Healthcare Improvement Scotland

Excellence in Care

Leading Excellence in Care (LEiC) Education and Development Framework: Evaluation

November 2025

NHS SCOTLAND

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Background

Healthcare Improvement Scotland's EiC programme and NHS Education Scotland (NES) worked collaboratively with stakeholders across Scotland to develop a new leadership education and development framework for Nursing, Midwifery and Allied Health Professionals (NMAHP) leaders that aligns to the principles of the EiC Framework and the NES Pillars of Practice.

In development since November 2022, the Leading Excellence in Care (LEiC) Education and Development Framework builds on the structure and principles of the prior tools developed by NES, the Leading Better Care programme and the Education Framework for Senior Allied Healthcare Professionals (AHPs). The LEiC Education and Development Framework identifies the specific capabilities, knowledge and skills required by NMAHP Leaders working in leadership roles across all settings and recognises that education, learning and development are key components in creating a motivated, adaptable and resilient workforce.

The resource was launched in November 2023 and is hosted on the NES Turas platform.

In November 2024, efforts to gather qualitative user experience data were sought to develop case studies which would be used to demonstrate the impact of the resource. However, through recruitment of the Board Clinical Lead networks, only two participants were identified. Given this challenge in identifying users, this measurement plan was developed to expand the data sources from which we are evaluating impact to mitigate future recruitment challenges.

This evaluation aims to:

- Explore how the LEiC Framework is being implemented within boards
- Assess the impact that the LEiC Framework is having on leadership development for users
- Explore any barriers and mitigating factors to implementation to inform future work

Methods

To address the above outcomes and associated evaluation questions, a mixed methods approach was developed using both the quantitative and qualitative data sources listed in the table below.

For the quantitative data sources, descriptive statistics were used where appropriate. Inferential statistics were not used due to the small sample sizes. For the qualitative data sources, thematic analysis was used.

Table 1. LEiC evaluation data sources

Concept/Measure Name	What/How to measure	Data Source	Frequency of Reporting	Chart Type
Usage analytics of Turas platform and MS Sway webpages	**Why measure?** Gather information on the number of visits to the resource pages over time **What to measure:** • Count number of visitors to be compared over time	NES Turas and MS Sway	• Monthly	• Run Chart
NES survey	**Why measure?** Gather information on how NES is using the guidance locally **What to measure:** Quantitative and qualitative analysis of the survey questions	MS Form with quants and qual questions	August-Sept 2025	Bar graphs, Line graphs, Pie charts as appropriate.
Stakeholder survey	**Why measure?** Gather information on implementation in boards, what they like or dislike about the resource, challenges to implementation, enables, and any suggested changes	MS Form with quants and qual questions	August-Supt 2025	Bar graphs, Line graphs, Pie charts as appropriate

	What to measure? Quantitative and qualitative analysis of the survey questions			
Case studies	**Why measure?** Explore with small sample of users: What was done? What went well? What could have gone better? **What to measure?** Qualitative analysis of the semi-structured interviews	Semi-structured interviews	Jan-Feb 2025	Qualitative thematic analysis
Engagement calls with boards	**Why measure?** Explore how resource is implemented at board level and allows for comparison over time Standard questions include: - How is LEiC being implemented locally? - What enablers have you introduced? What was the impact? - How have the resources been	Engagement call notes	4 a year	Qualitative thematic content analysis

	utilised to support NMAHP leadership development? - What topics are your NMAHP leaders identifying as needing additional resources?			
SG report themes	**Why measure?** An understanding on the QoC reviews and/or CAVs being undertaken locally. Consider: • Reason • Speciality • Outcomes • Local approach **What to measure:** Qualitative analysis from the SG feedback reports	SG Report Feedback	Biannual	Qualitative thematic content analysis

Usage analytics

One data source that was employed in this evaluation was the usage analytics (e.g. how many times the resource pages were viewed or downloaded) of the resource. The usage analytics are

available from the launch of the resource in November 2023 until September 2025, the end of the evaluation data collection period. The resource is hosted on Turas, the educational platform for health and care professionals in the public sector, with further pages hosted on Sway, a Microsoft website development program.

Overall use

In this data collection period, the total page views across all of the pages on Turas were 24,068, which indicates a high level of engagement with the resource. Unfortunately, the usage analytics available within Turas are unable to identify the number of unique users who have accessed these pages. Unsurprisingly, the most commonly accessed page was the resource 'home' page (Leading Excellence in Care Education and Development Framework), with 11,464 pages views, as evidenced in the chart below. The other resource pages were viewed between 878-2453 times. Whilst there has been a high level of engagement with the resource overall, the comparatively lower usage of the other pages may indicate that users are not exploring beyond the home page.

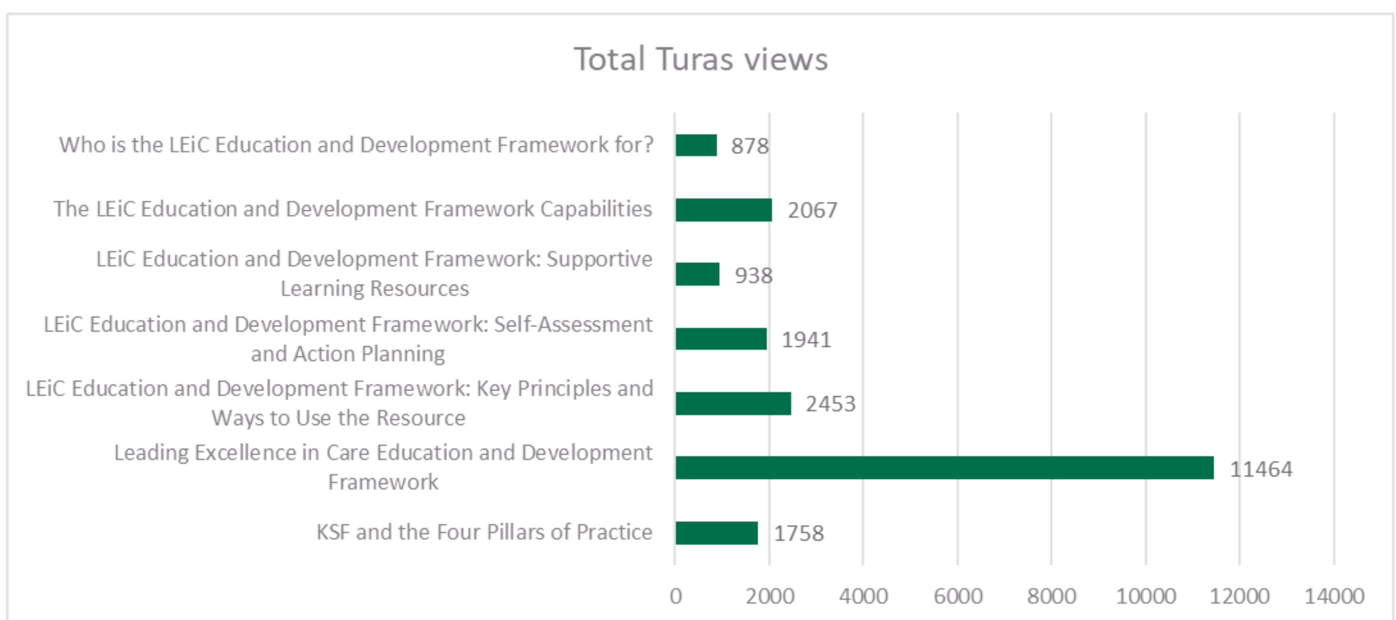

Figure 1. Total Turas views

A separate chart was created to demonstrate the views of the ten LEiC framework capabilities (below). The most viewed framework capability was '1. Provide Professional Leadership' with 795 views. The least viewed was 'Networking and Raising the Profile of the Services' with 80 views. The variation in the number of views of the ten capabilities may indicate that some areas are perceived to more valuable by staff than others.

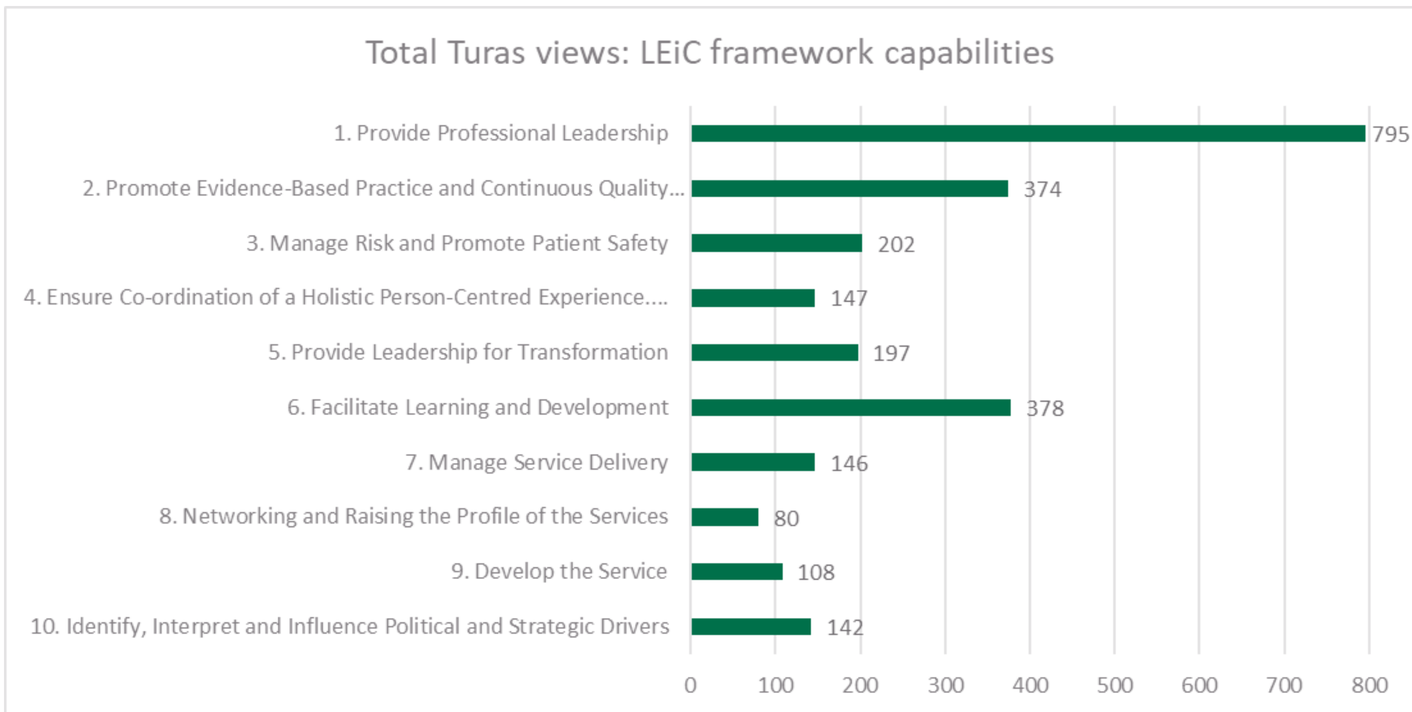

Figure 2. Total Turas views: LEiC framework capabilities

Sway views

Within the resource pages, there are further links to Microsoft Sway pages with further information on the topic area. Microsoft Sway is a presentation program, allowing developers to combine text and media to create a presentable website which can pull content from local devices or from internet sources. The total views of the Sway pages are presented in the figure below. The most viewed Sway page was the 'LEiC Supportive National Resources' indicating that users are interesting in exploring signposted resources that are perceived as relevant to further their leadership development. The views of the ten capabilities on Sway roughly align to the views of the corresponding capabilities Turas pages, indicating that users are primarily navigating to these Sway pages directly from the Turas platform.

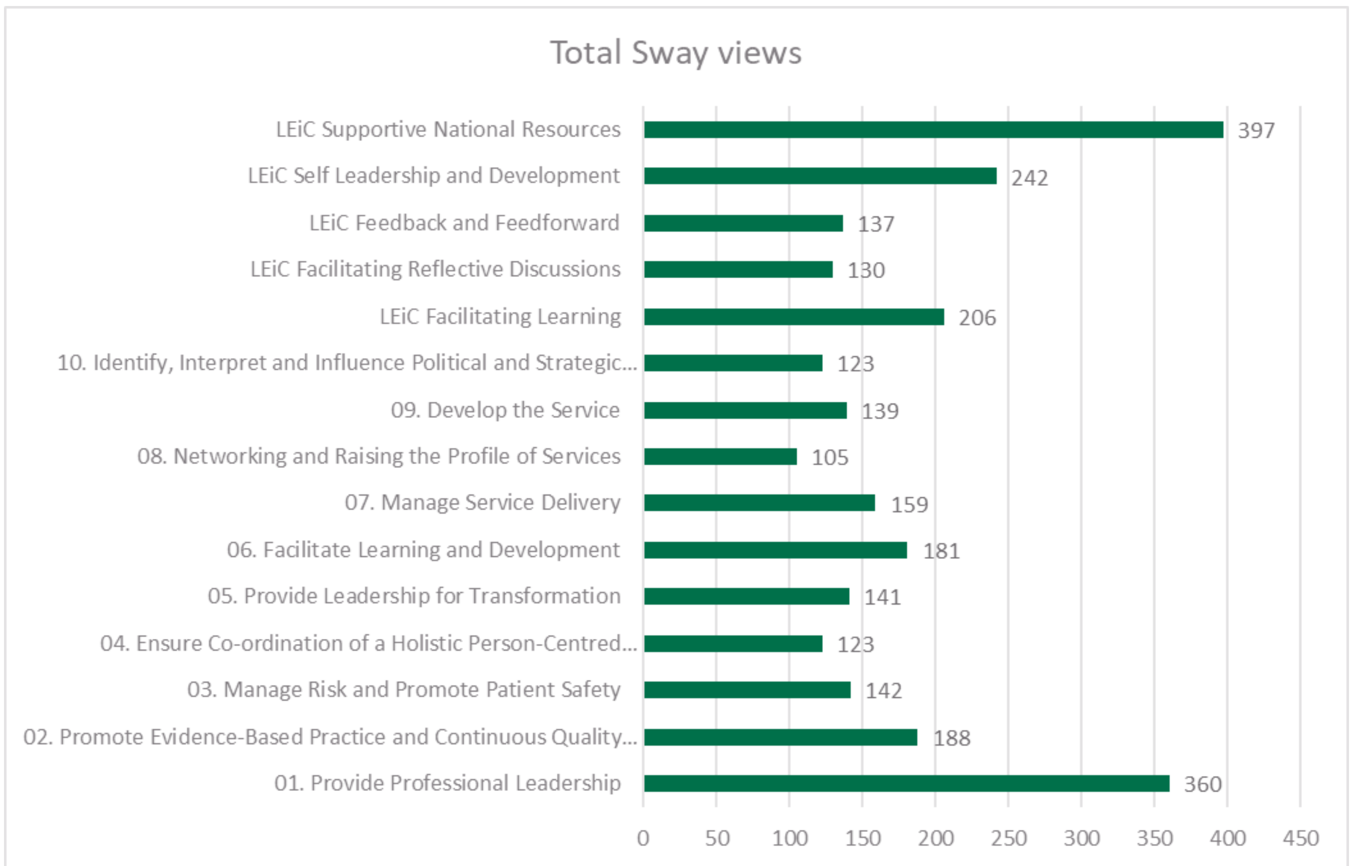

Figure 3. Total Sway views

Resource downloads

Users are also able to download resources from the LEiC framework, including a self-assessment, action plan, and completed templates (see figure below). The most commonly download resource is the self-assessment, with 1,059 downloads during the data collection period. This high level of engagement with this aspect of the resource is supported by the other data sources presented in this evaluation, with several boards reporting integration of the self-assessment within existing leadership programmes. The least downloaded resource was the ‘LEiC Education and Development Framework: all capabilities, knowledge and skills’. The comparatively low downloads

could be due to the availability of this information within the Turas pages (which demonstrate a considerably higher viewing rate than downloading rate).

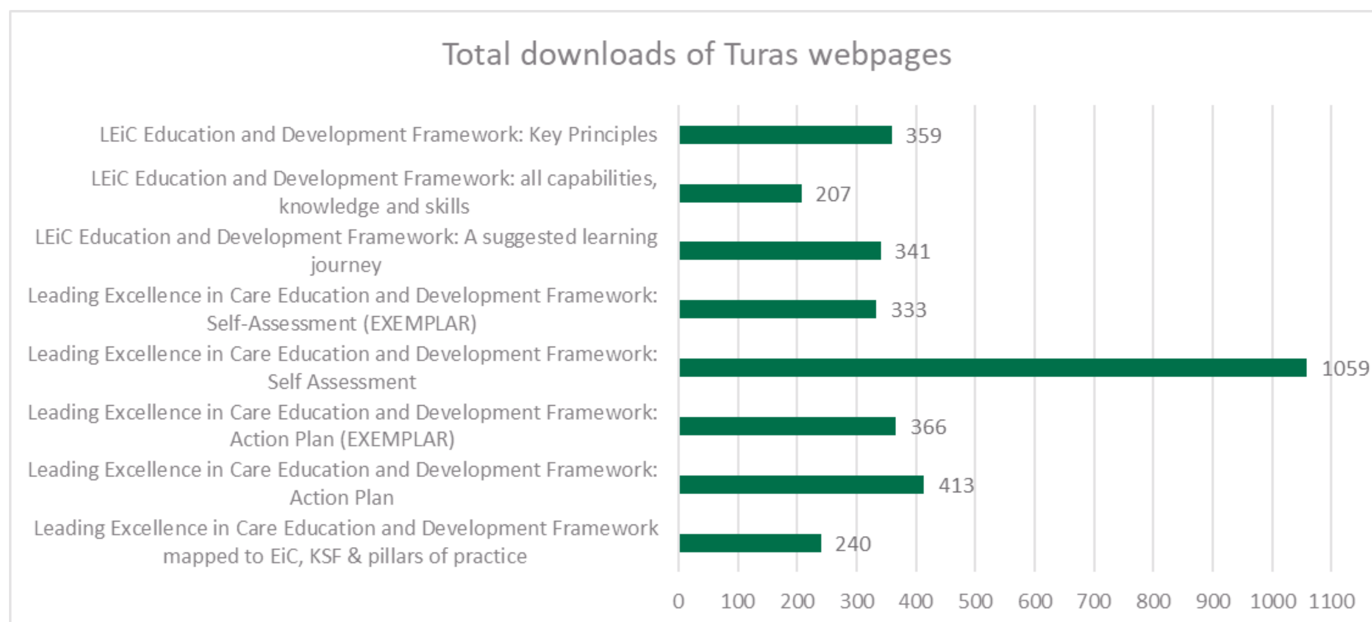

Figure 4. Total downloads of Turas webpages

Conclusion:

In summary, the usage analytics of the LEiC framework resource indicate a high level of engagement since its launch, particularly with the main landing page and the self-assessment tool. While the overall page views suggest widespread interest, the lower engagement with subpages and certain capabilities may reflect a need to enhance user navigation or promote the breadth of the resource more effectively. The alignment between Turas and Sway page views suggests users are following the intended pathways through the resource, and the high number of downloads of the self-assessment tool reinforces its perceived value in leadership development. These insights provide a valuable foundation for future iterations of the framework, highlighting areas of strength and opportunities to improve accessibility and relevance across the full spectrum of content.

Surveys

Stakeholder survey

This survey was distributed by email to EiC Board Clinical Leads (BCLs), Healthcare Staffing Programme (HSP) Workforce Leads, the Scottish Corporate Nurse Leaders (SCNL) group, and members of the LEiC Short Life Working Group (SLWG). EiC BCLs were also invited to share the

survey link with staff in their board who may have utilised the resource as well, particularly their AHP colleagues.

In total, there were 16 responses received. There was a moderate range of organisational representation with 12 boards having at least one respondent.

Of the 16 respondents, there was variety in the roles of respondents, with representation from EiC Board Clinical Leads (BCLs), practice and professional development teams, improvement teams, AHP leadership, and nursing executives.

Participants were also asked to describe their involvement with the LEiC framework (see figure below).[1] The majority (63%) of respondents have some involvement with the EiC programme as either BCLs, support nurses for EiC, or members of the LEiC SLWG. Almost one-third of participants were from the SCNL group. Only 6% of respondents identified as those in clinical roles as a 'nurse, midwife, or allied health professional', indicating that there may be limited awareness and use of the resource beyond EiC programme representatives and nursing leadership.

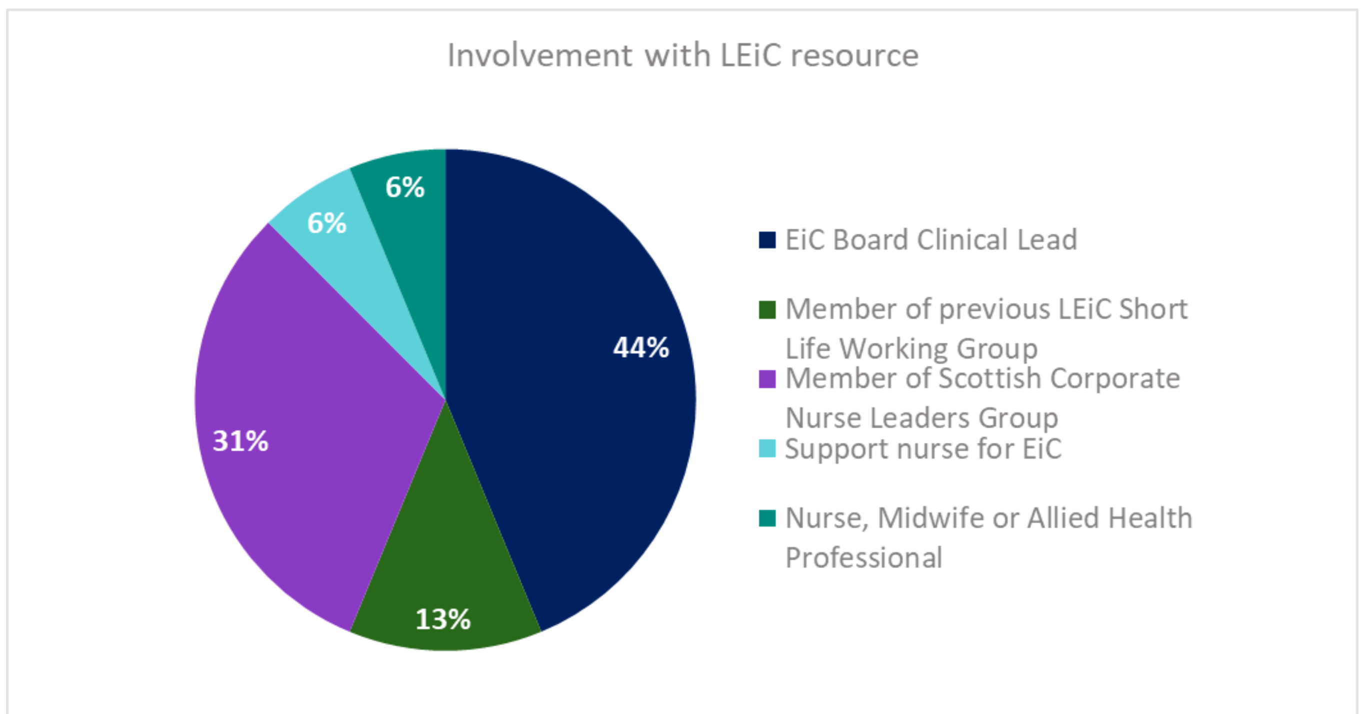

Figure 5. Stakeholder survey: Involvement with LEiC resource

Implementation of the resource

The primary aim of this survey was to explore how the LEiC framework has been embedded in respondents' boards. There is significant variation in how the resource is being used, with one-fourth of respondents indicating that the resource is either not being used or that they are unsure of its use. However, in contrast, one-fourth of respondents reported that the LEiC framework is being used as their board's primary leadership development tool. It was more commonly

[1] Note that respondents could select multiple responses (e.g. identified as both a EiC BCL and a NMAHP).

reported, by half of participants, that the resource is being used in some areas or that some work has taken place to embed the resource into local governance and development structures. There were also conflicting responses from representatives of some boards which indicates some variation in how it is being used locally.

Participants were also asked to describe policies, practices or procedures that have been put in place to help support the implementation of the LEiC framework and its use. Whilst approximately two-thirds of respondents either did not respond to this question or indicated that no such policies have been put in place, one-third highlighted that it has been integrated in some way into leadership programmes with protected time.

Of those who describe some level of use within their board, the LEiC framework was commonly used across NMAHP professions (34%). This was followed closely by use in nursing and midwifery professions only (33%). One-fourth of reported usage was by nurses only, and 8% was by AHPs only. This indicates that although in approximately one-third of respondents' settings were utilising the resource across the multidisciplinary team, two-thirds still limited their use based on professional background in some way.

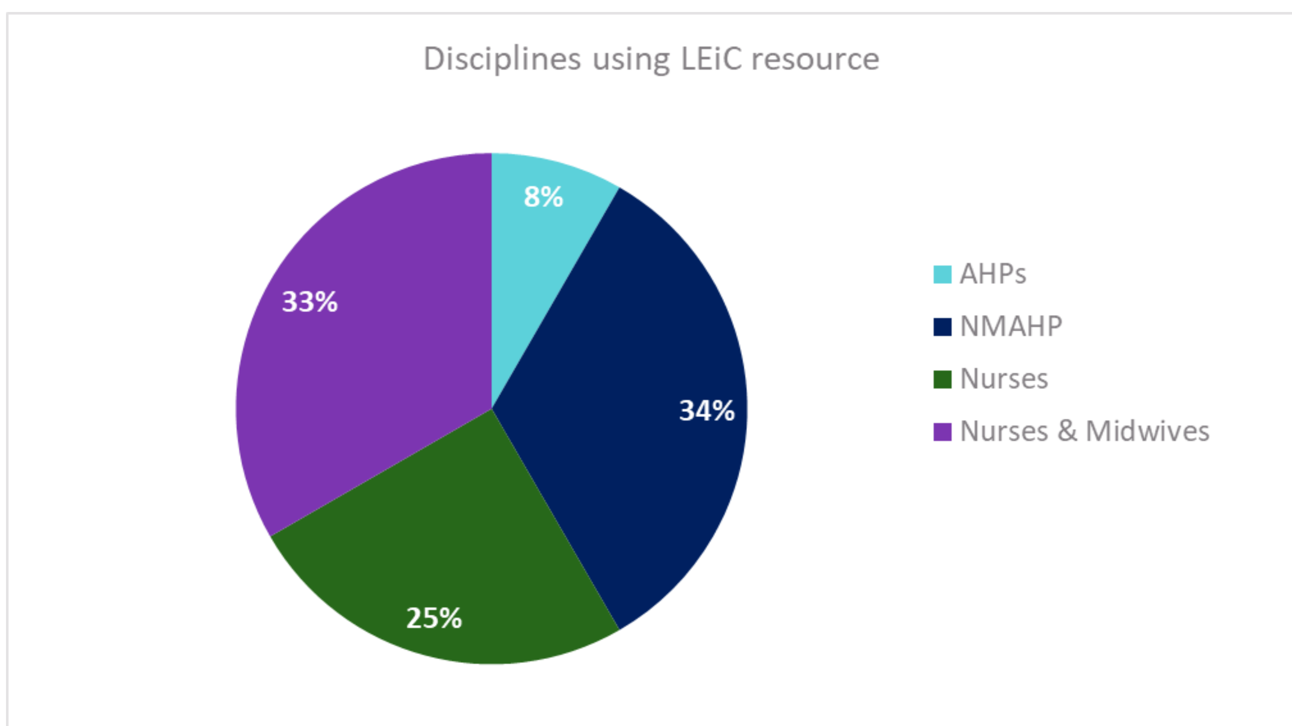

Figure 6. Stakeholder survey: Disciplines using LEiC resource

Participants were also asked about local plans to integrate the LEiC framework in the future, only four respondents answered this question, limiting its utility to generalise these findings. However, of those who did respond, a medium-sized board representative indicated that it would be used in time locally, whereas and small rural board representative was unsure. Interestingly, there were conflicting responses from a special board's representatives, with one reporting that they planned to implement the LEiC framework in the future whereas the other was unsure. This suggests that

even with boards, integration of the resource may still be in discussion, with ultimate decisions on the framework still to be made.

Positive features of the LEiC framework

Survey responses highlighted several themes that reflect what respondents value most about the LEiC framework and its potential contribution to leadership development.

The accessibility of the resource was highlighted by many respondents as a valuable feature of the framework, with its link to Turas specifically mentioned. It was also framed as being “simple to navigate” (large, urban board) and “user friendly” (small rural board). Respondents also appreciated the alignment with leadership principles such as the pillars of practice, as well as the signposting to relevant leadership resources.

Several comments highlighted the usefulness of the LEiC self-assessment tool in promoting reflection and identifying individual learning needs. As one participant noted:

“The reflection and information gives you insight into your own leadership styles and the formation of action plans.” (island board)

Respondents viewed this as a practical way to encourage staff to take ownership of their development and engage in meaningful conversations about leadership competencies.

Enablers to implementation

The most common enabler to implementing the LEiC framework was support from EiC leads, Practice Development and Organisational Development colleagues, and senior nursing and midwifery staff. Clinical leaders’ engagement has contributed to the development of leadership resources and their alignment with the LEiC framework, as described below:

“Using questionnaire's and focus groups to design a leadership programme with over 400 staff to then allow the outcomes of this to be mapped to the LEiC resources” (medium rural board)

Additionally, as discussed above, protected learning time has been executed in several boards to enable professional development including the LEiC framework. Moreover, alignment with existing leadership resources and local strategies were also highlighted as enablers to implementing the LEiC framework.

“Leadership Programmes as mentioned above facilitate and enable the delivery of LEiC, self assessment tools are undertaken by participants to measure learning pre and post programme.” (medium-sized board)

“Recently launched Nursing and Midwifery Strategy – [strategy name] which includes a strategic priority around how we lead our professions.” (large, urban board)

In mapping the framework to local resources, teams can raise awareness of the LEiC framework and signpost staff towards it when it may be most likely to be used.

Barriers to implementation

A dominant theme identified from these survey respondents is that the lack of time and staffing capacity to engage with the LEiC framework is a significant barrier to its implementation. Respondents repeatedly cited difficulty for staff to find time to engage with the resource. Service pressures further exacerbated time constraints making it difficult to prioritise LEiC despite recognising its value. As one participant explained:

"Lack of protected time, unless clinicians are allocated days out to attend programmes. Learning is often first to be postponed in periods of pressure." (medium-sized board)

Furthermore, respondents also indicated that given limited EiC resource within the board, their focus has been on implementing the Quality of Care (QoC) review guidance.

Several responses also referenced organisational changes as barriers to implementation. For example, one board respondent (island board) noted "changes to several executive directors" as a factor preventing the integration of the LEiC framework into their board. Another example (special board) described recent adoption of the EiC programme as limiting their implementation of LEiC thus far.

Some boards lack formal leadership programmes to support LEiC.

"We don't yet have an NHSH leadership programme to link LEiC to- this in in development. I've recently been asked to join the development group which should provide opportunities to explore how LEIC can be utilised across the board." (medium-sized rural board)

As highlighted in the engagement calls and SG reports data below, several boards have aligned existing leadership resources with the LEiC framework as a strategy to embed the resource within their board. So, as the above data indicates, for those boards without an existing leadership resource with which to align, this can limit their engagement.

Lastly, an inability to monitor staffs' usage of the resource was highlighted as a challenge to implementing the LEiC framework. This is in part due to the self-directed nature of the resource and the functionality of the platform on which it is hosted. Without ways to evaluate how staff are utilising the resource, boards are unable to report on the impact of the resource and demonstrate value.

Suggested changes to the LEiC framework

Whilst approximately one-third of respondents had no suggested changes to the LEiC framework, others presented possible changes to be made in the future. A common area highlighted for improvement pertained to the functionality of the resource, particularly in regard to difficulties navigating the tool:

"It can be quite convoluted to find the resources that you want and it involves lots of clicking through different sections to get there. I'd like to see it more streamlined with a clearer navigation to all the resources." (special board)

The digital and visual layout were recognised by one participant to be a result of being hosted as a Sway resource, and another suggested that it could be more user friendly if it was an app or portal on Turas.

Another suggestion regarded the barrier to monitoring uptake of the resource, with respondents proposing if each capability was able to be marked as 'complete', boards could pull data. This would then enable monitoring and evaluation of the resource at the local and national level. Given the recent evaluation of the QoC review guidance, exploring transferring the resource onto the Right Decision Service platform, which was valued for its usability and embedding analytics could be a solution to address both suggested changes.

NES colleague survey

A survey was also distributed to colleagues within NHS Education for Scotland (NES) given their instrumental role in driving engagement with the resource as it is hosted on NES platforms. There was a poor response rate, with only one individual completing the survey. Thus, a full analysis cannot be done. However, a summary of the response is included below, though limited conclusions can be drawn from a solitary response.

The respondent identified themselves as an educator within NES and reported that LEiC is being actively promoted to staff within NES. Links to EiC have been added to recruitment promotion for QI programmes, the CAIR dashboard is used as examples within eLearning modules, and 30 EiC places are funded for Leading QI. However, this participant identified that there is some confusion "between what Health and Social care does and what EiC does", thereby making it challenging for individuals when applying for QI programmes to identify which 'place' they should select. Whilst this activity indicates promotion of the broader EiC programme, there was limited reference to the LEiC framework itself. When discussing the LEiC framework, this participant valued the self-assessment, though they reported that there could be greater alignment between the assessment's terminology and that of the framework sections. They also described the resource as "quite clunky" and highlighted that some of the resource is not accessible to read. They also suggested that more examples of how it could be operationalised would be useful and that the resource needs updated given the recent release of the new Scottish Approach to Change. They reported that they were unaware of any increased interest in leadership, development, and improvement as a result of completing the self-assessment. They were similarly unaware if there had been any support provided in the form of coaching or mentoring.

Overall, this participant identified some ongoing work to promote EiC though it is unclear how much can be applied specifically to the LEiC framework, and they also highlighted some areas for improvement. However, the low response rate does indicate that a lack of engagement for NES colleagues regarding this resource which is concerning as it is embedded on their platforms.

LEiC user survey

An optional survey was embedded in the resource to enable users to provide feedback on the resource during their leadership journey. Since its launch in November 2023, this survey had 12 respondents from a variety of health boards. All but one participant identified themselves as from a nursing background; the other participant was an AHP.

When asked about their leadership level, one-third of respondents reported that they were in a manager role, whilst two-thirds indicated that they were in Team lead roles. Respondents overwhelmingly answered the survey at the start of their journey using the LEiC resource (n=11).

Participants expressed a range of expectations for using the LEiC resource, focusing on both personal and professional development. Many hoped to enhance the quality of person-centred care, improve practice standards, and support staff wellbeing. A strong theme was leadership growth, with participants aiming to become better leaders and managers, make teams feel valued, and prepare for career progression. Others sought to identify strengths and gaps in their knowledge, expand clinical and leadership skills, and build confidence in existing abilities. The resource was also seen as a tool for reflective practice, enabling documentation of growth opportunities and guiding future learning. Additionally, participants anticipated gaining insights to influence positive change and drive improvements in care delivery.

As only one respondent indicated that they were at the end of the LEiC journey, they were the only one who answered the questions regarding their perceptions of having use the resource. This individual reported using all ten capabilities, as well as the ‘supportive learning resources’, and ‘mapped LEiC capabilities’ pages. They also completed the assessment and action plan, for which they are currently planning their next steps. They reported that the resource met their expectations and strongly agreed that it helped support their education and development as a leader. This respondent also indicated that they would use the resource again and would recommend it to others. They did not report any mentorship support to engage with the resource, but they felt that the framework helped them identify areas for development and review key strategic drivers for leadership. However, they did find the resource difficult to navigate.

Whilst this survey was useful to gain some feedback from users, such as identifying demographic characteristics (board, discipline, role) which are unavailable from the usage analytics presented above, as well as their expectations and experience with the resource, the small number of respondents limits the generalisability of these findings. Though when considered with the other data sources in this evaluation, this data can contribute to informing next steps with the LEiC framework. However, to aid in future evaluation of the resource, it would be beneficial to consider additional ways to gather user feedback.

Conclusion:

The evaluation of the three surveys highlights mixed levels of engagement and implementation of the LEiC framework across boards and organisations. While some boards have embedded the

resource into leadership programmes and governance structures, others reported limited or no use, often citing time constraints, service pressures, and organisational changes as key barriers. Positive features of the framework include its accessibility, alignment with leadership principles, and the value of the self-assessment tool for reflection and identifying development needs. Enablers to implementation were linked to support from clinical leaders, organisational development teams, and integration with existing leadership strategies, whereas barriers included lack of protected time, absence of formal leadership programmes, and challenges in monitoring usage.

Feedback from users and stakeholders consistently emphasised the resource's potential to enhance person-centred care, strengthen leadership capability, and support reflective practice. However, usability issues—such as navigation difficulties and limited functionality—were noted, alongside suggestions for improved monitoring and clearer operational examples. The low response rate from NES colleagues and limited user survey participation indicates a need for stronger engagement strategies and more systematic feedback mechanisms. Overall, while the LEiC framework is valued for its purpose and content, further work is required to improve accessibility, embed it consistently across boards, and evaluate its impact on leadership development.

Case studies

A case study design was used to conduct an in-depth inquiry into how the LEiC Framework is being used in a local area to account for the contextual factors. By using a case study in this evaluation, it is possible to deeply explore how an organisation has used the LEiC framework. This can provide a more detailed and fuller understanding the value of this resource, and what enablers and barriers there are to its implementation in different contexts.

Case studies were recruited through existing EiC Clinical Lead networks, Nursing Directors, Midwifery Directors, and AHP Directors. For the purpose of this study, the inclusion criteria was limited to those who have used the LEiC framework or have worked to implement the resource within their board since its launch in November 2023. However, using this recruitment strategy, only two participants were identified. The case study interviews took place in January and February 2025. This is a self-selected case study sample. Only one case study is published in this evaluation, as at the time of writing, the other case study participant was unable to be reached to confirm their consent for the analysis to be published.

Case study 1: Fiona Reid (AHP Education and Teaching Lead) and Lynne Sheridan (AHP Practice Education Lead), NHS Tayside

What was done?

Post Covid-19 pandemic, the AHP Education Team in NHS Tayside felt there was a gap in support for more senior staff in terms of leadership development. Whilst there was a previous AHP programme and the NMAHP Development framework, it was felt that these existing resources

were no longer meeting the needs of AHPs in this board. Coincidentally, at this time, the LEiC framework was launched and was identified as a potential solution to this problem.

Tayside AHP Education Team went through the LEiC framework to identify the key points of the framework and how it might be developed into a programme that could be delivered in a group setting, taking it out of the self-directed learning sphere. The programme consists of four days, delivered across a four month period, with an additional half day every month to be used to complete required modules and self-reflection. Day one explores effective personal leadership, day two concerns person-centred culture and empowering staff, day three centres around creating a safe and positive team environment, and day four works to embed a culture of quality improvement. These themes were pulled from the framework and categorised into these sessions. Managers are also asked to share what they hope staff will gain from attending the programme and feedback on the impact.

Since the development of the programme there have been two cohorts with between 20-25 participants each. Although they have gathered feedback from participants (discussed further below), future work will provide a more detailed evaluation of this data.

What worked well?

The Tayside AHP Education Team valued that the LEiC framework was not exclusive to nurses or midwives, which was appreciated given the previous work of the EiC programme.

"But the fact that AHPs are front and centre alongside nursing and midwives for this framework has been a really positive from our experience so far." (Fiona)

The Tayside AHP Education Team indicated that no aspect of the framework felt like it was too directive, and could be applied across a wide range of disciplines, which was particularly necessary with the variation in AHP roles.

The feedback from staff who have attended the course has been overwhelmingly positive. The decision to have an in-person programme has been considered especially appreciated, allowing staff who work in different sites and professions to share their experiences, learn from one another, and recognise the skills that they may already have.

A particular area of improvement for leadership, noted by staff in a feedback session, was the confidence to address team culture, and have what could be potentially difficult conversations with their staff.

"We've definitely seen and heard and had fed back to the importance around team culture, so teams are now having open conversations about this. And actually team leads who've not felt confident to approach it have now had sessions within their teams over these really tricky conversations. Staff are now absolutely wanting to take that and deal with it." (Fiona)

Staff are also sharing the experience with the colleagues and promoting the programme to other members of their team. The Tayside AHP Education Team have had continued interest in attending the course for future cohorts.

What could have gone better?

Tayside leadership wanted to develop the LEiC framework into a programme, as they expressed some concern that a framework which requires self-directed learning would not adequately support staff to develop their leadership skills.

"This programme sits alongside the framework, which is really important. This programme guides and supports staff through the framework, which enables them having the time and head space to use it to it's fullest."(Fiona)

By operationalising the key tenets of the framework, they developed a space where staff could share their experiences and benefit from the camaraderie and learning of others as explored above. However, given this shift in direction towards a group setting, there were some parts of the framework that were not included in the programme, though these were not specified during the interview.

"There were definite parts that we didn't feel that was right for a group setting and were far more applicable for the leaders to take on within their own clinical settings." (Fiona)

Finding the time to engage with the programme could be difficult for staff, particularly the half day each month for self-directed learning.

"The half day session that we ask them to reflect on, can be really tricky for some and it's often the thing that goes when workloads get heavier." (Fiona)

Whilst having the dedicated space in their calendars for the in-person days was not considered to be as much of an issue, the self-directed learning time was highlighted as an area for slippage when capacity was limited. However, it was also noted that even for the in-person days, dedicated time could be interrupted if the programme was taken place within their work site.

"We're moving away off site for this next cohort, to support the staff to fully engage with the programme and remove any temptations staff may have felt to nip back and check on clinical areas." (Lynne)

The Tayside AHP Education Team are aiming to address these problems by scheduling in the self-directed learning time and by holding the course off-site to support uninterrupted learning.

Board Clinical Leads focus group

Two focus groups were held in July with EiC BCLs to explore local implementation of the LEiC framework. An additional interview was held with one board who could not attend the focus group date. Across this data set there was no representation from four territorial boards and two special boards.

The evaluation of the LEiC resource across multiple NHS Boards revealed a range of experiences and perspectives regarding its promotion, integration, usability, and impact. Several key themes emerged from the focus group and interview data.

Promotion and awareness

Promotion of the LEiC resource has been inconsistent across boards, with many participants reporting limited formal communication strategies. In several cases, awareness efforts were driven by individual Board Clinical Leads (BCLs) or educators rather than coordinated organisational campaigns. While some boards utilised posters, newsletters, and screensavers to raise awareness, others relied on informal conversations or local development days. A recurring challenge was the difficulty in locating the resource on Turas, with suggestions made to create a centralised portal or improve searchability. Participants emphasised the need for executive-level endorsement to enhance visibility and legitimacy of the resource.

Integration into existing structures

The integration of LEiC into existing leadership and governance frameworks is ongoing and varies significantly between boards. Some have begun embedding the resource into personal development plans (PDPs), appraisals, and leadership programmes, while others are still exploring how best to align it with organisational priorities. In certain areas, LEiC has been incorporated into new leadership initiatives, such as pilot programmes or development courses. However, there remains ambiguity around governance and accountability, with several participants unsure where responsibility for LEiC lies within their structures. This lack of clarity has hindered consistent implementation and evaluation.

Allied Health Professionals integration

The inclusion of Allied Health Professionals (AHPs) in the implementation of the LEiC resource has been variable across boards, with some making deliberate efforts to ensure equity of access while others have maintained separate leadership pathways for nursing, midwifery, and AHPs. In several boards, leadership programmes have been designed to encompass all NMAHP staff, with LEiC resources integrated into development sessions and promotional materials. For example, some boards have aligned their leadership strategies with the LEiC framework and offered joint sessions for nurses, midwives, and AHPs. However, other boards reported that leadership programmes for AHPs and nursing staff remain distinct, and there is uncertainty about the relevance and applicability of LEiC to AHP roles. Despite initial engagement, time constraints and competing priorities have limited sustained involvement from AHPs, particularly in areas where nursing staff have been prioritised due to operational pressures. Participants highlighted the need for clearer messaging and inclusive strategies to ensure that AHPs are fully engaged in leadership development efforts and can benefit from the LEiC framework alongside their nursing and midwifery colleagues. Whilst there is a role for the EiC National team to develop this communication, boards also need to endorse the integration of AHPs into local NMAHP development strategies.

Accessibility and usability

Feedback on the usability of the LEiC resource was mixed. Many participants appreciated the self-assessment tool, noting its reflective nature and alignment with the Excellence in Care (EiC) framework. The resource was described as straightforward and well-structured by some, while others found it difficult to navigate or overwhelming due to the volume of linked materials. Concerns were raised about the relevance of the resource to different professional groups, particularly medical staff even though this is out with the scope of the EiC programme, and the need for clearer guidance on how to begin using it. Suggestions for improvement included developing bite-sized learning formats, e-learning modules, and simplified pathways to engagement.

Staff engagement and capacity

Operational pressures and competing priorities were identified as significant barriers to staff engagement with the LEiC resource. Many participants noted that clinical demands often prevent staff from dedicating time to non-mandatory development tools. Engagement was frequently reactive, with staff accessing resources only when facing challenges rather than proactively. The voluntary nature of LEiC further complicates uptake, as staff may be unaware of its existence or unsure of its value. Participants stressed the importance of promoting LEiC as a supportive and enabling tool, rather than an additional burden, and called for stronger leadership support to drive cultural change.

Coaching, mentoring, and support

Support for staff using the LEiC resource is currently informal and varies across boards. While some BCLs and managers provide mentoring or guidance, there is no consistent structure in place. Role ambiguity was evident, with uncertainty over whether managers or BCLs should be responsible for supporting staff through the resource. Participants expressed interest in formalising coaching and mentoring pathways and integrating LEiC into supervision frameworks. This would help ensure that staff receive appropriate support and are able to make meaningful use of the resource.

Measurement and impact

Measuring the impact of LEiC remains a challenge for most boards. There is limited data on who is accessing the resource, how it is being used, and what outcomes it is generating. Participants proposed several ideas to improve tracking, including using Turas analytics, encouraging reflective submissions, and linking engagement to recognition schemes such as certificates or awards. The need to evidence learning and demonstrate value was a recurring theme, with participants calling for more robust evaluation mechanisms and clearer indicators of success.

Conclusion:

In conclusion, the evaluation of LEiC implementation across NHS Boards highlights several actionable recommendations to enhance uptake, usability, and impact. First, there is a clear need

for stronger executive-level endorsement and strategic promotion to raise awareness and legitimise the resource across all staff groups. The development of a centralised portal on Turas for EiC could improve accessibility and visibility, alongside bite-sized learning formats and e-learning modules to support engagement. Embedding LEiC into existing leadership programmes, appraisal systems, and governance structures will help normalise its use and ensure alignment with organisational priorities. Formalising coaching and mentoring pathways, and clarifying roles and responsibilities for staff support, will further strengthen implementation. Finally, introducing mechanisms to track engagement and evidence learning - such as Turas analytics, reflective submissions, and recognition schemes - will enable boards to monitor progress and celebrate achievements, thereby reinforcing the value of the LEiC resource in supporting leadership development across nursing, midwifery, and allied health professions.

Engagement calls and Scottish Government reports

This section of the report will combine the analysis from the engagement calls and Scottish Government reports. This approach allowed consideration for how boards have implemented the LEiC framework over time. Each board is presented individually, with key themes identified from across the boards highlighted in the conclusion of this section.

Data was pulled from any engagement calls occurring between the launch of the resource (November 2023) to the end of the data collection period (September 2025). The engagement calls are an opportunity to stay connected with Healthcare Improvement Scotland's Excellence in Care (EiC) Team. They aim to provide a platform for open conversations about the EiC programme and promote discussion about what's working, what's not, and where support might be needed. The number of engagement calls varied amongst boards, though it is recommended that each board have a minimum of four engagement calls per year, boards can also request additional calls with members of the HIS National EiC Team. Data was pulled from the available reports authored by Scottish Government in response to the biannually submitted updates from each board. The three reporting periods for the Scottish Government data covered from April-June 2024, July-September 2024 and October 2024 to March 2025.

Implementation of the LEiC framework across NHS boards in Scotland has progressed unevenly, with some boards demonstrating substantial integration while others remain in exploratory or early adoption phases. Some boards have made significant strides, embedding LEiC into leadership development programmes and aligning it with broader professional development initiatives.

Despite these successes, many boards face persistent challenges in implementing LEiC. Common barriers include resource constraints, competing priorities, and limited staff availability due to clinical workload pressures. Several boards noted that while plans are in place, staff engagement is hindered by operational demands. Tracking usage and evaluating impact also remain problematic, particularly where LEiC is not mandated or embedded within formal governance structures.

Allied Health Professional (AHP) involvement varies across boards, with some demonstrating strong engagement and others reporting limited or unclear participation. Some boards have

actively involved AHPs through workshops, ward-based meetings, and inclusive leadership programmes. In others. AHPs themselves have used the LEiC resource within their leadership courses, although their development resources remain separate from nursing-focused programmes. Conversely, other boards have not pursued AHP-specific leadership development using LEiC, citing perceived lack of applicability or opting for alternative leadership development approaches.

Overall, while the LEiC framework is gaining traction across several boards, its implementation is marked by variability in strategy, engagement, and evaluation. Continued efforts to address barriers, promote inclusive leadership development, and strengthen AHP involvement will be essential to achieving consistent and meaningful integration of the framework across Scotland's health services.

Discussion

The evaluation of the Leading Excellence in Care (LEiC) Education and Development Framework reveals a complex and evolving landscape of implementation across NHS boards in Scotland. Since its launch in November 2023, the framework has demonstrated potential as a valuable resource for leadership development among nursing, midwifery, and allied health professionals (NMAHPs). However, its uptake and integration have varied significantly, influenced by local contexts, organisational priorities, and resource availability.

Overall Use of the LEiC Framework

Usage analytics indicate a strong initial engagement with the LEiC resource, particularly with the main landing page and the self-assessment tool. The Turas platform recorded over 24,000 page views, with the self-assessment downloaded more than 1,000 times, suggesting that users value tools that support reflective practice and personal development. However, engagement with subpages and specific capabilities was notably lower, which may reflect limited awareness of the full breadth of the resource or challenges in navigation. The alignment between Turas and Sway page views suggests that users are following the intended pathways, yet the overall pattern points to a need for improved promotion and clearer guidance on how to use the resource comprehensively.

Survey data and focus group findings further support the notion that while the LEiC framework is recognised as a useful tool, its use remains concentrated among those already engaged with the Excellence in Care (EiC) programme. The limited representation of frontline clinical staff in survey responses suggests that broader dissemination and engagement strategies are needed to reach the wider NMAHP workforce.

Implementation Across Boards

Implementation of the LEiC framework across boards has been uneven. Some boards have made significant strides in embedding the framework into leadership programmes and governance

structures. These boards have developed tailored leadership courses, aligned LEiC with existing development initiatives, and actively involved AHPs in their strategies.

Conversely, other boards remain in exploratory phases or have yet to integrate the framework meaningfully. Barriers such as limited staffing capacity, competing priorities, and lack of formal leadership programmes have hindered progress. In some cases, organisational changes and unclear governance structures have further complicated efforts to embed LEiC. The voluntary nature of the resource and the absence of mandated usage have also contributed to inconsistent uptake.

The inclusion of AHPs in LEiC implementation has been variable. While some boards have made deliberate efforts to ensure equity of access, others maintain separate leadership pathways for nursing and AHP staff. This inconsistency reflects broader challenges in multidisciplinary leadership development and underscores the need for clearer messaging and inclusive strategies.

Challenges to Implementation

Several recurring challenges have been identified in the implementation of the LEiC framework. Chief among these is the lack of protected time for staff to engage with the resource. Service pressures and clinical demands often result in leadership development being deprioritised, despite recognition of its importance. The self-directed nature of the framework, while offering flexibility, has also been cited as a barrier, particularly for staff who may struggle with independent learning or lack familiarity with leadership concepts.

Usability issues have further impeded engagement. Participants described the resource as difficult to navigate, with excessive clicking and unclear pathways. Suggestions for improvement included streamlining the interface, developing bite-sized learning modules, and creating a centralised portal on Turas. The inability to monitor usage and track progress was another significant concern, limiting boards' capacity to evaluate impact and demonstrate value.

Organisational readiness also plays a critical role. Boards without existing leadership programmes or clear strategies for professional development face greater challenges in adopting LEiC. Additionally, the lack of formal coaching and mentoring structures has left some staff without adequate support to engage with the resource meaningfully.

Enablers to Implementation

Despite these challenges, several enabling factors have facilitated the use of the LEiC framework. Support from EiC Board Clinical Leads, practice development teams, and senior nursing and midwifery staff has been instrumental in promoting and embedding the resource. Boards that have aligned LEiC with existing leadership strategies and development programmes have reported more successful integration. Protected learning time, where available, has also supported staff engagement.

The framework's accessibility and alignment with established leadership principles have been widely praised. Its inclusive language and applicability across disciplines have made it a valuable tool for multidisciplinary teams. The self-assessment component, in particular, has been highlighted as a practical and reflective tool that encourages staff to take ownership of their development.

The case study from NHS Tayside illustrates how the framework can be adapted to local contexts. Tayside's development of a structured leadership programme based on LEiC components demonstrates how boards can operationalise the framework to support group learning and peer engagement.

Impact on Leadership Development

While the evaluation indicates that the LEiC framework has the potential to support leadership development, evidence of its impact remains limited and largely anecdotal. Feedback from users suggests that the resource helps identify learning needs, supports reflective practice, and encourages strategic thinking. However, the lack of robust monitoring and evaluation mechanisms makes it difficult to assess outcomes systematically.

Boards that have embedded LEiC into leadership programmes and appraisals report positive feedback from participants, including increased confidence, improved communication, and greater awareness of leadership competencies. The framework has also been used to support career progression and team development, particularly in settings where structured programmes have been developed.

Nonetheless, the overall impact on leadership development across Scotland is constrained by inconsistent implementation, limited engagement from frontline staff, and challenges in measuring outcomes. Strengthening evaluation strategies, formalising support structures, and promoting the framework more widely will be essential to realise its full potential.

Conclusion and recommendations

The evaluation of the LEiC Education and Development Framework highlights its potential as a valuable tool for supporting leadership development across Scotland's nursing, midwifery, and allied health professional (NMAHP) workforce. Since its launch, the framework has generated interest and engagement, particularly through its self-assessment tool and alignment with existing leadership principles. However, the extent of its implementation across NHS boards remains variable, with several boards demonstrating strong integration while others are still in early or exploratory phases.

To realise the full potential of the LEiC framework, a more consistent and coordinated approach is required. This includes improving accessibility, embedding the resource into governance and development structures, and enhancing mechanisms for evaluation and feedback. Strengthening support for staff and promoting the framework as a practical and enabling tool will be essential to drive meaningful engagement and sustained use.

1. **Enhance Visibility and Promotion**

First, enhancing the visibility and accessibility of the framework is essential, through ongoing local engagement via the EiC BCLS. This work will be supported through continued knowledge mobilisation through the EiC national learning system.

2. **Improve Usability**

Improving the usability of the resource is also critical. The current layout and navigation structure have been identified as barriers to engagement; therefore, streamlining the digital interface, in collaboration with NES, and introducing bite-sized learning modules or e-learning formats would support more intuitive use. Consideration should also be given to developing a mobile-friendly version or app-based interface to facilitate access in diverse clinical settings.

3. **Improve Monitoring and Evaluation**

Monitoring and evaluation mechanisms must also be improved through collaboration with NES. Enhancing analytics functionality to track usage and completion of framework components will allow boards to assess impact and demonstrate value. Mechanisms such as reflective submissions, feedback forms, and recognition schemes (e.g. certificates or awards) could be introduced to incentivise engagement and celebrate achievements.

4. **Expand AHP Engagement**

Efforts to expand AHP engagement should be prioritised. Messaging and resources must be tailored to AHP roles and contexts, and joint leadership programmes should be promoted to foster inclusive development. Addressing perceived relevance and applicability through targeted communication will help ensure that AHPs are fully supported in their leadership journeys.

5. **Update and Align Content**

Finally, the content of the LEiC framework should be reviewed and updated to align with current national strategies, such as the Scottish Approach to Change. Ensuring consistency in terminology across framework sections and assessment tools will improve clarity and coherence, supporting more effective use of the resource.

Appendix 1

Acronym	Meaning
AHP	Allied Health Professional
BCL	Board Clinical Lead
CAV	Care Assurance Visit
CCAT	Continuous Care Assurance Tool
CHSC	Community Health and Social Care
EiC	Excellence in Care
HB	Health Board
HIS	Healthcare Improvement Scotland
HSP	Healthcare Staffing Programme
IPC	Infection Prevention and Control
LD	Learning Disabilities
MH	Mental Health
NHS	National Health Service
NMAHP	Nursing, Midwifery and Allied Health Professions
PCAT	Person-Centred Assurance Tool
QAD	Quality Assurance Directorate
QI	Quality Improvement
QMS	Quality Management System
QoC	Quality of Care
RAG	Red-Amber-Green
RDS	Right Decision Service
SANL	Scottish Acute Nursing Leaders
SAS	Scottish Ambulance Service

SCM	Senior Clinical Manager
SCN	Senior Charge Nurse
SEND	Scottish Executive Nurse Directors
SLWG	Short Life Working Group

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