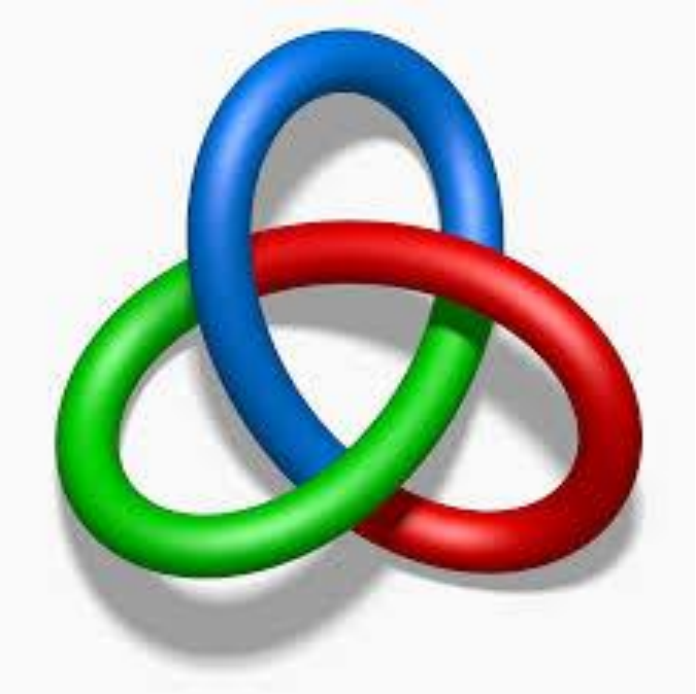
The Leadership Development Evaluation Framework

Developing evidence based interventions and creating a learning culture



'Triple Loop Learning –
Learning about how we learn'

Acknowledgements

The Leadership Development Evaluation and Research Group The (LeaDER Group) is a group of leadership development practitioners and academics working for and with the NHS Leadership Academy and its Local Delivery Partners. Thanks go to this group of dedicated and passionate people for their work on developing this framework and their continued support in creating a step change in the use, creation and development of an evidence base for leadership development in the NHS.

Paul O'Neill
Director – East Midlands Leadership Academy
Chair of the LeaDER group

Contents

Section 1: A common framework for evaluation

1. Purpose

Each year, our Leadership Development Partner (LDP) Network and the NHS Leadership Academy is responsible for supporting the development of thousands of NHS leaders, through either national or local bespoke, interventions.

However, the evaluation of these development interventions is too often an after-thought when programmes are designed. This makes the assessment of our collective impact difficult, and wastes valuable opportunities to share learning across our LDP Network.

By adopting a common approach, we can help LDPs make evaluation a standard and routine component of any intervention, and ensure that collective learning improves patient care through enhanced leadership.

This guidance note sets out such a common evaluation framework. It is a first attempt at co-ordinating our approach across LDPs and the NHS Leadership Academy. It is designed to be a 'living' document and open to development. It does not seek to impose a narrow or restrictive approach to evaluation practice, but rather provide a framework within which we can ensure collective learning.

2. Core Principles at the heart of the evaluation framework

The Evaluation Framework has been developed with reference to academic theory and best practice, which underpins the core principles:

i. **Any effective evaluation method needs to strike the right balance of quantitative and qualitative approaches.** Evaluation approaches are broadly of two forms: quantitative and qualitative. Quantitative methods, if used alone, which can be tempting as they are usually the more obvious ways of measuring, can risk only valuing those outcomes which we can quantify. Qualitative methods in contrast, are narrative or descriptive and provide a richer and deeper understanding although will usually take more planning and resource to deploy. To ensure that the benefits of each approach are realised a mix of the two is often best whilst balancing both the time and resource required for the evaluation with a proper exploration of the interventions effects, which may operate over long time frames.

ii. **The focus of our evaluation approach should be on formative evaluation** as opposed to summative assessment. That is, creating a feedback cycle which encourages us to learn and improve through experience over time rather than a 'pass or fail' approach.

iii. **Evaluation methods should cover the individual's state of readiness, and the level of support from their employer.** Evidence to date (including Hay 2011[1]) informs us that it is not only the delegate and quality of an intervention that has an effect on the impact but also the state of

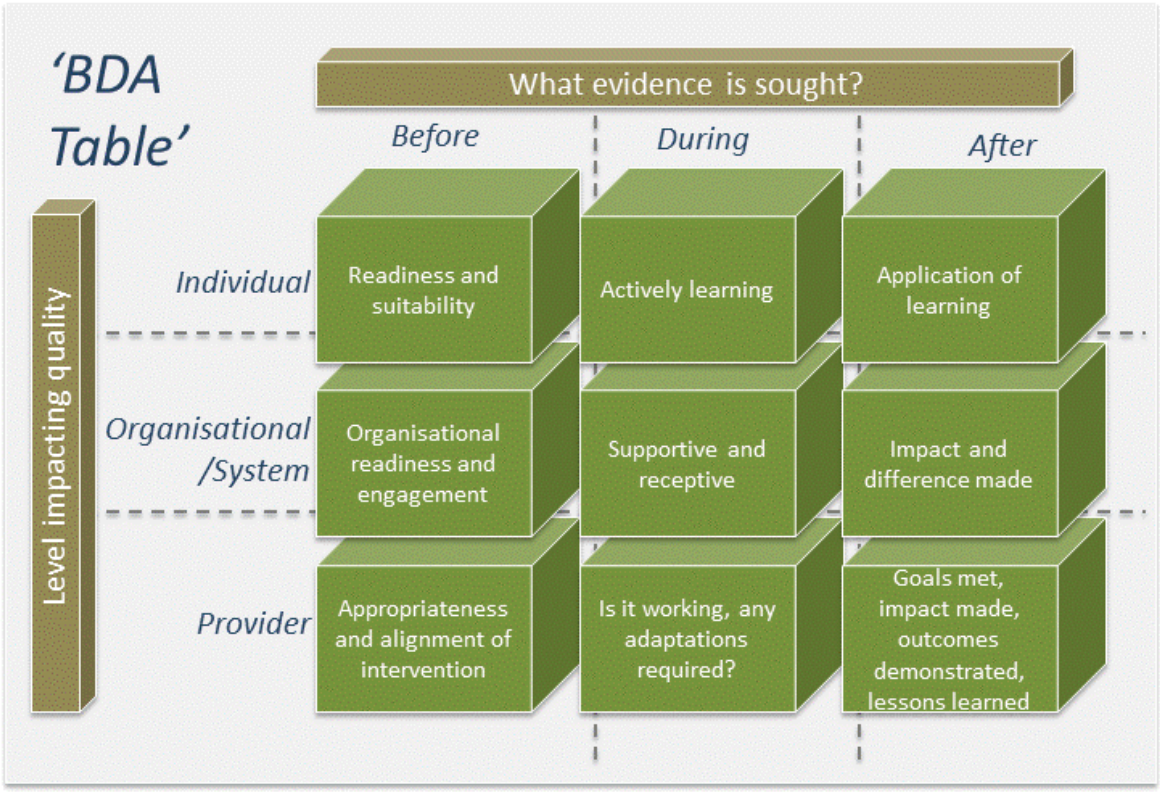
[1] Hay Group 2011 – Develop your leaders, The Rewards of Leadership Development

readiness to learn by the individual and the support provided to the individual by their organisation/sponsor.

iv. **Evaluation methods should, extend to cover post intervention learning.** We know, that most learning occurs in the workplace when new ideas or concepts are applied (North West Leadership Academy/Ashton Business School 2015[2]).

These principles therefore, encourage practitioners to think about the two intersecting dimensions they describe, that is: the level impacting the quality of the programme, be that the individual participant, their employing organisation or system, or the provider of the intervention; and at three time related stages, before (B), during (D), and after (A) the intervention has taken place. Figure 1 expands upon this – called the 'BDA' Table for short.

Figure 1. The 'BDA' Table



3. Using the Evaluation Framework

The full Evaluation Framework and process is laid out in Figure 2. It is broken down into three stages. Each of these stages is supported by a pro forma template, which can be found in Section 3.

Stage 1. Evaluation Planning

The Framework starts by requiring practitioners to think about the context (why is the intervention being made), what is going to be done, what 'theory of change' is being hypothecated, what changes

[2] North West leadership Academy/Ashton Business School 2015 – Beyond the 10% - Effective Leadership Development in Healthcare

are predicted and what evidence (before during and after) the intervention is there to support the hypothesis.

It is essentially a process of ensuring the right goals are being pursued, and then evidencing (or otherwise) whether these goals have been achieved. This applies 'theory of change' thinking to leadership development activities (Short - 2015[3]).

Stage 2. Evidence Gathering

At this Stage, the practitioner is encouraged to build on the Evaluation Plan and develop a list of evidence to be gathered before, during and after the development intervention. The detailed prompt questions in Section 2 can be used in conjunction with the pro forma in Section 3 to help with this process.

In summary:

i. **Before:** The overall aim at this stage is to ensure the intervention is the right one, its aims and goals are clearly articulated, that the benefits to participants and others are identified and that there is support and commitment to the intervention. The rationale for this as part of the evaluation framework is that the best and most effective interventions are those which are well planned and executed, timely, meet system and organisation objectives and the likely benefits are stated providing a datum or benchmark from which the effectiveness of the intervention can later be measured – i.e. has the intervention achieved the goals stated at this stage?

ii. **During:** The overall aim at this stage is to ensure any useful evidence/impact is being gathered. That the intervention, or rather the perceived benefits of the intervention, is being applied in the workplace/in practice. That significant others, apart from direct participants, are engaged in supporting the intervention to have its full effect. That evidence of 'early wins' is being collated and verified.

iii. **After:** The overall aim at this stage is to gather post-intervention data/information. This is likely to be where most benefits accrue and traditionally least time and effort is put into capturing it. Medium and longer-term benefits should be considered and tracked.

It is important to be pragmatic and proportionate in the evaluation of any intervention to the scale and size of the intervention – the BDA tables and questions to be used is a menu to be considered and chosen wisely from, not a comprehensive checklist to be followed doggedly in all situations.

Stage 3. Evaluation Report

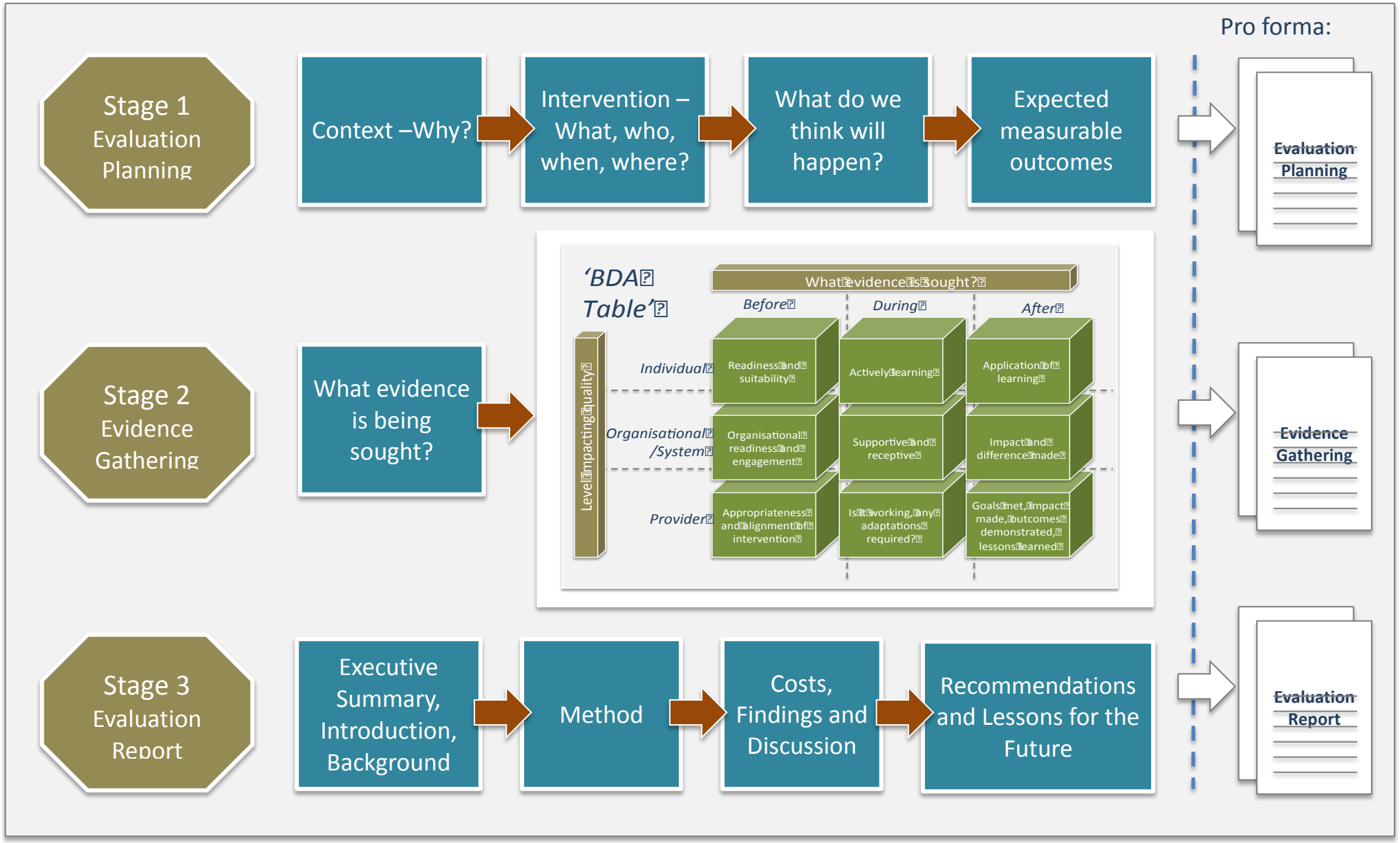
The reporting pro forma in Section 3, is designed to be used consistently across the LDP Network. The ambition is to create a library of these reports so that any practitioner can in the future, before designing a new development intervention, look back over the lessons learned by previous programmes. The Evaluation Report follows guidance published by The Health Foundation[4] in 2015 and is a straightforward design, it includes: Executive Summary, Introduction and Background;

[3] Short Lyndsay (2015) "Commissioning and Service Redesign- East Midlands Leadership Academy: Service Transformation Evaluation "Executive MBA Module assignment. University of Nottingham. – Unpublished – *also see end notes*

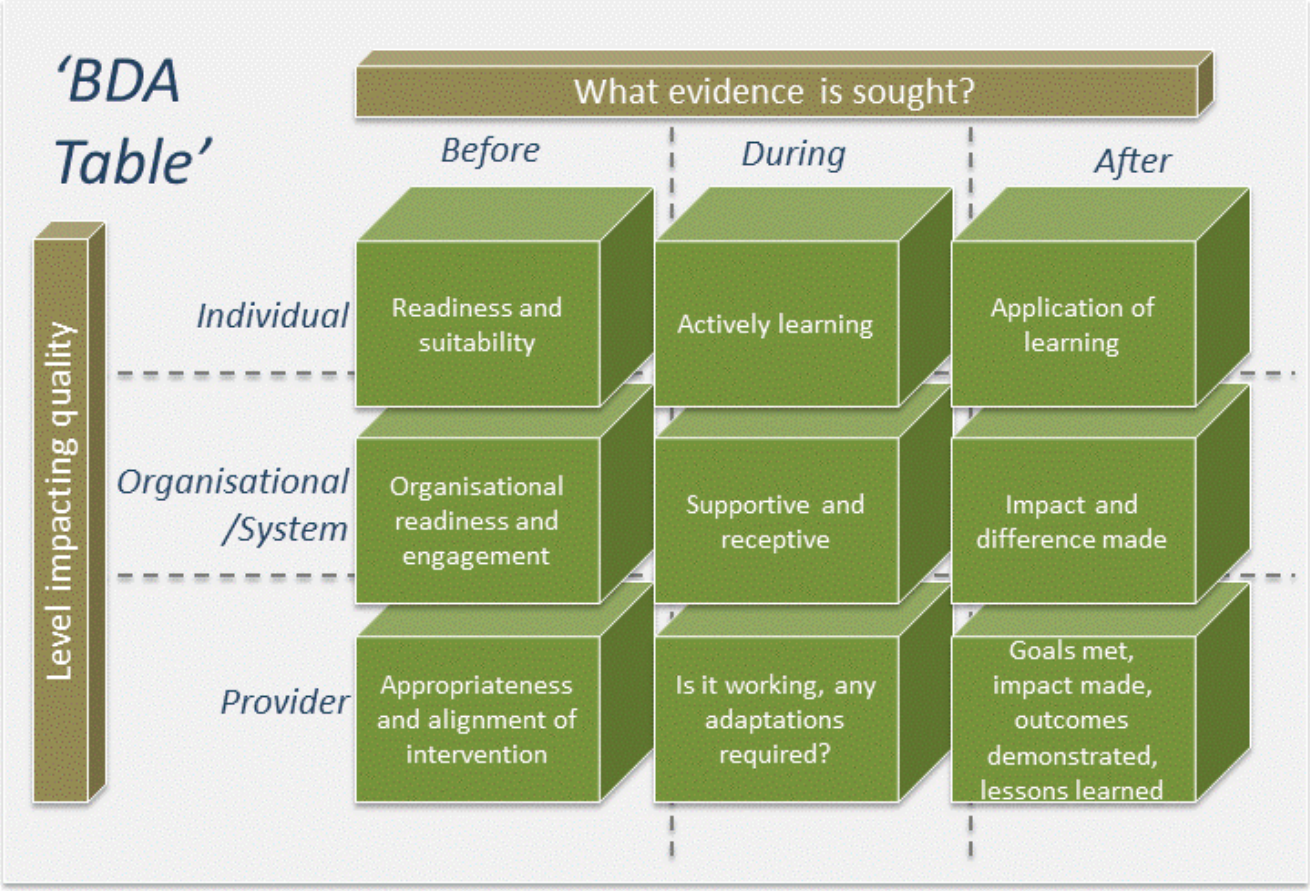
[4] The Health Foundation 2015- Evaluation: What to Consider

Method; Findings and Discussion; Recommendations and Lessons for the Future. Often, practitioners will seek feedback on interventions from participants and present the raw statistics and graphs as an evaluation. The intention of these Evaluation Reports is to ensure we draw the full insight and lessons out in a format that is easy for others to access.

Figure 2. The Evaluation Framework



Section 2: The ‘Before, During, After (BDA) Table’ prompt questions



The following pages provide a series of prompting questions to consider at each stage (Before, During and After the intervention) at each level, (Individual, Organisation/System, Provider).

There are many questions to use as a guide, practitioners will need to judge how important these questions are and therefore the associated evidence that might be gathered for the scale and context of the planned intervention.

Practitioners do not need to use every question, nor provide every piece of evidence. They are encouraged however to think about providing some evidence in each of the above areas, or at least be clear why no evidence is being sought in that particular area.

In terms of following up post-intervention, the ‘After’ phase, it is suggested that for short term interventions (e.g. a one day conference) any follow up would be within 2-4 weeks, and for longer interventions, e.g. a programme lasting several days spread out over several months, any follow-up activity takes place around 8-12 weeks after the intervention has concluded. It may be appropriate for some follow-up (e.g. career tracking) be carried out 12months+ but this would form an addendum to the original report rather than waiting this length of time before writing and sharing the main body of the report.

What evidence is sought? - BEFORE

WHO	QUESTIONS:	OUTPUTS might include…
THE INDIVIDUAL **(e.g. individual manager, leader, clinician, delegate, participant who receives the development intervention)**	• Is this development right for me at this time? • Have I got the support of my organisation? • What do I want to get out of this development? • What I can contribute/what do I bring? • In what ways am I looking to improve my leadership style, thoughts, feelings and behaviours? • How might it help patients, me, my team, my organisation?	• An application form /process making the case for the benefits of the intervention to the individual, organisation, patients. • Approval from the employing organisation including a commitment to provide support. • Health Care Leadership Model feedback with identified areas of development. • Statements from self/peers/others about how they are experienced by those 'on the receiving end of me' • An assessment process with developmental feedback especially to those who were unsuccessful. • Some clear goals that the individual is hoping to achieve which articulate the benefits to them and their organisation, patients and carers. • A description of what the individual may contribute and the experience they bring to the learning environment.
THE ORGANISATION/SYSTEM **(e.g. Trust, CCG, other health and social care organisation, group of organisations, 'the system')**	• Have we got talent management processes in place to identify the right individuals who are most ready for this intervention? • Can we articulate the likely benefits to the organisation/patients of this intervention? • Have we effectively marketed this opportunity to the right target audience and created the conditions which will support those involved? • Are we clear how we will support the intervention and those involved to maximise their learning during and after the intervention? • What kind of cultural change are we hoping for, what is the culture like now and how do we hope it might change?	• A talent management process with 'ready now' candidates identifiable. • A narrative which is able to articulate the benefits of the intervention to the organisation. • Some clear goals/expectations that the changes which are likely to be possible as a consequence of the intervention. • Evidence of effective communications to all relevant personnel from which the right candidates are identified to benefit from the intervention. • A statement of commitment to support those involved during the intervention and how any new learning will be incorporated and applied. • How team/organisational culture is now and what do we want leaders to do and be like to impact positively on the organisational culture.

WHO	QUESTIONS:	OUTPUTS might include…
THE PROVIDERS **(e.g. the commissioners, providers, deliverers of the intervention)**	• Are we clear why we are offering this particular intervention at this time? • Is this a priority intervention for our health economy? • Is there support/sign up/demand for this in our health economy? • Can we articulate the reasons for doing this and its likely benefits to the target audience/organisations/patients? • Can we describe the features of the intervention and more importantly its benefits? • What are our beliefs about how this intervention will impact on an organisation's and system's culture and performance? • What type of change the organisations participating in this intervention hoping it will achieve, what type of 'hard' and 'soft' measures would be success for them? • Have we got credible people / team to deliver it? • Is this or a similar intervention being carried out by another LDP around this time – does this provide any potential opportunities to evaluate or work collaboratively or do any form of comparative analysis? • Is this part of a wider programme of change, and if so are there any interdependencies that need to be considered? • If this is a commissioned intervention what elements of the evaluation are we building into the contract?	• A document which describes the offer, its likely benefits, its aims and content /form of intervention. • Evidence of demand/drivers/relative priority- that answers the question Why this? Why now? • Process materials about who this is right for, any criteria that need to be met by the individuals/supporting organisations (see above). • Descriptions of culture now, and hoped for in the future • Statement of OD aims ie how might the organisation improve as a consequence of this intervention. • A description demonstrating the credibility of those involved in its delivery. • A joint statement from two different providers explaining how they will compare and contrast findings, work together or deliberately do things differently (changing variables) to ascertain any possible impact. • Links with other interventions explained and how these will be considered separately and together. • Contracts between commissioners/providers of the intervention reflecting who is doing what in terms of evaluation.

What evidence is sought? - DURING

WHO	QUESTIONS:	OUTPUTS might include…
THE INDIVIDUAL **(e.g. individual manager, leader, clinician, delegate, participant who receives the development intervention)**	• Have I committed to the intervention, completed any pre-work or diagnostics? • Am I engaged with the intervention, trying out new ways of thinking, understanding, behaving? • Am I giving my full attention to my learning and the development of others involved? • Am I putting into practice what I am learning? • Have I completed all assignments/diagnostics I am being asked to do? • How am I feeling about how this intervention is going, do I believe it will make a positive difference?	• Completed diagnostics/pre-work • Attendance at face-to-face sessions, participation on virtual sessions, progress through leaning materials. • Feedback from colleagues about new behaviours. • Completed assignments successfully • Evidence of learning from any diagnostics taken • Part-way feedback from individuals about what they think of the intervention so far and how are they feeling about it?
THE ORGANISATION/SYSTEM **(e.g. Trust, CCG, other health and social care organisation, group of organisations, 'the system')**	• Are we supporting any individuals involved in the intervention? • Are we allowing/encouraging new ways of thinking to impact how we do things? • Are we providing the right kind and new opportunities for those involved to practise their new found skills and maximise the impact on our work?	• 1:1s with sponsors/line managers and participants to develop plans to apply learning / new assignments • Examples of projects/initiatives undertaken and completed as part of the intervention • Examples of applied learning, new ways of working/feeling/thinking/behaving • Descriptions of how participants are showing different leadership styles and the way this is being received by others

WHO	QUESTIONS:	OUTPUTS might include…
THE PROVIDERS **(e.g. the commissioners, providers, deliverers of the intervention)**	• Have we got a plan for individual diagnostics to be collated/aggregated? • How will we ensure we capture individuals' and groups' progress and present it? How are we going to gather reports of changed/improved behaviour that are wider than just self-reports? • Are we in touch with other agencies who we have agreed a joint approach with to ascertain their experience/data to date?	• Aggregate 'scores' of diagnostics eg before and after Health Care Leadership Model 360s • Case studies/examples of ideas into practice • Reports/data of attendance, completed courses/assignments • Summary of Kirkpatrick level 1 and 2 feedback. • Testimonials from sponsors/line managers as well as participants in changes in behaviour seen. • Comparing and contrasting information exchange with other agencies • Consideration of related interventions and how they are working.

What evidence is sought? - AFTER

WHO:	QUESTIONS:	OUTPUTS might include…
THE INDIVIDUAL **(e.g. individual manager, leader, clinician, delegate, participant who receives the development intervention)**	• In what ways am I applying new ways of thinking/understanding/relating/behaving? • Have I met my original goals? • Can I give examples of progression/service improvement as a consequence of the intervention? • Have I progressed in my career/opened up new opportunities? • How am I keeping my new learning going? • Am I approaching my work and interactions with others differently? • Am I a better leader?	• Examples of changed behaviours • Before and after 360s • Evidence of goals being met • Changes to career pathways and/or promotion • Maintained contact with learning set • Identifying new development opportunities • Reflections about how individuals are thinking, feeling, being and doing things differently
THE ORGANISATION/SYSTEM **(e.g. Trust, CCG, other health and social care organisation, group of organisations, 'the system')**	• How have we benefitted from the intervention? • To what extent have our expectations been met? • Have we adequately supported individuals involved? • How has this affected our talent management approach? • How are we capturing/demonstrating the value of the intervention? • Is this impacting on our team and organisational culture and any areas of performance?	• Examples of expected benefits being delivered • Examples of how participants have been supported, encouraged to apply and develop their learning. • Talent pool grown, examples of people progressing to more senior/advanced roles. • Examples of projects/improvements are highlighted and shared. • What are our people saying about differences in how they are treated and led by participants?

WHO:	QUESTIONS:	OUTPUTS might include…
THE PROVIDERS **(e.g. the commissioners, providers, deliverers of the intervention)**	• How are we maintaining contact with those involved in the intervention and ascertaining the difference it is making? • Is it appropriate to record any career progression and if so how? • Are there any longer term impacts/benefits following a period of consolidation? • Are we collecting and sharing joint data with other partner development agencies both qualitative and quantitative?	• Reports/summary of impact of intervention based on all of the above. • Feedback from participants/line managers/organisations about benefits seen and demonstrated. • Active involvement of alumni in development of others. • Longer term follow-up of those involved to track career progression and application of learning. • Comparisons with other agencies findings if relevant. • Interdependencies with other interventions.

Section 3: Pro Formas

1. Evaluation Planning
2. Evidence Gathering
3. Evaluation Report

EVALUATION PLANNING PRO FORMA

Development Intervention	*[Insert Title]*
Sponsor/Lead	*[Insert Name]*

Context	*[Insert Text]*
Intervention	*[Insert Text]*
What do we think will happen?	*[Insert Text]*
Expected measurable outcomes	*[Insert Text]*
Evidence	*[See separate template – Appendix 1]*
Reporting and Dissemination	*[See separate template – Appendix 2]*

EVIDENCE GATHERING PRO FORMA

Development Intervention	*[Insert Title]*
Sponsor/Lead	*[Insert Name]*

	Before	During	After
Individual	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*
Organisational	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*
Provider	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*

EVALUATION REPORT PRO FORMA

Development Intervention	*[Insert Title]*
Sponsor/Lead	*[Insert Name]*

Date	*[Insert Text]*	Author	*[Insert Text]*

1. Executive Summary

[Insert Text]

2. Introduction

[Insert Text]

3. Method

[Insert Text]

4. Findings and Discussions

[Insert Text]

5. Costings					
Staff Time (estimate)	Third Party costs (commissioned provider/external speakers)	Venue related (Accommodation, room hire AV support. Catering)	Materials	No. of Participants	**TOTAL COST**
Comments on Costings:					

6. Recommendations for the future and lessons learned

[Insert Text]

EVALUATION REPORT PRO FORMA

APPENDIX: EVIDENCE FOUND	Before	During	After
Individual	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*
Organisational	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*
Provider	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*

Section 4:

The Pro-Formas: Three examples of increasing complexity

EXAMPLE 1 – LEVEL OF COMPLEXITY: LOW

EVALUATION PLANNING

Development Intervention	A One Day Conference on Using Social Media in Healthcare:
Sponsor/Lead	J. Smith, South West Leadership Academy

Context	Social media is a growing way of engaging with staff and patients. Many leaders are keen to use these tools but don't always know how to use or maximise the benefits.
Intervention	A one day conference for all leaders who are keen to use social media in a work setting. A mixture of plenary sessions highlighting examples of good practice. A series of related 'how to' workshops on particular themes eg using Twitter and Facebook, or holding a webinar or tweet chat. Details to be circulated at least 3 months in advance and to be held centrally at a venue in the region. There will also be facility to follow and join in some of the sessions remotely via Skype – as a way of demonstrating enabling technology.
What do we think will happen?	That when leaders know how to use the technology they will. That leaders will be inspired by good examples and replicate good practice. That people will engage with the conference remotely That people will be more positive about the value of social media in the workplace and feel more likely to use it pro-actively.
Expected measurable outcomes	A number of people will register with Twitter, Facebook and Linked- in on the day. That there will be a number of good practice examples adopted and spread as a consequence of the conference. That the conference itself will trend on Twitter and there will be a number of 'impressions' by the end of the day. That in discussion groups during the conference people say they are positive about using social media and can describe examples of how they might do so.
Evidence	See separate Evidence Gathering template
Reporting and Dissemination	See separate Evaluation Report This report sent to all delegates, circulated to HRD community, available on web site and lodged in Leadership Community's Evaluation Repository.

EXAMPLE 1 – LEVEL OF COMPLEXITY: LOW

EVIDENCE GATHERING

Development Intervention	A One Day Conference on Using Social Media in Healthcare:
Sponsor/Lead	J. Smith, South West Leadership Academy

	Before	During	After
Individual	nil	Delegates engaged Energy levels Positive feedback from live tweets	New people signed up to social media accounts Examples of individuals increased use of social media in a work setting.
Organisational	Statements about organisations wanting to use social media more	Nil	Organisations supporting use of social media 'campaigns' – case studies
Provider	Stakeholder support Alignment with organisational development plans	Numbers engaged remotely in the conference Promoting conference live across social media platforms and monitoring and responding to comments Identify those likely and committed to apply learning afterwards Whether discussions about its potential were frequently noted during the conference and examples of verbatim quotes from these discussions.	Number of tweets about the session Themes from tweets Increased number of leaders signed up to SM accounts Follow up of those who were keen to use SM more in workplace and case studies.

EXAMPLE 2 – LEVEL OF COMPLEXITY: MODERATE

EVALUATION PLANNING

Development Intervention	Aspiring chairs programme:
Sponsor/Lead	B. Jones, North West Leadership Academy

Context	Governing Bodies are key to any organisation's success in developing its strategy and assurance of its performance. The Chairs of these bodies need to be highly effective and credible individuals. The talent pipeline of these individuals is scarce and this programme aims to develop existing non-executives or other lay persons into effective potential chairs.
Intervention	A four day programme covering 1 – Chairing effective governing body meetings 2 – Having difficult conversations 3- Legal and regulatory accountabilities 4 – Hearing the Patient / Citizen' s Voice in the Governing Body The intervention will also include buddying up with a suitable mentor for the duration of the programme.
What do we think will happen?	That individuals will be more skilled in key aspects of the role of a chair of a governing body. That these individuals will be confident to apply for Chair positions as they arise.
Expected measurable outcomes	Self-assessment and in the opinion of mentors that participants are more skilled and confident in the aspects of the Chairs role covered in the programme. Reflective diaries kept by participants illustrated a better understanding of their role and examples of applying learning in their current role. That some individuals on the programme will apply for and be successfully appointed to Chair role.
Evidence	See separate Evidence Gathering pro forma.
Reporting and Dissemination	See separate Evaluation Report. This report sent to all delegates, circulated to HRD community, available on web site and lodged in Leadership Community's Evaluation Repository.

EXAMPLE 2 – LEVEL OF COMPLEXITY: MODERATE

EVIDENCE GATHERING

Development Intervention	Aspiring chairs programme:
Sponsor/Lead	B. Jones, North West Leadership Academy

	Before	During	After
Individual	Individuals are existing Non-Executive Directors or Lay members and have a realistic chance of being appointed as Chair in next period. Self-nominated and sponsored by existing Chair. Of the 4 elements covered in the programme a self-assessment and sponsor assessment of confidence and ability is completed.	Active participation and attendance at all four days. Accessing and using identified mentor.	Self-assessment and confidence in 4 dimensions covered has increased. More willing and confident to apply for a Chair's post. Delegate able to provide examples of higher quality contributions to governing body meetings which they link to the experience gained during the programme.
Organisational	Suitable delegates identified. Supportive of intervention.	Provides opportunities for participants to practice new skills.	Extant Chair identifies improvements in contribution to governing body by participant. Statements of observed improvements by the individual and extant Chair are made.
Provider	Programme covers the areas most needed by stakeholder organisations.	On the day ratings of each element are positive and positive reporting of mentoring relationship	Testimonials from participant, chair and mentor are made about effectiveness of the programme. Participants are tracked and successful applications and appointments to Chair roles within 2 years of the programme are identified and captured.

EXAMPLE 3 – LEVEL OF COMPLEXITY: HIGH

EVALUATION PLANNING

Development Intervention	Developing systems leadership across Countyshire:
Sponsor/Lead	J Bloggs, East Midlands Leadership Academy

Context	The Five Year Forward View outlines the need for more integrated services, less hospital and more community care, new models of care and ways of working and a shift from curative to preventative care. The leadership challenge in this area is significant with leaders at all levels and from all agencies needing to lead in different ways, in essence without positional authority and more in communities and with influence rather than control. In Countyshire, there is a desire to engage with leaders at different levels and from multiple agencies and help equip them for the future.
Intervention	There will be 4 elements to this intervention. 1 – Developing Relationships and Connectivity Facilitated conversations with key stakeholders across multiple agencies to develop a joint narrative and shared vision. 2 – Learning and Capacity Building Development of an online resource to explain the need, models and theory of systems leadership and its benefits. 3 – Individual Effectiveness A 'Leading Transformational Change Programme' which will develop and assist those with 'real life projects' to develop the skills they need to lead transformation across a system. 4 – Innovation and Improvement A series of one day 'Introduction to Improvement Science Skills' workshops 5- Action learning sets Sets are established to support key individuals involved in leading systems change
What do we think will happen?	1 – Developing Relationships and Connectivity That better relationships, understanding of others' perspectives, development of a shared vision and narrative will aid the willingness to 'do business' together and people and organisations are more willing to cede established structures and positions for the benefit of their patients, citizens and communities. 2 – Learning and Capacity Building That by providing case studies, frameworks and information, the

EXAMPLE 3 – LEVEL OF COMPLEXITY: HIGH

	recipients of the knowledge will be better informed and more willing to implement the right kind of changes and work from an evidence base of what works. 3 – Individual Effectiveness That delegates on this programme will lead transformational projects successfully, will understand their own personal journey and changes they have needed to make and have helped others embrace change positively. 4 – Innovation and Improvement That participants in these workshops will have an increased knowledge and understanding of improvement science methodologies and will apply it in their workplace. 5- Action learning sets Enhanced questioning insight through action learning sets as described by Reg Revans is a key component of effective leadership.
Expected measurable outcomes	1 – A published shared vision and joint narrative document produced and owned by all agencies across Countyshire 2 – That an on-line hub exists as a repository for case studies and articles and is being actively used by people across agencies in Countyshire. 3 – That there are a number of transformational projects successfully implemented and led by delegates on this programme. 4 – Examples of the application of improvement methodologies in the workplace can be provided by workshop participants. 5- Reflective logs of set members and reflective account from set of their shared learning about the management of their projects.
Evidence	See separate Evidence Gathering pro forma
Reporting and Dissemination	See separate report. This report sent to all delegates, circulated to HRD community, available on web site and lodged in Leadership Community's Evaluation Repository.

EXAMPLE 3 – LEVEL OF COMPLEXITY: HIGH

EVIDENCE GATHERING

Development Intervention	Developing systems leadership across Countyshire:
Sponsor/Lead	J Bloggs, East Midlands Leadership Academy

	Before	During	After
Individual			
Multi-agency Facilitated Conversations	Completion of 'Team Culture' diagnostic	Active participation in the discussions Regularly attending any planned conversations	Repeat of 'Team Culture' diagnostic Showing improvements
Building a resource hub		Multiple contributors from different agencies are sharing information via the resource hub	Individuals are accessing and using the resource hub
Leading Transformational Change Programme	Application for the programme is made and able to demonstrate willingness and appropriateness to attend programme	Feedback sheets are showing inputs are being received well	Successful delivery of transformational project including the engagement and commitment of others in the project.
Introduction to Improvement Science workshops	Skill and knowledge gap in improvement methodology. Pre intervention scores of level of knowledge complete	High levels of turnout and engagement are evident	Post intervention scores of level of knowledge completed and show improvement
Organisational			
Multi-agency Facilitated Conversations	The right people to lead this work are identified and made available for these discussions		A shared narrative and joint vision is published. Regular cross-agency meetings are occurring with examples of joint work. Participants describe their relationships as more positive, collaborative and 'warmer' Action learning set reflections demonstrate range and depth of learning.

EXAMPLE 3 – LEVEL OF COMPLEXITY: HIGH

Building a resource hub			An on-line resource hub exists and contains contemporary articles/case studies of systems leadership
Leading Transformational Change Programme	The right people are identified for this programme who will benefit the organisation's improvement priorities.		The organisation/system can demonstrate the benefits of successful service improvement projects Those involved describe being better able to use innovation thinking in the workplace
Introduction to Improvement Science workshops	Organisation/system are keen and receptive to idea of improving knowledge and experience of improvement science		The organisation/system is supporting the wider adoption and spread of improvement methodology Organisations describe a more open culture to improvement methodology and that this is spreading in their organisations.
Provider			
Multi-agency Facilitated Conversations	A document stating the aims of the intervention is produced and agreed with all stakeholders	Feedback on progress is sought and adjustments made accordingly on quality of facilitation being provided	Very positive ratings of the facilitation are provided by participants
Building a resource hub			Data is produced showing usage/access to resource hub and examples as to how this has influenced work in the system are provided
Leading Transformational Change Programme	The providers are credible and experienced in delivering this sort of programme.	High levels of attendance and engagement in all aspects of the programme	Examples of greater system working/ successful projects are gathered and shared.
Introduction to Improvement Science workshops	Development plan/content/ learning outcomes of workshop clearly identified.	Immediate feedback on the day of workshops is positive	Case studies showing adoption and spread of improvement methodology are published.

Section 5:

Example of a Completed Evaluation Report

(One day conference on using social media in healthcare)

EXAMPLE OF EVALUATION REPORT – LEVEL OF COMPLEXITY - LOW

Development Intervention	*A One Day Conference on Using Social media in Healthcare*
Sponsor/Lead	*J.Smith – South West leadership Academy*

Date	*[dd/mm/yy*	Author	*J.Smith*

1. Executive Summary

This report provides some data and commentary on a one day conference held in (*month/year*), designed to encourage health care leaders to understand how to use social media in a practical sense and to support wider OD/engagement strategies.

The conference was broadly a success, with increased take up and application of social media during and after the event with examples of how the use of social media was being used to enhance engagement activities being cited and increased as a direct result of holding this conference.

2. Introduction

Social media is a growing way of engaging staff and patients. Many leaders are keen to use these tools but are not always sure how to use or maximise their benefits. This one day conference was devised to provide some practical hands on experience of how to use social media tools such as Twitter and LinkedIn. Additionally the aim was to present ideas as to how the use of social media supports organisations' strategies and offers some practical examples of organisations using social media for their campaigns, engagement and gathering opinions.

Through a series of meetings with leaders across the NHS it became clear that many of them were aware of the potential benefits but lacked the practical skills and knowledge of how these methods could be used to support medium to longer term strategic objectives.

3. Method

A one day conference was planned which would include a series of workshops covering the practical 'how to' elements of using social media including demonstrations of how to sign up and create Twitter accounts and Facebook pages. Plenary sessions were also planned for people with experience in using social media at scale to engage and communicate with a wide audience and also some real examples from the region of where organisations had effectively used social media to engage and communicate with staff, patients and wider stakeholders.

4. Findings and Discussion

The 'theory of change' for this intervention was that:

1 By showing healthcare leaders how to register themselves in social media platforms that some would subscribe to these services on the day and others would do so following the event.

2 That following the conference, leaders would take some of the examples they had heard about and adopt similar methods for use in their own organisations to communicate and engage with staff and others.

3 That given the advanced promotion of the conference, and the facility to engage with the conference remotely, that some leaders would follow the proceedings on Twitter and access the video streaming facility provided to take part in plenary sessions.

4 That people would be more positive and feel more likely to use social media in their everyday work.

As can be seen from the evidence presented in the tables above and in the appendices, overall this event should be regarded as a success. There was a quantifiable increase in knowledge and several examples of application. The theory of change has been supported with evidence of increased registrations into social media, examples of adopting social media into campaigns, the conference itself trending on Twitter during the day and the changing behaviour of some delegates in starting campaigns within their organisations subsequent to the conference itself. The detail of this is described in the table above and in the attached appendices.

5. Costings					
Staff Time (estimate)	Third Party costs (commissioned provider/external speakers)	Venue related (Accommodation, room hire AV support. Catering)	Materials	No. of Particpants	TOTAL COST
£3,000	£5,500	£10,000	£500	150	£19,000

Comments on Costings:

It was difficult to estimate the staff time spent on this project and so we have allowed for two people (1 @B6 and 1@B4) planning and supporting this event, full time for 3 weeks.

6. Recommendations for the future and lessons learned

Whilst the conference delegates related it highly and would recommend to a colleague, it is unknown at this stage whether a repeated conference would be as enthusiastically received or whether this conference has met the immediate need of those who attended and whether a second conference may need to include more advanced information and examples, or whether another event like this which was primarily aimed at those new to social media would be the best use of resources.

It is therefore recommended that if another conference is planned along similar lines, then it includes both novice and advanced elements with good signposting enabling delegates to attend which is most appropriate to them.

EXAMPLE OF EVALUATION REPORT – LEVEL OF COMPLEXITY - LOW

Clearly the workshop which evaluated poorly should not be repeated and the facilitator should not be used in this context again.

The communications teams contacted after the event had not necessarily been aware that the event had been taking place and finding examples of new campaigns within their organisations after the event proved difficult to ascertain. It is recommended therefore that any future events, communications teams are contacted in advance of the conference with the aim of securing their support immediately afterwards to translate the learning from the event into actions within their organisations.

EVALUATION REPORT – LEVEL OF COMPLEXITY: LOW

EVIDENCE GATHERED

	BEFORE	DURING	AFTER
Individual	156 registrations for the event were received in advance of the day and 142 delegates attended. As part of the application process all applicants were asked to confirm that they were keen to expand their own knowledge about the use of social media in healthcare settings and they had their organisations support to attend the event.	Electronic voting technology was deployed and asked a number of questions at the start of the event which were repeated at the end. The results of these can be found at appendix one but the highlights are: 1 How confident are you to use social media in a work setting? 35% of people said they were confident or very confident at the start of the day which rose to 65% at the end of the day. 2 How likely are you to use social media to engage with staff, patients and others? 22% of people said this was likely or very likely at the start of the day which rose to 55% by the end of the day. Delegates were encouraged to tweet throughout the day and a few examples of these live tweets are included at appendix two.	An online survey asking for delegates experience on the day was sent out 24 hours after the event had completed. A summary of these results can be found at appendix three and the highlights include the following: • 92% of delegates rated the event as good or excellent • 96% of delegates would recommend the event to a colleague • 85% felt the conference had given them increased knowledge • 62% said they were likely to use social media in a positive way at work. Two weeks after the event 142 delegates who attended were contacted via email and 75 of them responded, of these 26% had a Twitter account before the event and this is now 65%. When asked had they tweeted in the last week, 52% said that they had. 8 individuals said that they had already planned in the next month to use social media for a wider engagement activity with staff and/or patients.

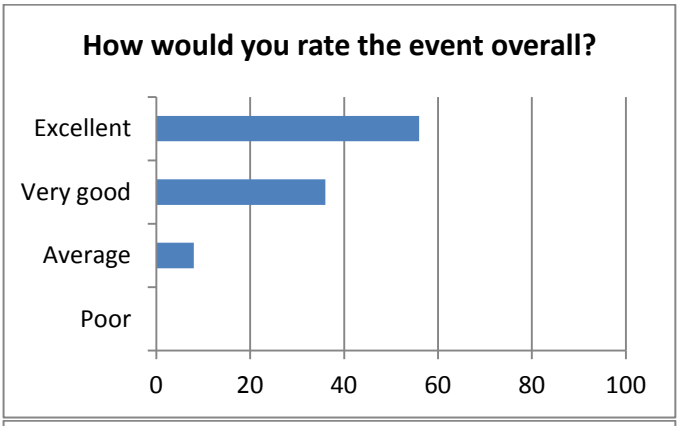
EVALUATION REPORT – LEVEL OF COMPLEXITY: LOW

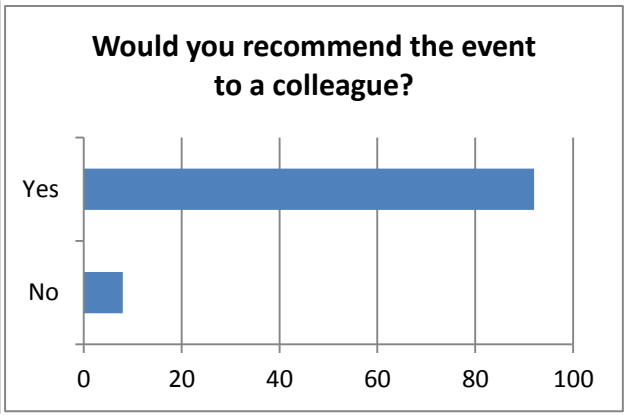
	BEFORE	DURING	AFTER
Organisation	As part of an annual survey about development needs within organisations 42 out of a possible 46 organisations completed an online survey indicating the types of interventions, including conferences, they would like to see provided locally during the following financial year. Of these 42, 29 indicated that they would like to see their leadership community better equipped in using social media as a means to communicate and engage with staff, patients and others.	It was noted that a number of communications teams and individuals in the region were following this event on Twitter and made several supportive comments about the utility of the conference throughout the day. Some of these typical comments are enclosed at appendix two.	The delegates attending the conference came from 31 different organisations. The communications teams at 25 of these were contacted and asked if they had noticed an increased use of social media within their organisations or had been asked to provide support to new campaigns in the month following the conference. 6 of them said that new campaigns had started within their organisations, at least 4 of which were directly attributable to the attendance of delegates at the conference. These included topics such as: • Improving attendance rates outpatient clinics • Engagement with teenagers in a CAMHS service • A patient safety campaign within an acute hospital • Setting up a new IT helpline across a group of CCG's

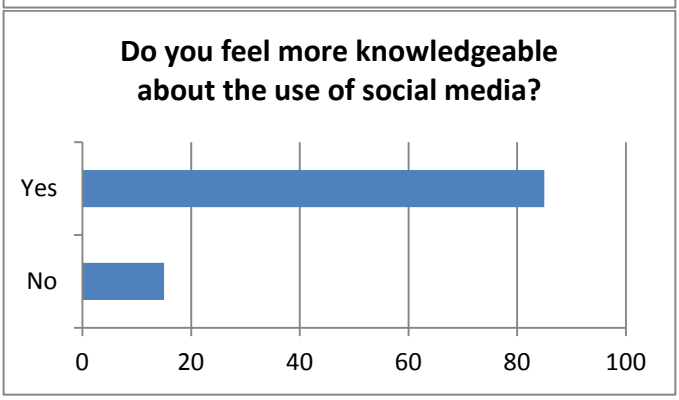
EVALUATION REPORT – LEVEL OF COMPLEXITY: LOW

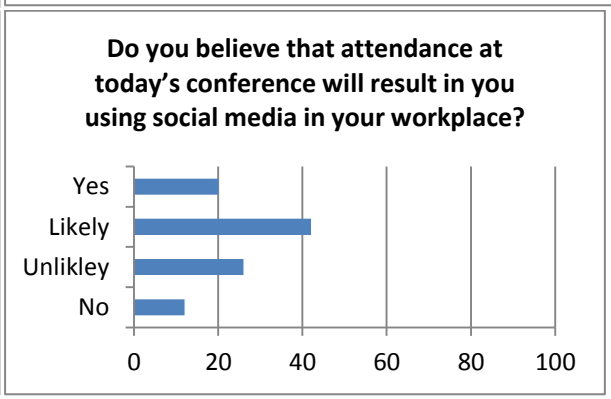
	BEFORE	DURING	AFTER
Provider	Based on the organisational survey referred to above, we as the local leadership development partner, built into our planning for the year a conference including workshops which would address the issue of spreading social media use and expertise to our leadership community. Key note speakers were identified who have a presence on social media. A number of workshops planned with people who are familiar with particular aspects of social media to explain how they work at rudimentary and advanced levels. Practical examples and case studies of effective use of social media in organisations were also sourced.	During the course of the day 26 people registered for a Twitter account, 15 for LinkedIn and 12 for Facebook. During an exercise discussing application of social media three organisations identified campaigns that they already had planned and were now going to incorporate social media use into those campaigns.	The feedback received from the online survey identified that one of the workshops had not gone as well as the others. Delegates felt the workshop leader was dry and too technical and the subject matter introduced little use of known social media and was felt not very relevant to a healthcare setting. The 4 campaigns that we were now aware of that had included a social media element as a consequence of our conference would be followed up in 12 month time to see if their plans did come to fruition and to see how effective the social media element has been. Over 4.2 million impressions (ie the use of the hash tag for the conference that day #SoMe) were registered in the 24 hours from the start of the event. Informal discussions on the day indicated that people not only enjoyed the event but felt it was relevant to their work and could see several ways in how they could better apply the use of social media. The live streaming of the event was only accessed by two people and a question for future events therefore is whether this was worth the cost or whether this was under promoted and may be better accessed at future similar events.

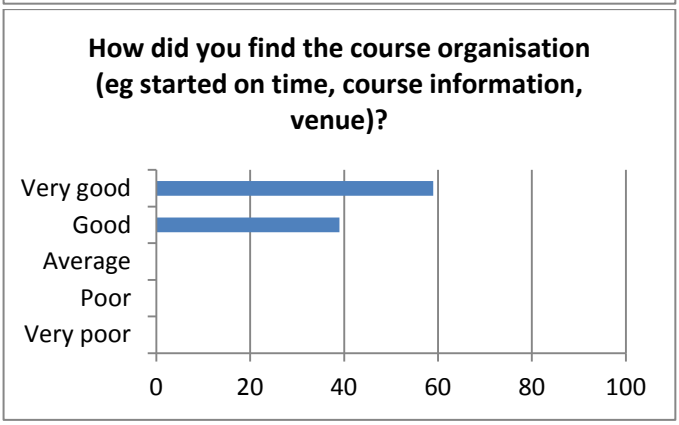
APPENDIX 1











What were your key learning points?

1	How to use Twitter as a resource for information sharing.	6	Did not feel I learnt anything.
2	The rate at which social media use is growing and that it's not just the younger generations. The opportunities available to engage and involve communities via social media are great.	7	Facts about the different platforms. How to maximise opportunities. How to confront the challenge around risk.
3	To understand when you should and shouldn't use social media.	8	Twitter how to use SoMe for professional purposes.
4	Social media is more than just Facebook and Twitter!	9	How effective Twitter is and how you can make a big difference.
5	Social media is a key tool for the future.	10	How to use Twitter.

APPENDIX 2

Examples of individual Tweets made during the day:

"I am tweeting for the very first time #SoMe"

"Learning how to use social media to engage with patients, potentially really useful #SoMe"

"#SoMe loving the social media conference City Trust"

"#SoMe City Trust uses Twitter to engage with troubled teens, great outcomes"

Examples of communication team Tweets made during the day:

"Following the conference online, wish we could be there #SoMe "

"#SoMe Looking forward to hearing new ideas from delegates and using back at base"

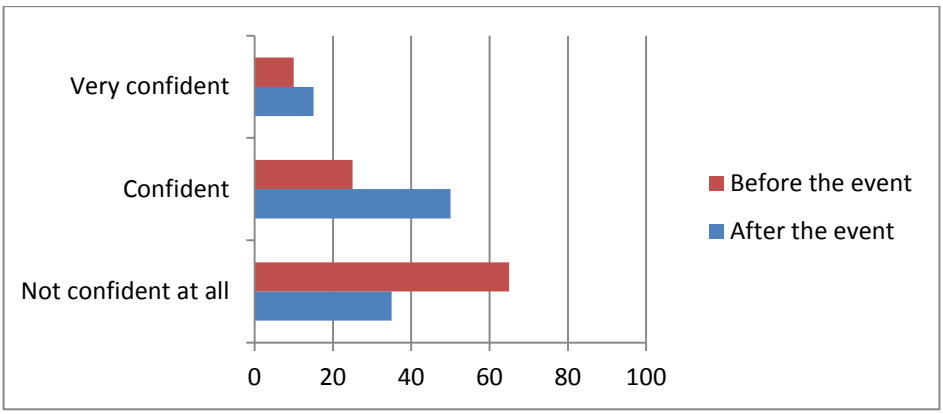
"Great to see leaders embracing new technology #SoMe"

"Over 200 tweets today and it is only 10am! #SoMe"

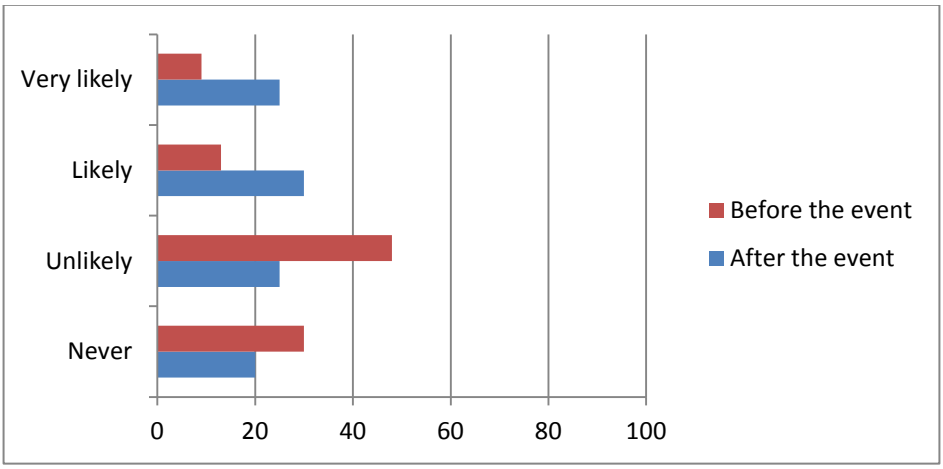
"Just watched presentation online – inspirational #SoMe"

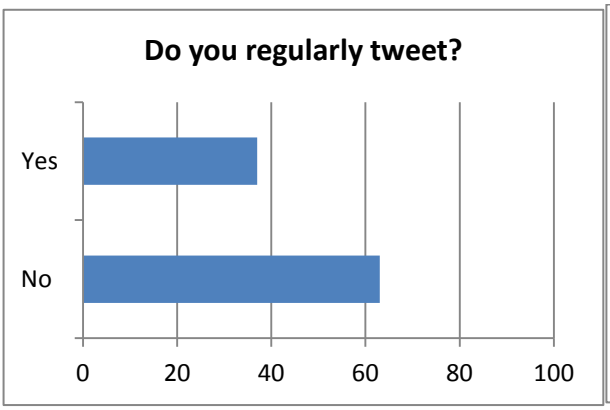
APPENDIX 3

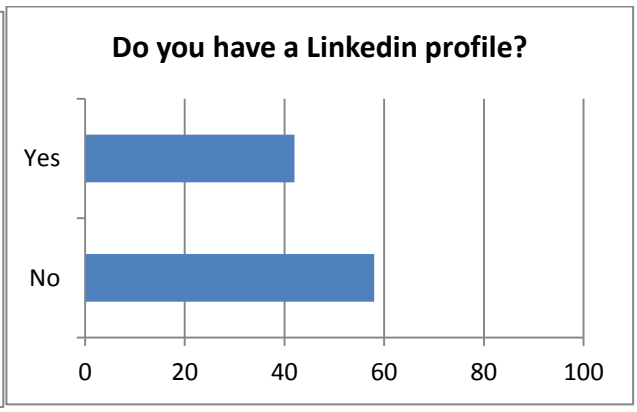
How confident are you about using social media in the work place setting?



How likely are you to use social media to engage staff, patients and others?







Section 6: Evaluating the framework

Using this evaluation framework consistently across the NHS Leadership Academy and the LDP's is a new strand of work for 2016/17 and we are keen therefore to gather your views and feedback on how using the framework assists your evaluation approach.

Please take a few minutes to answer the following questions and include the feedback in your submission of any reports to the central knowledge sharing platform.

1 What did you find useful/helpful about using the framework
2 What did you find not so useful/not so helpful about using the framework
3 What suggestions, if any, do you have for improving the framework?

EVALUATION FRAMEWORK – VERSION CONTROL

Version	Prepared by:	Date:
Draft v8	LDP Network Leader Group	December 2015
Draft v9	LDP Network Leader Group & Open Crossings Ltd	20th January 2016
Draft v10	LDP Network Leader Group & Open Crossings Ltd	21st January 2016
Version 11	Paul O'Neill	26th January 2016
Version 12	Paul O'Neill	29th January 2016
Version F1.0	Paul O'Neill & Implementation Advisory Group	3rd February 2016
Version F1.1	Paul O'Neill Minor tweaks and typos in advance of roll-out	7th MARCH 2016
V F1.2	Paul O'Neill – minor amends	17th March 2016

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Director of East Midlands Leadership Academy
Chair of Leadership Development Evaluation and Research Group (LeaDER Group)
Workstream Lead for Evaluation – LDP Network

Relevant references used by Short (2015)

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2. Chen, Huey-Tsyh (1994) "Theory-driven evaluations: Need, difficulties, and options." Evaluation Practice 15.1 p79-82.
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