvement.[[26]](#footnote-27)

* + - 1. Reported change in personal effectiveness



Further analysis revealed that these mean scores reflect the underlying response pattern, with the majority of participants (ranging from 55% to 67%) across all nine domains reporting **a small to medium increase in effectiveness** (1-3 points), and sizeable minorities reporting **larger improvements** (4 points or more) or **no improvement at all**. Only very few participants across all domains reported improvements of 5 points or more (which reflects the fact that particularly poor starting scores were unlikely among this group of Programme participants s).

Analysis of individual variance revealed that the majority of participants tended to report relatively consistent improvements across all nine leadership domains assessed – two thirds reported differences varying by up to 3 points pre- and post-Programme (where 3 is the difference between the largest and smallest reported change in effectiveness). Overall, these findings appear to point to an incremental change in overall self-reported leadership effectiveness which translates into largely consistent perceived improvement across all of the nine leadership domains. This is corroborated by findings from the case studies which are described in detail in the remainder of this section.

Overall, those interviewed unanimously thought that their participation in the Programme coincided with a notable improvement in their effectiveness as leaders, and these improvements were typically seen to be a result of participation in the Programme. Case studies explored the overall perceptions of an individual’s leadership before and after the Programme. Typically both the participants themselves, as well as those working with or around them interviewed as part of the case study, described improvements at the overall level rather than describing changes in individual practices. In many cases participants reported that the Programme had either **strengthened pre-existing leadership skills** that they possessed or that it had confirmed that **current leadership practices were in line with good practice**, contributing to the development of a sense of confidence in leadership ability, as discussed later in this chapter. This is expected as the Programme is addressed to mid-career managers with a pre-existing experience in leadership roles – rather than to lead to the development of new sets of leadership practices that participants did not have previously.

"I think it honed my skills, rather than develop a whole load of new skills if you see what I mean?"

Participant, Clinical, Non-NHS funded care, ID 100008

Similarly, line managers and direct reports tended to describe an overall improvement in a participant’s leadership, and often found it difficult to isolate this to any particular aspect(s) of leadership or any particular skill(s). This is to be expected given potential lack of familiarity with the specific leadership practices comprising the HLM.

***“I think there has been a change in the positive. They've always been a good manager but they now try to look at different ways of becoming more effective… …so they've always been good but now they seem to have more armoury to their arsenal, I can't really put my finger on it though.”***

Direct report, Clinical, NHS funded care, ID 100390

Tutors interviewed made the link between the values of the Programme and everyday practice, both during participation, but also following completion.

‘What [the EGA Programme] delivers is practical examples of how leaders and their teams can deliver against the nine dimensions [of the Healthcare Leadership Model]’

Tutor

In addition, Case studies attempted to explore leadership practices in detail with participants, building on their responses to the survey. Participants typically found self-assessing their leadership practices before the Programme quite challenging, which is understandable given the amount of time between the start of the Programme and the interview (in some cases, over three years). When probed around perceptions of improvement, or lack thereof, in individual leadership domains participants also found it quite difficult to unpick change in their own behaviour as leaders at such a level of granularity.

However, a number of very clear themes emerged in terms of what those taking part in case studies identified as the major direct effects of the Programme were for them personally. These themes in turn correlate with the observed improvements in all of the individual leadership domains looked at.

3.1.2 Key drivers of change in leadership practice

Where participants, or those working with or around them, in the case studies thought that they had improved as leaders, this was usually considered to be linked to improvements in the following areas, often thought to be directly related to participation in the Programme:

* improvements in **confidence**;
* **self-reflection**;
* taking a more **strategic / holistic view of** their service / organisation / the NHS; and,
* being able to **ground leadership practices in theory** and **evidence** (in particular the validation this gave to existing practices).

Some or all of these benefits were spontaneously mentioned by most participants and others when asked whether any changes leadership practice since the start of the Programme. When probed around changes in the individual leadership domains of the HLM, participants and others typically identified these themes as underpinning other, more specific changes in behaviour and leadership practice. For example, an improvement in confidence allowing someone to better their ability to connect the service.

Confidence

Throughout the case studies, one of the most commonly reported individual outcomes of the Programme was increased confidence, which in turn led to improvements in multiple areas. For example, participants reported that they were now able to communicate messages in a clearer, more concise manner, thereby improving their ability to **share the vision** effectively and secure buy-in within teams. Participants thought that this additional confidence had helped their decision making abilities, which was often linked to a recognition from others that they had completed the Programme and subsequently held a Masters in Healthcare Leadership. It was also often reported that participants were able to now pursue areas at work that they had previously wanted to but had previously been unsure in themselves about

"I feel like it's given me the confidence and ability to step back in situations which might be very difficult because I feel like I have now got this extra suit of armour.”

Participant, Clinical, NHS Funded Care, ID 100008

"For me, it's given me a lot more confidence in doing some of the things I wanted to do but also confidence in myself to innovate."

Participant, Non-clinical, ID 100390

Colleagues of those that have been through the Programme also noted a change in the confidence of participants since they have finished the course, as evidenced by the following examples.

"100% I can say that… …when I first met [participant], ok they were rather shy but now they come over very confident. They know what they want, which is fair play to him and they will go out of their way to help staff, patients and himself to get what they want. They're an excellent negotiator and they know what they like out of life and fair play to him.”

Direct report, Clinical, NHS Funded Care, ID 100226

"They've become confident in their ability to talk in larger situations and get their point of view across". "They was doing it before but not to the level they are now, and not as concisely or as informative as they are now"

Peer, Non-Clinical, NHS Funded Care, ID 100133

“[Participant has become] more of a leader and less of a manager.”

Direct report, Non-Clinical, NHS Funded Care, ID 100130

Likewise, the programme tutors also highlighted the sense of confidence that completing the Programme instilled in participants, particularly in dealing with change and managing teams through change, and to challenge more senior leaders within their organisations. Given the large-scale programmes of transformation that are currently underway, and likely to come in the near future, throughout the health and social care sector, this is clearly an important skillset for leaders in the sector to possess.

Self-reflection

Another way in which the Programme that was typically seen to have positively affected participants’ leadership was through encouraging and enabling self-reflection – the ability to examine your own style of leadership and understand how that comes across to others. Participants reported spending a lot of time during the course doing this and thought that the ability to be reflective had positively impacted on their work since finishing the Programme.

***“We did so much reflection - forced into it but in hindsight, that was exactly what I needed to do.”***

Participant, Clinical, NHS Funded Care, ID 100008

Participants reported that it had helped them to understand their own leadership better and adapt their leadership practices where required. It helped to improve abilities in **leading with care**, as participants better understood the impact of their actions on others. The self-reflection also helped participants to understand the different styles of others and appreciate why their colleagues and other people may act or react in certain ways, which helped to avoid or diffuse potentially difficult or conflict situations. There was some evidence that this led to a greater effectiveness in **engaging the team** and **developing capability** by being able to respond to and capitalise on this improved understanding of these differences within the team.

***"The course helped to understand me. My limitations, the complexities of leadership, the complexities of building a team and I think the confidence of the wider system you're operating in"***

*Participant, Non-Clinical, NHS-Funded care, ID 100133*

Line managers and colleagues of participants also recognised that the course had led to an increased focus on self-reflection amongst participants. Some of those interviewed viewed this as a beneficial effect that had improved firstly the participant’s ability to lead and secondly their personal relationships with the participant.

"There was a lot of self-reflection in there as well, which I think was good for them.”

Former line manager, Clinical, NHS Funded Care, ID 100039

"It gave them that opportunity and insight to stop and reflect on their own practice."

Peer, Clinical, NHS Funded Care, ID 100039

Tutors also reported, based on their discussions with participants, that the Programme had led to changes in the way in which participants engaged with their teams, in particular making the link with participants identifying a greater role for themselves in setting the vision for their team, and being able to improve morale. While itself a short-term outcome, this is also closely related to the realisation of some medium-term outcomes, as discussed in further detail later in this chapter.

“From what they [participants] have told me, it has fundamentally changed how they work with individuals.”

Tutor

Although most of the participants thought as though the self-reflection in the course had been beneficial for them as leaders, some did report that there was potentially too much emphasis placed on this. This brings the risk that participants begin to question every decision they make, as highlighted by one participant below, and also by some colleagues of participants.

“[There was] almost an implication that decision making and acceptance of decision making was being questioned all the time, and that was quite an uneasy thing to accept."

Participant, Non-clinical, NHS and Non-NHS Funded Care, ID 100376

Strategic / holistic view of the organisation/service/the NHS

Some participants also spoke about acquiring a more holistic, “bird’s eye” view of their service and their organisation within the healthcare system more generally and as a result of completing the Programme. This understanding centred around how people, roles and organisations fit together and an awareness of not only participant’s own organisations but how they fitted in within the NHS overall.

For example, one participant was described by their line manager as *'inward looking'* before the Programme and reported that the course, in their opinion, made them to start reflect on how the Trust fits into the wider context and the health economy more widely. The mix of participants from very different backgrounds and organisations within the health and social care sector was seen to have played a huge part in enabling participants to understand their own role and that of their organisation within the wider landscape. Having a networking group of their cohort members which can continue to serve as medium for facilitating knowledge-sharing and collaboration was also identified as contributing here.

**Case study Example 1**, below, demonstrates some of the positive outcomes that participation in the Programme can have in relation to connecting teams within organisations and the health service more generally.

1. **Case Study Example 1 (Non Clinical)**
2. **This participant manages a team of seven with a Programme Management and Transformation function. The team had always worked well together and relationships were positive, however the participant, and consequently the team that they led, were quite “*inward looking*” and rarely considered the rest of the organisation in objective setting nor the overall vision of the Trust. Awareness of the team and its role was perceived as low within the Trust, which was further challenged when a new CEO joined the Trust, during the participant’s time on the programme, who started to question individuals, their teams and roles.**

**By engaging with people from different backgrounds on the course and being encouraged to think about how health services connect, the participant started to look closer at how their team fits within the Trust, what the Trust is doing more generally and how it links into the wider health economy. This was something the participant had not previously done, because the service was quite separate to the rest of the Trust, so they had had to work hard to create and maintain links. The participant initiated work within their own team to involve them more in decisions, to set team objectives which were in line with the organisation’s, and to agree on a shared vision: also linked to the Trust’s. Module two especially helped the participant realise how much more they could be doing, which meant that they subsequently opened things up to the team so that the team could start shaping how they work and what the work consisted of. This part of the course gave the participant both the practical tools to engage the team, as well as the theoretical grounding to back up what they were doing. The participant also started to connect more with people across the rest of the organisation and do more work around how the team fitted into delivering the organisation’s vision.**

**Redefining the team’s role, objectives and vision and linking these more widely to the rest of the Trust has meant that the team are now clearer on how their work fits into the bigger picture and themselves feel more “*embedded*”.**

**Due to the proactive work of the participant following their time on the Programme and after utilising what they had learnt, taking a step back and thinking about the way the team fitted into and interacted with the rest of the organisation, there have been changes to the way that the team now reports, shares information and disseminates the results from the work that they are doing. Consequently, awareness of the team and what it does has increased, with some very positive feedback from others outside of the team on the information the team has been providing.**

**Evidence was also gathered which suggests that the participant’s drive to connect the service and be involved in more externally facing work, having been on the course, has led to improvements in Patient Outcomes. For example, the participant, and others interviewed, reported that they had lead a project which brought a patient transport service together with the emergency services. This scheme, which is now up and running, is for patients with certain conditions and in very specific circumstances, and involves a decision being taken around which service is sent to the scene. The scheme has benefitted patients as they are attended to quicker and it has also saved some lives using cardiac arrest.**

The participant is starting to do some work outside of the Trust too, for example by being a governor in another Acute Trust, and getting involved with some of the work of the Vanguards. Tutors also highlighted the importance of achieving a good mix of participants, in terms of personality and role, in order with one tutor describing it as follows:

“A powerful and effective mix… …the participants found this to be positive.”

Tutor

Despite this, there is clearly also a need for careful consideration of the mix of participants during the selection process, as tutors reported that, in hindsight, some participants in Intakes One and Two would have been better suited to other courses within the Leadership Academy’s stable. In particular, it was seen to be important that participants are able to cope with the intensity, academic rigour and level of focus on their own leadership that the Programme brings. While this may relate to the information provided to prospective participants ahead of, and during, the application process, tutors generally reported that the selection process had now improved to address this somewhat.

The ability to take a more strategic view of their personal role or the role of their team has a number of potential positive consequences. For example, this has helped participants in **connecting their service** as highlighted by the above case study.

However, an increased ability to think strategically was not universally reported across the case studies. One line manager commented that overall they thought it had been a very positive experience for the participant, they singled out strategic decision making, an area which would have expected to have been covered during the Programme, as an area that the participant would still need to work on in order to progress to a director-level role.

Closely linked to this, some participants also spoke about having an increased understanding of how their job role or the team they lead could contribute to **improving patient care** **and experience** which is an important step in enabling these participants to make positive contributions to the realisation of medium and long-term outcomes.

Theory-based leadership practices

A further positive outcome at the **individual-level** was also reported by participants to be the grounding of good and effective leadership practice in theory throughout the Programme. This relates closely to the development of **confidence** as the Programme served to help participants understand what good leadership practice was, and why certain techniques and approaches can be effective. While the practices discussed may well have been things that participants thought they were already doing, providing them with the evidence to substantiate the effectiveness of these practices helped to develop the confidence and conviction to follow through. This was viewed as a constructive way of developing skills, as opposed to a focus on poor leadership practice to avoid. Provision of theoretical models (such as the HLM, or the Barret Values-based Leadership model), amongst other things, were also seen as useful in enabling or supporting elements when implementing and embedding effective leadership practice as part of participants’ daily work.

***"You got more tools on the course to help you to [lead] in a controlled and focused way, whereas I kind of just winged it before"***

Participant, Clinical, NHS Funded Care, ID 100039

Differences across participant type

Participants in the case studies came from a wide range of roles within the NHS, and while their experiences of the Programme are likely to be affected by this to some extent, the variety makes it difficult to identify any consistent patterns within the qualitative data. However, there is some evidence to suggest that the Programme has slightly different benefits for those in clinical and non-clinical roles. In particular, for those in non-clinical roles identified the elements of the Programme focussing on patient experience as particularly useful in helping them to understand how they could contribute to impacting upon patients as part of their work.

3.1.3 Attribution of positive change to Programme

Participants in the survey who reported a positive change in their effectiveness in one or more aspects of their leadership practice were asked to what extent they considered this a result of their participation in the Programme. The majority (94 out of 97 individuals) considered the change in leadership practice to be at least *partly* influenced by their participation in the Programme, 10 individuals attributed the change *entirely* to the Programme, and 60 said that this was *mainly* the case.

The survey findings are supported by the qualitative research. Participants in the case studies recognised that participating in the Programme had helped them to develop these leadership practices, but typically they were not able to attribute this solely to their participation, but rather that the positive changes experienced were also partially the result of their ongoing development as leaders. Indeed, the very fact that participants had actively sought-out a leadership programme is evidence of their awareness of the importance of developing strong leadership practices, regardless of their motivations.

"I don't think you can attribute anything entirely to the Programme... …you'd be foolish to do that."

Participant, Non-clinical, NHS Funded Care, ID 100240

"[The EGA] reinforced that some, if not all of my behaviours are suitable or congruent with me being a good leader… …in general, it kind of made me reflect and think."

Participant, Non-clinical, NHS and Non-NHS Funded Care, ID 100376

This was echoed by the line managers and peers interviewed – many stressed that the respective participant already had good (or reasonably good) leadership qualities before the course, but the Programme helped reinforce these and further develop them. Some stressed that in order to benefit from the course, participants required a willingness and commitment to continuous learning and self-improvement.

Career progression

The Theory of Change for the Programme identifies *career progression to leadership positions* as a medium-term outcome at the individual-level. Therefore, progression to new roles within the timeframes of the evaluation should be seen as one indicator of a positive outcome. However, some participants may have recently progressed into new leadership roles before embarking upon the Programme, and would therefore not be expected to have already further progressed during or since their participation.

A majority (61%) of survey participants reported that they had changed role since they started the Programme. Of those who reported a change in role (62 individuals), three quarters (47 individuals) reported that their new role was **more senior**, with the remaining 15 individuals having maintained the same level of seniority after changing roles.

* + - 1. Reported career progression



The vast majority (58 individuals, out of 62) reported having increased responsibility in one or more of areas of work[[27]](#footnote-28). In particular, more than eight in ten (53 individuals) said they now had greater responsibility for service delivery, while three quarters (47 individuals) had increased responsibility for quality of care. Participants surveyed reported a consistent number of **direct reports** pre and post participation, but the mean number of **indirect reports** had reportedly increased from 110 to 140.

In the case studies, both participants and their colleagues were vocal about the impact of the Programme on their careers. The fact that the Programme resulted in the award of an MSc qualification was often cited as a reason for this, as well as increased confidence to make the next career move. Most of the participants interviewed had moved organisations since beginning the EGA Programme, and those that hadn’t had typically moved roles or had been given more responsibilities in existing roles

Some participants in the qualitative research had applied for new roles but had not been successful. Even where this was the case, they viewed the Programme as having been helpful in terms of the application process for new roles, or making them more likely to be successful when applying for new roles.

"I haven't got a new job but I feel like I'm in a better position."

Participant, Clinical, NHS Funded Care, ID 100039

Line managers and other colleagues were also able to identify the impact of the Programme on participants’ careers. In one case a new senior leadership role was now being actively developed with the participant in mind.

"It's enabled him to move from the clinical area to a general manager with quite some ease."

Line manager, Non-clinical, NHS and Non-NHS Funded Care, ID 100376

"Had they got this job promotion, they'd have gone two bands higher in pay grade…now that they've got that confidence… …I think they'll be more open minded and broad minded to think 'what's next'?"

Former line manager, Clinical, NHS Funded Care, ID 100039

***"Before the Programme,* [the participant] *didn't really have a team or lead a team… …since then they've become a bit more involved in managing some other people… …in the future they're going to take on managing quite a big team"***

*Peer, Non-Clinical, NHS Funded Care, ID 100133*

* 1. Team, service and organisational-level outcomes

Before longer-term system-level outcomes are realised the Theory of Change assumes that effects will be felt at the staff and organisation level. These medium term outcomes are a direct result of the nine short-term outcomes realised by the individual, and again are based on the nine domains of the HLM.

The realisation of positive outcomes for individuals discussed thus far highlight the clear potential for positive outcomes at a team, service and organisational-level to be observed. Here, we consider each of these levels in turn – using detailed examples drawn from the case studies to highlight the ways in which the Programme is seen as having contributed to these outcomes.

* + 1. Outcomes for teams, services and organisation

In the absence of objective measures, generated through management information, through which to measure the outcomes for teams, services and organisations, it was necessary to rely on self-reported measures gathered from participants in the survey and case studies. The survey collected a range of measures relating to the perceived outcomes of participation in the Programme upon participants’ teams and organisations: the **morale of their team**; **communication between their own and other teams** within their **organisation**; **connection between their own and other organisations**; **outcomes**, **experience** and **quality of care for patients**; and the **financial efficiency of their team** and **organisation**.

Participants perceived a positive outcome across the majority of these areas – in particular in relation to **team morale** (81% said this was *very* or *fairly positive*), **communication between teams** (78%) and **connection between organisations** (74%). Around seven in ten also thought the Programme had positively impacted **quality of care** and **patient experience** (both 70%), and on **outcomes for patients** (68%). However, participants were less likely to report a positive impact for the **financial performance of their team and/or organisation**[[28]](#footnote-29).

* + - 1. Outcomes for team, services and organisation



The case study interviews further explored this by asking participants, their line managers, peers and direct reports to identify changes in the performance of the **teams**, **service** and **organisations** and sought to understand the role of the Programme in generating these changes.

Team outcomes

In line with the survey results, the case studies provided some evidence that better self-awareness and improved communication skills, as a result of the Programme, had led to positive outcomes on the functioning of the participant’s teams more generally. For example, some direct reports mentioned an improvement in the frequency as well as quality of one-on-one catch ups with participants who manage them. Some also thought that the participant appeared to attach more importance to their wellbeing and were better at making sure that members of the team were listened to and their input into decision making sought and valued. There was also evidence of an improved ability to manage difficult personalities and resolve conflicts within the team, which improved relationships between other members of the team where conflicts had occurred.

Some participants also identified practical ideas and improvements they had implemented since taking part in the Programme, some of which were reported too by those working with or around them, for example team building exercises or workshops around functional/dysfunctional teams which seemed to be directly derived from learnings from Module Two of the Programme. A small number of participants had introduced or reinstated 360 assessments within their teams following the positive impact that these were seen to have had on them during the Programme.

***"I brought back team-building* [from the Programme]*, so one of the people I manage has been running team building days with staff - and that's been really successful and the feedback's really good"***

Former line manager, Clinical, NHS Funded Care, ID 100039

The detailed example from one participant below illustrates the improvements to the functioning of the team that they reported having brought about utilising skills and tools gained during the Programme. This case is closely related to a number of the Programme’s medium-term outcomes, primarily: *teams / organisation share values, a vision and a purpose; team members are valued, engaged and developed. Team capability improved.* This case also highlights the potential positive consequences for the performance of the team and service in terms of perceptions of efficiency and quality of care.

Case Study Example 2 (Clinical)

Having moved into a new role, this participant found themselves leading a team with low morale and feeling isolated from the senior leadership team within the organisation and from various other related issues. As a result, the team had a relatively high rate of long-term sickness with stress-related conditions.

The participant drew-upon some of the leadership tools they had been given as part of their participation in the Programme to seek to identify the cause of these issues and address them. In particular, the participant organised a workshop with the members of the team focussing on learnings from the Team Journey, and Barrett Values-based Leadership approach. The workshop explored the organisation’s values, their own personal values, and their application to work, to understand the inter-relation and alignment of the organisation’s values and their own values. As a result, the team became more closely-knit. As well as providing the specific tools to help with this exercise, this participant also cited the Programme has having given them the *courage* to undertake this exercise with a new team.

The main direct impact was cited as being the contribution this exercise made to the productivity of the team. As a consequence of this there have been a number of tangible benefits, measured through specific performance metrics as outlined below:

A. Since the participant has taken over the team, sickness absence rate has decreased, now one of the lowest levels of staff turnover within the whole organisation. In addition, whereas they previously had one of the lowest levels of completion for appraisals and mandatory training, they are now meeting all of their targets.

B. There have also been demonstrable improvements in a number of hard metrics related to quality of service / patient care:

I. Staff Friends and Family Test (FFT)[[29]](#footnote-30): Improvements from c.50% of staff *recommending as a place to work*, slightly more *recommending in terms of treatment and care*, to 98% and c.85% respectively in the most recent survey.

ii. Their most recent CQC inspection saw all domains the team is involved in receive an “Outstanding” rating, cited as being a marked improvement on previous ratings.

As discussed earlier, some participants worked within organisations undergoing significant structural reorganisation and change. While it is impossible to disentangle changes resulting from the individual’s participation in the Programme from the wider background noise of change, it is apparent that participation in the Programme positively equipped participants with the skills to better manage a service or team going through significant change. Successful change management can be as important as instigating the changes themselves.

***"They certainly have affected change using their management skills… …I think with regards to restructuring of the clinical administration team…and with regards to their working relationships with the consultants, I think they manage that very well as well"***

*Line manager, Non-Clinical, NHS and Non NHS-Funded care, ID 100376*

Service / organisational-level outcomes

It is not always possible to differentiate between the impact participation in the Programme has had on their team from the outcomes for their service – while some participants were responsible for a whole service-stream, others were responsible for a team that delivered a small part of a wider service. However, it is possible to identify examples of outcomes across three areas: **organisational relationships, service delivery,** and **wider organisational outcomes**.

**Outcomes for organisational relationships**

Throughout the case studies, there was evidence that participants in the Programme have been able to join-up services within their organisation, and to bring about improved communication and closer working relationships between their own teams and other parts of their organisations. An example of this is provided in **Case Study 3** later in this chapter. This example, as well as the quotations below, provide evidence of the link between improved working relationships and other service / organisational-level outcomes (e.g. efficiency and quality of care), both through the involvement of their team directly, but also through improved information-sharing. In some cases, this was also related to an ability of the participant to think more strategically and therefore represent their team / service better in higher-level conversations and make positive contributions, for example in developing new service offers.

***"How their part of the service interacts with others has definitely improved"***

*Line manager, Non-Clinical, ID 100352*

***"They is much better now at saying technically this piece of work isn't down to my team but my team could take it forward, and that will benefit patients - why don't we offer to do it".***

*Direct report, Non-Clinical, ID 100352*

**Outcomes for service delivery**

Many participants were in roles that enabled them to impact directly upon service delivery through their leadership. As the examples described here shows, the potential for impact on service delivery (*improved quality of care; better patient outcomes* and *improved patient experiences)* stem from the team / organisation outcomes discussed already.

Case Study Example 3 (Non-Clinical)

This participant had been in their current role as head of service for a team of Allied Health Professionals for 5+ years prior to commencing the Programme, and the division has been through a number of changes recently, making it difficult to distinguish the effect of the Programme.

However, one of the main areas that this participant has had a direct impact in is the way their team is represented within the organisational changes that have been taking place over recent years. The participant has played a central role in reducing the professional boundaries between AHPs and clinical practitioners within their Trust – which the participant’s line manager attributed to the confidence to try new things that had been gained through the Programme. Improved integration across the service has led to new approaches to flexible resourcing, which was cited as having saved c.20 bed days over a very small number of patients, and eliminated the waiting list for one element of the service. This has positive efficiency / cost benefits for the organisation, but also positive outcomes for patient experience / outcomes / quality of care.

While it is not possible to attribute this solely to participation in the Programme, it is clear that it has been an important contributory factor.

Beyond this, there was also some evidence of the Programme helping participants to think more about how their service is delivered, and how to monitor delivery to enable continuous improvement. This in part is linked to the focus on self-reflection in leadership practices outlined earlier, but also to an increased focus on holding teams / services to account and using evidence to monitor delivery. While by no means universal, this was evident in the way participants were able to provide evidence of the impact they had been able to make to their service, setting clear objectives that can be monitored on an ongoing basis. **Case Study Example 4** below highlights the effect that improved use of information can have on a service.

1. **Case Study Example 4 (Non-Clinical)**

**At the end of the Programme, this participant moved between a clinical role at one organisation into a non-clinical management role at a new organisation. In their new role, colleagues use a clinical system to record information, make assessments, and create action sheets for patients. Part of this system involved clinicians making requests for services for their patients on paper. This participant saw an opportunity to develop an electronic system to do this which would be simpler for clinicians to use, which would ultimately benefit patients.**

**The participant initially approached other members of staff and suggested the development of a system to generate electronic requests, to replace the existing paper-based system. They were at first met with scepticism as others thought that this would involve a lot of work, and they were unsure of the potential rewards of doing this. However, the participant used what they had learned from the Programme to try to see others’ points of view and understand why they were against the idea. They used what they had learned to influence their team and sell their vision, and managed to convince them that the concept was a good idea. Soon afterwards the organisation developed an electronic replacement for the paper system.**

**Improving this clinical system has had an immediate effect on the participant’s colleagues. Clinicians are now more efficient and save time by completing requests using the online system rather than on paper. Having seen the success this system, the staff who were initially reluctant to aid this development are now eager to help the participant innovate further; they are now more open to ideas to improve.**

Furthermore, **Case Study Example 5** below highlights the tangible effect that the increase in confidence in leadership, that was cited by most participants in the case study work, can have on service delivery.

1. Case Study Example 5 (Clinical)
2. A particular service within the division that the participant had recently started heading was running very inefficiently, with a growing waiting list of over 1,000 patients - way above guidelines and what was manageable within the available resource. The participant was regarded as a talented manager before the Programme, but sometimes lacked confidence to assume firm leadership when dealing with complex, difficult situations.

As noted by themselves and their line manager, the Programme contributed to an improvement in confidence and self-belief as a leader, as well as their ability to engage people within and outside the team to work together effectively. When the problem with the service was identified, they recognised that a service redesign had potential to significantly improve performance and confidently assumed leadership of the exercise. A comprehensive risk assessment was undertaken short-term measures put in place to reduce the waiting as quickly as possible, resulting in it being cleared within 4 months with all patients being seen and validated. A long-term plan was then put in place involving changing the skill mix, working practices, and ultimately improving the pathway.

The direct impact of this exercise is a drastic improvement in efficiency of the service -patients of are seen much more quickly and the waiting list was reduced from over 1,000 to under 30 patients. Furthermore, the service redesign exercise is likely to have led to an estimated saving in the region of £70,000 (with the total service budget before the redesign of about £200,000).

There was also a reported increased patient-focus within the teams of some Participants from Intakes One and Two, related to the Programme’s focus on patient experience, and understanding their perspective. For example, one participant has implemented a team of volunteers across their directorate to go out and collect patient stories / experience examples from the wards, an approach that has subsequently been adopted across the organisation as a whole.

However, despite these positive examples and cases, some participants did caution that in their case it was too early to identify any outcomes for service delivery arising from their participation in the Programme.

**Wider outcomes at organisational-level**

Among those interviewed from intakes One and Two, only a very small number of staff within individual organisations had been through the Programme. Given this, and the mid-level leadership roles within organisations that participants typically fulfil, evidence of organisation-wide outcomes arising from involvement with the Programme was found to be limited, as would be expected.

"I think we're too early to see that yet [impact on organisation more widely], but as they settle into the associate director role, I think that's where you'll see [the participant’s] influence".

Former line manager, Clinical, NHS-Funded care, ID 100039

**Case Study Example 6** below highlights one example of the way in which a participant in the Programme was having a wider influence across their organisation as a result of the improved leadership practices they developed during the Programme.

1. **Case Study Example 6 (Clinical)**
2. **This participant has worked in their clinical field for a long time and is well respected for their experience by their colleagues. However, both their and their colleagues thought that their leadership style could be quite reactionary, spontaneous, and not well planned, which could cause stressful situations. This in turn placed tensions on their working relationships with some of their colleagues.**

**Through self-reflection undertaken as part of the Programme, the participant became aware of potential improvements to their leadership style and how their current approach may impact on others. They learned tools as part of the Programme that help them to change their style to leading in a more thoughtful and focused way, thinking carefully about their actions and planning decisions. Having this forethought and considered approach improved their ability to communicate with their colleagues, as they were involving them in decision-making rather than simply reacting to any issues that arise.**

**Changing their style of leadership had a positive impact on the participant’s ability to communicate, which in turn improved working relationships within the trust. The people that they directly manage thought that the participant was now happier and calmer in their work since completing the Programme, which had a beneficial impact on their working relationships.**

**The participant’s new style of considered, reflective leadership has also had an impact on working relationships more widely within the trust; since completing the Programme, the participant has been instrumental in bringing together two previously separate teams and improving communications between them. The participant is now also making more contributions to senior meetings.**

However, a number of participants were able to identify that other colleagues across their organisations were currently going through the Programme, or other NHS LA leadership programmes appropriate to their level of seniority. It was also recognised that until a greater volume of staff had been through the Programme, organisation-level outcomes would be unlikely to be realised. To ensure that a sufficient volume of NHS staff apply for the Programme, it is important that key decision makers within organisations are motivated to support applications from appropriate members of their staff. The change, following Intakes One and Two, to mean that employers would have to contribute to the cost of a place on the Programme has had a reported mixed impact amongst those employers included within the case studies here. There is a split between those who would now be less likely to support applications from employees now there is a financial cost associated, while others said that they would still support applications, but would be more selective over which employees they put forward.

In addition, some participants were able to identify ways in which they might actively share learnings from the Programme with other colleagues, initially within the team, but it would be hoped that this would have some spill over effects to other areas of the organisation. This took the form of both informal and formal sharing as illustrated below.

***"I did use to do presentations back to the team on what I was learning, and obviously they went on the Team Journey with me. I just think we have all grown and become more sophisticated. Our performance has always been good, but it has become better and we can evidence that now, and that's where we have become more sophisticated."***

Participant, Non-Clinical, NHS Funded Care, ID 100130

***"So lots of the tools and things we used on the course, you know, dealing with difficult people, the team building… …I talk to a lot of people about it"***

*Participant, Clinical, NHS-Funded care, ID 100039*

If it is intended that participants in the Programme are able to disseminate learnings to other peers across their organisations, and indeed colleagues within other organisations, to expand the reach of the positive outcomes of the Programme, it is important that participants are able to make ongoing use of the teaching materials used as part of the Programme. Tutors, and one participant, did raise the lack of ongoing access to the Virtual Campus, which was identified as being a very powerful resource, as something that may constrain the outcomes here both at an individual and wider level, given the wealth of material contained within the course.

“Materials on the virtual campus are so good; it is a good resource that people did not always have time to make the best use of”

Tutor.

* 1. System level outcomes

The Theory of Change assumes that if its short- and -medium-term outcomes are realised, they should lead to benefits for the health and social care system as a whole (long-term outcomes). The ultimate beneficiaries of the Programme are the patients: in the medium-term it is expected that individual organisations will realise these patient level outcomes, with patients across the NHS, and indeed the whole health and social care system, feeling the benefits in the long-term.

Because this evaluation is constrained to Intakes One and Two and the realisation of these long-term benefits relies on a critical mass of leaders progressing through the Programme, the scope of the evaluation was restricted to exploring, as far as was possible, the realisation of the short- and medium-term outcomes (as discussed earlier in this chapter).

The evaluation team have nevertheless considered the available evidence provided by the case studies and were able to identify some early signs of the ways in which the desired long-term outcomes may be generated beyond individuals and their respective teams / services / organisations.

Early evidence of system-wide outcomes

The increase in confidence extends to relationships not just within, but also outside of participants’ own organisations – there is some limited evidence of participants being more outspoken (i.e. likely to challenge existing practices/put forward ideas) in situations when speaking at wider forums, such as conferences or workshops, or of being involved in other wider initiatives (such as the New Models of Care programme[[30]](#footnote-31)).

Several participants were, at the time of this evaluation, leading major service redesign / transformation projects within their organisations, and there is some reported evidence of improved effectiveness in managing change as a result of completing the Programme. While this does not provide direct evidence of system-wide outcomes yet, in the current NHS landscape (for example STPs), having a cohort of leaders capable of skilful and effective management of change will be crucial, especially the effective involvement of clinical leadership, as argued by the Roffey Park Institute[[31]](#footnote-32).

It is clear that there will be different potential ways in which an individual’s participation in the Programme may contribute longer term to wider system outcomes, and this will vary by type of organisation they work in and the role it plays in the wider system. For example, there is a significant representation of CCGs among Intakes 1 and 2 participants, and there is some evidence from case studies with these type of participants that they are better able to tackle poorly performing practices.

* 1. Summary

Individual leadership practices

* Participants in Intakes One and Two who took part in the evaluation were very positive about their experiences, and would speak positively about the programme to others. In some cases, experiences exceeded initial expectations.
* This positive experience was also manifested in the increased leadership effectiveness that participants thought they had gained during the course of the Programme – with positive change evident across all nine domains of the Healthcare Leadership Model. Case studies showed that the course was seen to have **strengthened** **existing leadership practices or confirmed that these were in line with best practice**, emphasising the need for participants in the Programme to have a sufficient base-level of practice.
* Key drivers of the positive improvements in individual leadership practice were identified as being related to **confidence; self-reflection,** being able to form a more **strategic view;** and being able to **ground leadership practice in theory / evidence.**
* While the Programme was seen to have had at least some role in developing leadership practices or on career progression, participants in the evaluation were unable or unwilling to attribute change to their participation in the Programme wholesale.

Team / service-level outcomes

* Reported measures at the team and service-level also demonstrated perceived positive outcomes from the Programme. Participants in the survey identified a positive outcome across a range of prompted areas. The most positive outcome was identified in relation to **team morale**, **communication between teams**, and **connection between organisations**. Participants were less likely to report that the Programme had a positive impact on the **financial performance of their team and / or organisation.**
* In particular, a number of participants in the case studies were able to articulate clear examples of how they had been able to deploy skills and / or tools gained through their participation in the Programme to deliver a positive outcome on the team’s morale, sense of shared vision, and engagement.
* In turn, positive changes in at the team-level were also seen to have knock-on effects for service delivery, as teams that have greater morale, and are better engaged, were seen as being more likely to be productive and efficient.
* In addition, participants also provided examples of ways in which they had delivered positive outcomes for service delivery, viewed as being both directly and indirectly resulting from their participation in the Programme.

Organisational outcomes

* Evidence of wider outcomes for the participants’ organisations was more limited, due to the longer timescale needed to realise these, and the level of seniority at which participants were operating. However, some positive examples, building on the same themes identified within the team and service-level outcomes were realised.
* Some key factors that could further facilitate the embedding of learnings from the Programme across organisations were identified, in particular continued access to materials (e.g. those contained within the Virtual Campus).

System-level outcomes

* Although beyond the scope of this evaluation to draw conclusions as to the realisation of system-level outcomes, the positive evidence as to the realisation of most of the short and medium-term outcomes should be viewed as a positive sign. However, realisation of system-level outcomes is dependent on a number of external factors beyond the control of the NHS Leadership Academy.
1. Conclusions and Recommendations
	1. Conclusions

Isolating the outcomes of the Programme against the background noise of wider initiatives and changes across the NHS is extremely challenging. The absence of a counterfactual or comparison group, or a body of objective data against which to assess the impact of leadership, precludes a robust assessment of the of the impact of the Programme for participants in Intakes One and Two. However, the evidence gathered throughout this evaluation allows an assessment of the extent to which the desired **short-term,** and to a lesser extent the **medium-term outcomes,** of the Programme have been achieved, and an early exploration of the achievement of the **long-term outcomes**.

* One of the primary aims of the Programme is to contribute to the development of a **large-pool of people with improved leadership skills** across **mid-career and more senior leadership positions in the NHS**. It is anticipated that the creation of a cadre of skilled leaders within the NHS will contribute to the generation of **positive outcomes for the teams, services, organisations they lead**. In turn this should benefit the NHS as a whole, and ultimately help the NHS to deliver high-quality patient care, improve patient outcomes, patient experience, and more efficiently.
* Outcomes **across the nine HLM domains** were all identified by participants involved in the evaluation as having been subject to improvements during the EGA Programme. Given the importance attached to the HLM in **underpinning good leadership across the NHS**, and in delivering the short, medium and long-term outcomes of the Programme this should be viewed very positively.
* Case study participants typically reported that the improvements in their leadership practices were at least partly resulting from their participation in the Programme. The perceived contribution of the Programme to developing these leadership practices and skills was often viewed more as **an enabling factor making an important contribution to honing or reconfirming leadership skills**, but not solely responsible for these changes. This in part stems from difficulties participants have in isolating the impact of the Programme, but also because of the nature of participants, all being ambitious mid-career managers who saw themselves as possessing relatively strong leadership abilities to begin with (as evidenced by the assessment of existing leadership practice in the survey). This was also, but not always a view held by line managers, direct reports and others interviewed as part of the case studies.
* Beyond the leadership practice outcomes, participation in the Programme was reported as having **contributed to development of participants as leaders in at least four other ways**, all of which participants described as contributing to enhancing their ability to positively influence their team, service delivery, and to a lesser extent, their organisation.
	+ Increased confidence
	+ Self-reflection
	+ Ability to think strategically
	+ Grounding of leadership in theory
* While comprehensive evidence of the extent to which the team / service-level short and medium-term outcomes have been realised is not present, the survey work highlighted that this was perceived to be the case across many of the outcomes of interest for the Programme.
* The case studies also proved important in providing clear examples of how participants had been able to utilise, both directly and indirectly, the skills and tools gained through the Programme to **generate positive outcomes for their teams, services, and patients**. Examples include evidence of delivering better patient experience and / or outcomes (e.g. reduced length of hospital stay), as well as outcomes that would generate financial or other efficiency savings for the organisation (e.g. reduction in waiting-lists).
* Given the relatively limited time that has lapsed since participation in the Programme, the limited number of participants per organisation, and the longer timeframes over which organisational changes would be expected to occur, evidence of organisational-level outcomes being realised is more limited in this evaluation.
* Based on the evidence in this evaluation, it is apparent that participation in the Programme has a positive effect on the leadership abilities of those who participated in the evaluation, in the ways intended in the Theory of Change. This in turn provides evidence that the Programme is progressing towards its overall aim of developing the abilities of those leaders within the NHS who participate in the Programme.
	1. Recommendations

Enhancing realisation of outcomes

While the Programme was generally reported to be successfully delivering upon its aims, it has also been possible to identify a number of areas in which the Programme could be further refined to improve its ability to deliver the intended outcomes. Some of the changes made to the Programme since Intakes One and Two participated may have addressed these issues.

* While the application and selection process appears to have generally worked well, a couple of areas of improvement can be identified:
	+ **Level / accuracy of information about the time requirement** of the Programme. Participants in case studies seemed to find that completing the relevant learning tasks and assignments took a greater amount of time than anticipated. While this does not appear to have had any significant adverse consequences for those interviewed, those involved did often comment that knowing what they know about the level of work involved, they would be cautious when it came to recommending the course, either in terms of the types of people they may / may not recommend it to, or more generally. Therefore, working to ensure potential participants have a greater clarity over the volume of time they will be expected to commit to participation would be beneficial.
	+ Similarly, participants involved in the case studies generally received only a **small amount of study leave from their organisations** and largely had to utilise their own free time, if any. It is appreciated that due to the level of seniority of participants, and staffing pressures within the NHS, releasing members from staff for significant amounts of time to complete the Programme is unlikely to be feasible. However, communicating with line managers and employers as to the value of even a small amount of study leave, and other ways participants can be supported, may have a positive effect.
* Participants and tutors gave very positive reports as to the breadth of materials made available within the **Virtual Campus**. However, it is clear that some participants did not have the time during the Programme to make the best use of the materials beyond those directly relevant to each module / assignment / residential workshop. Providing longer-term access to some or all of the content on the Virtual Campus would likely help in two ways:
	+ Allowing participants to engage in ongoing learning and development, revisiting key elements of the Programme.
	+ Allow participants to share learnings from the Programme with their peers and other colleagues, potentially extending the reach of the Programme’s outcomes.
* It was also occasionally noted that a more formal alumni programme would be beneficial to those who have completed the Programme, in order to facilitate continued networks and shared learnings.
* Realisation of the outcomes at system level will depend on the Programme successfully delivering outcomes at an individual-level and a sufficient volume of participants taking part in the Programme. However, based on the evidence collected as part of this evaluation it is not possible to say whether an increased throughput through the Programme would be beneficial in achieving this or would compromise the ability of the Programme to deliver upon its aims. However, successful promotion of the Programme is essential, especially given that employer organisations post-Intakes One and Two must part-fund participation in the Programme. Promotion could focus on the benefits to participants, and their organisations, beyond the acquisition of a Masters qualification.

Future evaluation options

This evaluation has focussed on understanding the outcomes experienced by those participants in Intakes One and Two. It is anticipated that NHS LA will commission future evaluations of later intakes, or of the Programme as a whole. Fundamental to successfully measuring the impact of the Programme overall would be the following:

* + **Collecting / identifying baseline data** – establishing baseline data (for example through 360 assessments for individual outcomes, or monitoring information at a service/organisation-level) using measures that could be readily repeated during and following completion of the Programme would allow. Working with Programme participants to identify suitable metrics through which to measure the impact of the Programme on their service and organisation.
	+ **Identify comparison group** – Identifying a suitable comparison or control group, along with the collection of longitudinal data, would help to provide a more robust basis upon which to assess the impact of the Programme. A variety of options were explored during the scoping of this evaluation, which while they were not feasible at this stage, may be possible for future stages. For example, for Intakes One and Two, the volume of participants who did not complete the Programme was not deemed sufficient to allow inclusion in the evaluation. If the Programme were to be evaluated at the overall level, then the volume of ‘drop-outs’ may provide a sufficiently robust sample size to allow a completer vs. non-completer evaluation approach. Other possible approaches would be comparing the outcomes delivered for participants in different intakes. Both of these approaches depend on being able to generate sufficient quantitative evidence. It may also be possible to consider approaches such as those involving constructing synthetic control groups.

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1. Tutors interviewed had all been tutors for multiple cohorts within Intakes One and Two, but were not necessarily tutors of those who participated in case studies. [↑](#footnote-ref-2)
2. [http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report](http://webarchive.nationalarchives.gov.uk/20150407084003/http%3A//www.midstaffspublicinquiry.com/report) [↑](#footnote-ref-3)
3. <https://www.gov.uk/government/publications/morecambe-bay-investigation-report> [↑](#footnote-ref-4)
4. http://www.cqc.org.uk/sites/default/files/20151221\_cqc\_state\_of\_care\_report\_web\_accessible.pdf [↑](#footnote-ref-5)
5. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf> [↑](#footnote-ref-6)
6. https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/445738/Lord\_Rose\_NHS\_Report\_acc.pdf [↑](#footnote-ref-7)
7. <http://www.nuffieldtrust.org.uk/our-work/projects/state-nhs-finances-and-%C2%A322bn-efficiency-challenge> (accessed 22 December 2015). [↑](#footnote-ref-8)
8. <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/> [↑](#footnote-ref-9)
9. http://www.leadershipacademy.nhs.uk/about/ [↑](#footnote-ref-10)
10. http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/ [↑](#footnote-ref-11)
11. <http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/nhsla/anderson-programme-handbook.pdf> [↑](#footnote-ref-12)
12. Content for Intake Three onwards have been adapted slightly but the focus nonetheless remains the same. [↑](#footnote-ref-13)
13. As outlined in the Conceptual Framework Document for the Programme. [↑](#footnote-ref-14)
14. A Theory of Change outlines how and why a desired change(s) is expected to come about, identifying the causal links between the design of a programme / intervention, the intended change, and the outcomes / impacts of this change. A Theory of Change is usually presented in diagrammatic form, accompanied by a detailed descriptive write-up. [↑](#footnote-ref-15)
15. Contact details for only 20 line mangers were provided via the online survey. Taking into account the fact that not all of these would have responded, it was decided that we would not carry out a quantitative survey of line mangers but instead ensure that their views were prioritised as part of the case studies. [↑](#footnote-ref-16)
16. Tutors interviewed had all been tutors for multiple cohorts and were not necessarily tutors of those who participated in case studies. [↑](#footnote-ref-17)
17. Participants were also surveyed on an ongoing basis as part of the in-programme evaluations, which is likely to have affected response rates to the survey conducted as part of this evaluation. [↑](#footnote-ref-18)
18. The contractual definition of the attrition rate excludes participants that fall into certain categories including those withdrawing/deferring as a result illness, bereavement, acute family illness, change in professional circumstances, pressure of personal circumstances/adverse personal circumstances or deceased. [↑](#footnote-ref-19)
19. Figures correct as of the evaluation report presented to the EGA Programme Board on the 21st June 2016 [↑](#footnote-ref-20)
20. The number of awards granted here may not represent the final total for intake one as several participants had outstanding submissions or extenuating circumstances in the latest information available. Intake two data will be included if this is available. [↑](#footnote-ref-21)
21. N.B. This information is, on the whole, presented at an aggregated level across the intakes completing surveys within each period preceding the drafting of the report and therefore it is not possible to report findings restricted to intakes one and two. [↑](#footnote-ref-22)
22. Participants were asked to self-report to what extent they thought that they were better able to demonstrate the mind-sets and behaviours specified in the golden threads, namely ‘I and my team remain constantly in tune with how the quality of care provided to patients, matches what we would want for the people we love most’ and ‘the way in which I and my team understand equality and diversity, and implement this proactively in our leadership of healthcare’. [↑](#footnote-ref-23)
23. Increased understanding of the subject, intellectual stimulation, effectiveness of education methods and clarity of assessment criteria. [↑](#footnote-ref-24)
24. 63% reported that they would speak highly about the Programme without being asked. [↑](#footnote-ref-25)
25. N.B. All participants were surveyed after they had completed the Programme, and therefore were asked to retrospectively assess their perceived level of performance against the nine domains of the HLM at the time of their application for the Programme. There is, therefore, some risk that participants were unable to accurately recall how effective they were in each of these areas when more than three years could have passed since their initial application. [↑](#footnote-ref-26)
26. N.B. Due to the relatively small sample sizes differences in mean scores across the leadership practices are not statistically significant and should be treated as indicative only. [↑](#footnote-ref-27)
27. Financial performance, service delivery, patient experience, quality of care, patient outcomes. [↑](#footnote-ref-28)
28. 52% reported a positive impact on their team’s financial efficiency; 32% reported that the Programme had positively impacted upon their organisation’s financial efficiency. [↑](#footnote-ref-29)
29. <https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/> [↑](#footnote-ref-30)
30. <https://www.england.nhs.uk/ourwork/new-care-models/> [↑](#footnote-ref-31)
31. What makes successful change in the NHS, Roffey Park Institute, July 2012, <http://www.nhsiq.nhs.uk/media/2612249/what-make-change-successful-nhs-south-england-report.pdf> [↑](#footnote-ref-32)