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# EVALUATION OF HENCEL, HENWL, HESL PROFESSIONAL SUPPORT UNIT'S COACHING AND MENTORING SERVICE FOR DOCTORS AND DENTISTS

## FINAL REPORT

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# Abstract

This report describes a research project commissioned by the Professional Support Unit* and conducted by the team of researchers at Oxford Brookes University. The Professional Support Unit is hosted by Health Education North West London but provides professional support to health professionals in North East and Central London, South London as well as North West London

The aim of the project was to select or develop a set of suitable measures and to use them to evaluate the coaching/mentoring programme that was established in 2008. Three established measures were selected for this purpose: employee engagement, self-efficacy and self-compassion. An additional questionnaire was developed with a focus on evaluating any changes brought about by coaching in the context specific to Coaching and Mentoring Service coaching clients. The questionnaire, developed from semi-structured interviews with stakeholder representatives, elicited unique information about the nature of changes that clients identified as the result of the programme related to their place of work. It also included a self-estimation by the coached clients to what extent they could attribute each change to the coaching received.

120 (78%) of matched responses pre and post coaching were analysed to test if participation in coaching improved employee engagement, self-efficacy and self-compassion and if participants could identify a change in a range of context-related aspects of their work.

The overall conclusions of the evaluation described in this report on the basis of both quantitative and qualitative analysis indicate that the coaching and mentoring programme provides an effective service for their clients. Well-validated measures that were selected for this evaluation show that employee engagement, self-efficacy and self-compassion of the participants significantly improved. The bespoke questionnaire developed for evaluating changes that participants perceived in their working life also showed improvements particularly in relation to the impact on self (confidence in their ability). This questionnaire provided an opportunity to evaluate the extent to which clients attributed the above changes to coaching rather than to any other factor. The analysis convincingly shows that coaching was a major contributor to this success.

# Acknowledgements

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**The Coaching and Mentoring service and Professional Support Unit were previously part of the former London Deanery. In April 2013 both services became part of the newly established organisation, Health Education England, and its local education and training boards, of which there are three in London: Health Education North Central and East London, Health Education North West London, Health Education South London.*

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# INTRODUCTION

The Coaching and Mentoring Service for doctors and dentists was established in London in 2008. The Coaches were trained by an established leadership coaching provider and their performance was assessed at the end of the training. The quality and standards of the service were established following guidelines of the General Medical Council and European Mentoring and Coaching Council (EMCC). The outcome of the service was measured by individual feedback from the service users. However, it was viewed that although this provided some data on how the service was performing, the data collected did not quantify any performance changes in the recipients. The service was publicly funded thus it was viewed that it should be properly evaluated to ensure value for money. Preliminary work looking at the literature evaluating the benefits of coaching and mentoring did not reveal an established methodology for conducting such a review. The Oxford Brookes team of researchers won a bidding process for the research based on their proposals for developing novel methodologies for the evaluation of the service. The aim of the project was to establish whether the tools selected could measure change in performance and attitudes of doctors undergoing the brief coaching intervention, since ultimately the purpose of the coaching is to improve the performance of doctors and dentists for the benefit of the patient. This paper describes the process of the literature review, selection and development of scales and the results of the evaluation.

The research team suggested applying three established measures that could help to identify the changes in users of the service, administered at two stages: at the beginning of the programme and at the end of it. It was also proposed that an additional questionnaire, tailor-made for the specific context of the Coaching and Mentoring Service clients, would evaluate significant aspects of changes in the clients' working lives that would serve as an important measure of value added by the service. This questionnaire was designed as the result of a qualitative analysis of interviews with various stakeholders of the Coaching and Mentoring Service and included in the evaluation at the final point of measurement.

The Coaching and Mentoring Service was initially established as a mentoring service since this was an established role in medical careers, however, it was viewed from the published data that coaching techniques were more effective at enabling changes in behaviour than advice giving. Although the service provided by the Coaching and Mentoring Service practitioners is better described as coaching (see Section 2.1 of the literature review) traditionally the users of the service called it mentoring. For the purpose of transparency the terms mentoring, mentor or mentee were retained whenever they were used as such by clients and stakeholders of the service. However, in the rest of the report we use the terms coaching, coach and client and only address the issue of differences in terminology when they are needed in the literature review and in the discussion.

This report describes all the stages of the project from the literature review to the implications of the findings. In the literature review we considered the state of knowledge about outcome studies concerned with evaluation of coaching programmes and theoretical underpinning for selected measures. The methodology chapter describes all the stages of the research design and the process of the qualitative part of the research with the aim of developing a new tailor-made questionnaire. The main features of the analysis process are also discussed, together with the challenges and limitations of the methodology. The findings of the project are presented in two sections: 4.1 statistical analysis of the data produced by selected and designed instruments and 4.2 analysis of qualitative data, one part of which was gathered through interviews with stakeholders and the other as qualitative information provided in the final questionnaire stage of data collection. We finish the report with a discussion about the implications of the findings and conclusions that include our recommendations.

# LITERATURE REVIEW

The focus of the literature review is to discuss issues associated with the evaluation of coaching outcomes and to provide the background context which informed the selection of measures used in this project.

## Issues of the outcome research in coaching

Although the demand for coaching and mentoring in organisations has grown enormously for the last 10-15 years, suggesting that it adds value to employees, the question of whether coaching is effective still attracts the attention of many interested parties. Grant (2013) suggests that the answers to this question depends "on the contextual and situational factors at play and who is asking the question – and why" (p. 15).

Before looking at these factors it is important to start with what is meant by coaching in principle and how this practice is differentiated from other similar helping practices and, in the context of this study, from mentoring. Coaching has been described as "a human development process that involves structured, focused interaction and the use of appropriate strategies, tools and techniques to promote desirable and sustained change for the benefit of the coachee and potentially other stakeholders" (Bachkirova et al, 2010, p. 1). Although Garvey (2010) argues that there are more similarities than differences between coaching and mentoring he and others (e.g. Ragins & Kram, 2007) admit that specific features of mentoring that are usually much less present in coaching are advice-giving from the position of a more experienced mentor, longer term relationships and a shared context. As mentoring is often a voluntary practice, the question of the effectiveness of mentoring is not so pressing for organisations which are concerned with the most economical way of developing their employees. This question of cost-effectiveness also differentiates coaching from mentoring.

Returning to the question of effectiveness of coaching from the position of different stakeholders, the first group concerned with this question is the coaches themselves. They have a vested interest in a particular answer to this question. On the one hand they wish coaching to be seen as effective for marketing purposes, but they are also interested in improving their practice: for example, they are not particularly satisfied with only a 'yes' or 'no' answer; they wish to know much more about why particular interventions do or do not work. Purchasers of coaching are usually interested in the question of whether coaching works because they want to know if coaching is cost-effective, rather than the nuances of the coaching process. That is why their measure of success is often ROI (return on investment). Both of these stakeholders have a vested interest in asking this question and may take action to investigate it but they do not always have training in research methods.

Researchers and academics in the field of coaching are viewed to be well-placed to explore the effectiveness of coaching using rigorous research methods. They are also interested in developing evidence-based practice for coaching (Fillery-Travis & Lane, 2006; Briner, 2012). However, the number of interested academics is very small and those who undertake research encounter many difficulties in applying scientifically respected methods to researching coaching practice (Ellam-Dyson, 2012; Drake, 2009). In order to apply these methods the nature of practice has to be significantly oversimplified, leading to excessive reductionism. For example, outcomes may be selected because they can be measured, rather than because they are appropriate for individual clients or reflect the nature of coaching (Marzilleier, 2004; Easton & Van Laar, 2013).

Coaching is a complex intervention influenced by many different factors such as the client's attitude, coaches' skill, coach/client relationship, making it difficult to tease apart the process. In addition if coaching is sponsored by an organisation it is difficult to establish who the main provider of information about the effectiveness of coaching should be: the client, the coach, the purchaser of the service or those on the receiving end of the changes that are made by the client. Additional questions that also increase the complexity of evaluating the effectiveness of coaching are:

- What role does the context of coaching contribute to the outcomes? and
- Is it possible to assume that coaches from different backgrounds, training and styles are delivering the same type of coaching?

In comparison to other helping practices these questions for coaching are more difficult to answer.

Various research methodologies aim to address the difficulties and questions described above in different ways with certain advantages and disadvantages in each of them. Grant (2013) differentiates as rigorous three types of outcome studies:

- Case studies that can provide valuable descriptive data but do not allow generalised evaluations or the comparison of results between different coaching interventions.
- Within-subject outcome research which allows comparison of the impact of coaching on a group of individuals. The group is assessed before and after the coaching interventions. This is the most commonly used study design in the literature. With sound design, it can provide valuable quantitative data of change but causation cannot be attributed only to coaching.
- Between-subject and Randomised Controlled Studies, which are considered the 'gold standard' particularly in medical research and can measure change and relate it to the intervention. However, the utility of these designs for studying coaching is strongly contested (Cavanagh & Grant, 2006; Greif, 2009; Briner & Rousseau, 2011) due to problems with delineating a

control group, maintaining the blind condition and constructing placebo interventions. Uses of self-coaching, peer-coaching or 'waiting list' are considered serious issues in terms of implementation in relation to coaching studies (Hicks, 1998; Franklin & Doran, 2009; Cavanagh & Grant, 2006; Greif, 2009; Williams, 2010).

In a wider research literature it has been argued that classic RCTs and other quantitative methodologies represent a positivist paradigm which requires the search for general relationships between a small number of discrete variables across wide varieties of context. However, these contexts, from a constructionists' point of view, have a large impact upon these relationships (Fishman, 1999, p. 235). Without consideration of context the findings of such studies may lead to conclusions that are so generic and in a way obvious that their practical value becomes questionable in the light of effort required for conducting a large scale study (Orlinsky, et al, 1994; Grief, 2007).

It is not surprising that there is significant movement in research communities to resist the situation when only one notion of research is recognised as science: the one identified with modernistic positivism. It has been argued that there are other meanings of science, for example, as disciplined, critical, reflective thought that compares and contrasts evidence, arguing for alternative interpretations or explanations of a particular phenomenon (Fishman, 1999; Cronin & Klimoski, 2011). In coaching research Grant (2013) argues that "an evidence base per se does not purport to prove that any specific intervention is guaranteed to be effective, nor does it require that a double-blind, randomised, controlled trial is held as being inevitably and objectively better than a qualitative case study approach" (p.33).

Therefore the evaluations of coaching could be approached from different research paradigms (pragmatism, contextualism, interpretativism) and may benefit from mixed designs. For example it can include retrospective questionnaires validated by traditional positivist procedures (Passmore, 2008), but also include new instruments that were developed with considerations of factors such as the type of coaching, the organisational level of the coachee, the specific objectives and context of each coaching engagement (De Meuse et al, 2009). Mixed method was the design that was chosen for this study.

## Measures used for the evaluation of coaching programmes

According to Fillery-Travis and Lane (2006) before we can ask whether coaching works we must ask what it is being used for. A fundamental difficulty of coaching outcome research is the extreme heterogeneity of issues, problems and goals which can be picked out as themes in different coaching interventions. For example, in therapy there are general indicators of the quality of service such as subjective well-being, symptom reduction and life functioning (e.g. Mental Health Index, Howard et al, 1996). In coaching, however, it is difficult to identify the outcome measures which are applicable to the whole range of coaching interventions (Greif, 2007, p. 224). Grant (2013), providing many examples from the vast range of issues addressed in coaching, concludes that there is an almost endless list of applications. The majority of these outcomes are difficult to quantify. For example, use of ROI (Return on Investment) has been severely criticized by many authors (De Meuse, 2009; Grant, 2010, 2013).

Often practitioners create a battery of measures which might reflect the context of the study, their priorities and those of their client or organisation commissioning the evaluation. A combination of measures or indicators can sometimes help to avoid oversimplification with an intention to work towards meeting a particular target that is measured (Easton & Van Laar, 2013).

Greif (2007), for example, proposes general measures (degree of goal attainment and client satisfaction with coaching) and specific measures (result of business coaching). The specific outcomes criteria that could be used are:

- Problem clarity and concreteness of goals
- Social competences
- Performance improvement
- Self-regulation
- General traits and abilities

In this project the Coaching and Mentoring Service was interested in two variables which are theoretically related to the individual change process: employee engagement and self-esteem.

### Employee engagement

Employee engagement is a relatively new concept that developed as the result of research on burnout in the workplace. It is made up of three scales: vigour, dedication and absorption. Research over the past ten years has shown the importance of this concept in relation to understanding key organisational outcomes, such as low turnover (Schaufeli & Bakker 2004), high organisational commitment (Demerouti, Bakker, de Jonge, Janssen & Scaufeli, 2001), and customer-rated employee performance (Salanova, Agut & Peiro, 2005). This research overall provides good evidence for the utility of measuring

employee engagement for the purpose of evaluating the value of a coaching and mentoring programme. If this study could show that the coaching and mentoring programme does improve employee engagement then this is likely to be an indirect way of measuring 'customer-rated' employee performance as well as reduced turnover and increased organisational commitment.

A typical instrument for measuring employee engagement is the Utrecht Work Engagement Scale (Schaufeli & Bakker, 2003). The authors have been building up validity and reliability data and other leading researchers in the field are also using this particular scale for understanding this concept in relation to other key organisational concepts. The authors claim in their provisional manual that the scale does in fact have satisfactory psychometric properties including:

- Three subscales that are internally consistent and stable across time.
- The three-factor structure is confirmed and seems to be invariant across samples from
- different countries.
- Employee engagement that is measured with the UWES is negatively related to burnout, albeit that instead of loading onto burnout, professional efficacy loads on engagement.

On the whole this suggests that the UWES is a valid and reliable indicator of work engagement and is a suitable measure for this study.

**Self-Esteem**

The specification for this study details self-esteem as another measure that the Coaching and Mentoring Service was interested in evaluating in relation to coaching and mentoring interventions. We agreed that self-esteem has been associated with many positive and personal outcomes (Mruk, 2006; Bachkirova, 2004; Maxwell & Bachkirova, 2009) and there are measures that could be used to evaluate self-esteem in this study. For example, Janis-Field Feelings or Inadequacy Scale (JF scale; Eagly, 1967) is a 20-item Likert scale, which has been widely used to measure self-esteem, and its reliability and validity have been demonstrated (Church, Truss & Velicer, 1980). It is also possible to use the TSBI (the Texas Social Behaviour Inventory) (Helmreich, Stapp & Ervin, 1974) or the Rosenberg Self-Esteem Scale.

However, recently the concept of self-esteem has been criticised from many different angles. In spite of a steady stream of research it has become clear that the meaning, power and importance of self-esteem remain less than fully understood (Baumiester, 1999; Baumiester et al., 2003). The most problematic issues relate to the different behaviours of people with high self-esteem. Although the above factor may be less prominent in this study, a more serious issue of concern is that people with low self-esteem "exhibit less evaluative consistency in their self-descriptions", which makes their self-report data questionable (Cambell, 1999). Another concern related to self-esteem is that it is a global measure of self-worth and therefore derived from all areas of a person's life. It is recognised that people may improve their confidence and self-efficacy beliefs in some particular situations but this may or may not affect their overall sense of self-esteem (Pervin, Cervone & John, 2005; Bachkirova, 2004; Maxwell & Bachkirova, 2009). Therefore this measure may not be specific enough to evaluate the impact of work related interventions.

We suggested two other indicators instead of overall self-esteem:

**Self-Efficacy**

Perceived self-efficacy refers to beliefs about one's competence to deal with challenging encounters and the "belief in one's capabilities to organise and execute the courses of action required to produce given attainments" (Bandura, 1997, p.3). It is clear why this concept is related to beneficial coaching and mentoring outcomes. There is now a large body of research that strongly supports a relationship between measures of perceived self-efficacy and performance (Stajkovic & Luthans, 1998). Similar to employee engagement, if this study can show that the coaching and mentoring programme is improving levels of self-efficacy it is likely that it would be indirectly measuring improvement in client performance.

The most accepted instrument for this purpose is the General Self-Efficacy Scale (GSE) by Schwarzer & Jerusalem (1995). Cross-cultural research has been carried out which confirms the validity of this scale, showing consistent evidence of associations between perceived self-efficacy and other psychological constructs (e.g. health behaviours, well-being, social cognitive variables and coping strategies (Luszczynska, Scolz & Schwarzer, 2005).

**Self- compassion**

Another concept that is gaining interest in the field of coaching and development is self-compassion, originally proposed by Neff (2003). As self-esteem has been frequently associated with negative social comparisons and internalised self-judgments, so self-compassion instead has been introduced as a better individual measure that is also a powerful predictor of the ability to cope effectively with adversity and good mental health. Research studies have consistently linked self-compassion to reduced fear of failure, enhanced perceived competence and emotionally-focused coping strategies, suggesting that this indicator is a promising one for coaching (Neff, 2009; Neff & Vonk, 2009; Neff & Lamb, 2009).

Self-compassion could be measured with the Self-compassion Scale (SCS, Neff, 2003), which consists of 26 items and six subscales. It has been found to have high internal consistency and reliability and at the same time does not correlate with Narcissistic Personality Inventory the way the Rosenberg Self-Esteem Scale does.

**A specifically designed measure**

Following the discussion in section 2.1 about the

importance of being creative when facing various issues associated with measuring and therefore under-representing the qualitative nature of coaching it appeared that another instrument was needed for this evaluation. As also indicated by the Coaching and Mentoring Service it was important to address the more specific contextual relationship between the coaching/mentoring service provided to their clients and noticeable behavioural and attitudinal changes that might be linked to their work performance and, consequently, patient care.

With this task in mind it was considered important to conduct qualitative research that aimed to explore what behavioural changes as the result of coaching and mentoring could be linked to generic improvements in work performance and, potentially, patient care. Therefore this research included interviews with appropriate stakeholders: the users of service (clients), the coach/mentors and those referring clients to this service. A grounded theory approach (Strauss and Corbin, 1990) was used as the main methodology leading to the design of a short questionnaire for the clients to complete at the end of the six-month coaching period. The responses to this questionnaire were included in the list of variables and contributed to the evaluation in order to add contextually meaningful data to this evaluation.

# METHODOLOGY OF THE PROJECT

This section of the report describes the rationale and design of the project, the approach that we took in developing a bespoke questionnaire and how data was collected and analysed.

## Overall design

The project was designed as mixed methods research with a 'QUANT/qual' formula (Tashakkori & Teddli, 2010) which means that a large proportion of the data, as requested by the client, were of a quantitative nature using qualitative data to further inform the results.

The quantitative element of the study aimed to establish whether the coaching and mentoring provided by the Coaching and Mentoring Service practitioners had an impact on clients by comparing their scores from the Time 1 (pre-coaching) and Time 2 (post-coaching) online measures. It was assumed that the difference between the results for Employee Engagement, Self-compassion and Self-Efficacy would demonstrate the changes in clients that could be attributed to the coaching received.

An additional questionnaire (SWRQ – Specific Work-Related Questionnaire) about the potential impact of the coaching/mentoring sessions on more specific aspects of clients' work was designed and included in the Time 2 stage of data collection. In addition to identifying 10 aspects to measure, this questionnaire intended to evaluate to what degree a client believed each of the changes they noticed could be attributed to coaching.

This study is a 'Within Subject' type in Grant's (2013) categorisation. For pragmatic reasons it was not possible to include a control group in the design of the evaluation. In this type of study a typical limitation is the fact that it is impossible to claim that changes happening to coached clients are the results of coaching rather than any other influences or combination of influences. In order to minimise this limitation we added another question to our bespoke questionnaire in which clients themselves could indicate to what degree coaching contributed to each identified change. Although this indication is a self-report measure we believe that the well-educated clients in this study had sufficient insight into the relationship between various influences in their lives and therefore could provide potentially useful information about the role of the service they received.

The qualitative part of the study included interviews with the main stakeholders of the programme in order to identify what significant aspects of the clients' work might be influenced by coaching/mentoring. The designed questionnaire also provided an opportunity for clients to comment on their experiences of the service. These comments were analysed for themes and used in the overall analysis of the study.

## Measures for the qualitative part

### Measure of Employee Engagement

The Employee Engagement Scale used was the Utrecht Work Engagement Scale (Schaufeli and Bakker, 2003) although the authors suggest respondents see it as the Work and Wellbeing Study. This scale consists of 17 items, six of which measure Vigour, six measure Absorption and five measure Dedication.

Schaufeli & Bakker (2003) describe engagement "as a positive, fulfilling, work-related state of mind that is characterised by vigor, dedication and absorption….. Vigor is characterised by high levels of energy and mental resilience while working, the willingness to invest efforts in their work and persistence even in the face of difficulties. Dedication refers to being strongly involved in one's work and experiencing a sense of significance, enthusiasm, inspiration, pride and challenge. Absorption is characterised by being fully concentrated and happily engrossed in one's work, whereby time passes quickly and one has difficulties with detaching oneself from work" (p.135).

The scale consists of 7 points from 0 = Never had this feeling, 1 = almost never, a few times a year or less, 2 = rarely, once a month or less, 3 = sometimes, a few times a month, 4 = often, once a week, 5 = very often, a few times a week, to 6 = always, every day.

The mean scale score of the 3 subscales is computed by adding the scores on the particular scale and dividing the sum by the number of items of the subscales involved. A similar procedure is followed for the total score. Hence, UWES yields 3 subscales scores/ and/or a total score that ranges from 0 to 6, where:

0.99 – 1 = once a year or less

1.00 – 1.99 – 2 = at least once a year

2.00 – 2.99 – 3 = at least once a month

3.00 – 3.99 – 4 = at least a couple of times a month

4.00 - 4.99 – 5 = at least once a week

5.00 - 5.99 – 6 = a couple of times a week or daily

Internal consistency using Cronbach's alpha have all been in excess of 0.75 value considered to represent good reliability (Coolican, 2004).

D Bruin (2013) carried out an Item Response Modeling analysis on the UWES-17 and found that it provides the most precise measurement for people with relatively low levels of the engagement. By comparison, measures of people with higher levels are less precise (i.e. the scale is less successful in distinguishing between people in the upper range of the engagement continuum).

### Measures for Self-Efficacy

Self-Efficacy was measured using the Generalised Self-Efficacy Scale, GSE (Schwarzer & Jerusalem, 1995). General perceived self-efficacy pertains to optimistic beliefs about being able to cope with a large variety of life stressors. It is measured using a 10-item scale that was developed to use across different cultures. Self-Efficacy affects how we feel and think; e.g. low self-efficacy is associated with negative moods and problems with depression, anxiety and helplessness. In relation to thinking, high levels of self-efficacy translate to a strong sense of competence, which facilitates cognitive processes and performance in a variety of settings, including quality of decision-making, which is obviously vital for doctors. Self-Efficacy is also highly related to motivation, people with high levels tend to choose more challenging tasks (Bandura, 1995 as reported by Schwarzer and Jerusalem, 1995): 'They set themselves higher goals and stick to them'. People with high levels of self-efficacy persist with tasks longer and put more effort in than people with lower levels.

The 10 items are scored using a 4 point scale: 1= not at all true, 2=hardly true, 3=moderately true and 4 =exactly true.

Schwarzer and Jerusalem (1995) found that the internal consistency varied across cultures but ranged from 0.78 to 0.91 and concluded that it was very satisfactory, considering that the scale only has 10 items.

Scherbaum et al (2006) used Item Response Theory to test the GSE Scale and found that it works best for individuals with average or below average levels of GSE. The GSE Scale is less precise at above average levels of GSE.

### Measures for Self-Compassion

Self-compassion comprises being kind and understanding towards oneself when experiencing pain or failure as opposed to being harsh and self-critical. Research has shown that self-compassion is significantly correlated with positive mental health and greater life satisfaction (Neff, 2003). Neff suggests that self-compassion is directly related to feelings of compassion and concern for others: self-compassion entails acknowledging that suffering, failure and inadequacies are part of the human condition, and that all people, oneself included, are worthy of compassion.

Self-compassion has three basic components: 1) extending kindness and understanding to oneself; 2) seeing one's experiences as part of the larger human experience rather than as separating and isolating, and 3) holding one's painful thoughts and feelings in balanced awareness and not over-identifying with them. Self-compassion should not be associated with tendencies toward narcissism and self-centredness that have been associated with high self-esteem (Baumesieter, Bushman & Campbell, 2000, as reported by Neff, 2003).

The 12-item scale was used with items 2 & 6 for self-kindness, items 11 & 12 for self-judgement, items 5 & 10 for common humanity, items 4 & 8 for isolation, items 3 & 7 for mindfulness and items 1 & 9 for over-identification.

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgement, isolation and over-identification (i.e. 1=5, 2=4, 3=4, 4=2, 5=1) - then compute a total mean.

Neff (2003) found that internal consistency was above the acceptable: 0.75 level for overall and subscales. Test/re-test reliability of overall scale plus subscales was also found to be acceptable (0.93 overall).

There is no current information detailing the sensitivity of this scale to detect changes in self-compassion other than the reliability information given above.

## Design of the bespoke questionnaire

The questionnaire design was based on the key issues which arose during the in-depth semi-structured interviews with seven different stake-holders of the service. The interview questions appear in Appendix 1.

The interviewees comprised two matchers (who link clients to coaches), two coach/mentors (one from the Service, one a GP) and three clients (two consultants and one GP). The interviews lasted between 30 and 60 minutes. Five were undertaken face to face, two by phone.

The interviewer took extensive notes and sent each interviewee a copy of the draft report of the interview as a means of supporting reliability in qualitative research. The interviewees were invited to make any changes they deemed necessary; three of them made minor alterations to the notes of the interview. The final versions, approved by the interviewees, were used to design the questionnaire.

The following themes which emerged as the result of the qualitative analysis were particularly useful in the development of the bespoke questionnaire:

- Reason for undertaking coaching/mentoring
- Choice of coach-mentor
- Strengths of the current system: coachees' perspective
- Impact of coaching/mentoring

### Reason for undertaking coaching/mentoring

The consultants expressed similar reasons for needing coaching. They found the new role overwhelming and needed help with work-life balance. In addition, one was concerned about safety issues while the other talked about the change from the short-term perspective of regular rotations to the long-term role of a consultant. The GP wanted to consider future career options.

From the coaches' perspective, the coachees seemed to fit within three categories: change, choice or challenge. The challenges could be hurdles to pass like an exam, an interview or a promotion board. The choices could be decisions about a career or location. The change was often a new job, for example, a new consultant or GP. The GP mentees tended to focus on adapting to working independently as a professional without close supervision; maintaining a sustainable work pattern; dealing with change and structure; professional development; and partnership relationships.

In some cases, the coachees were encouraged to do coaching by the Service; in other cases by a colleague who had found it beneficial.

### Choice of coach-mentor

The inteviewees felt that they were offered an appropriate range of possible coaches and all had found a coach they deemed helpful. Issues they considered were: location,

specialty (not necessarily choosing the same specialty as the coachee), type of career (portfolio, academic, NHS, non NHS), level of experience (seniority), additional interests (one chose a family therapist because of home issues). Coachees appreciated the first session being 'no-fault' with the freedom to change mentors if necessary.

## Strengths of the current system: coachees' perspective

Coaching provided an opportunity to analyse a situation and a safe place to explore different options. Sometimes talking through a problem had solved it.

Coaching helped with career decisions, demonstrating that there were lots of career choices. Instead of feeling earmarked for the next post, coachees found it helpful to look at other options.

## Impact of coaching/mentoring

Several of the interviewees said that they thought it was difficult to assess the impact of coach-mentoring on patient care, in some cases because patient care was not its focus. One interviewee suggested: "it is like trying to work out whether a doctor is good. Some patients get better on their own, some would do just as well with another doctor." Another interviewee felt that the benefits of coaching would be likely to have an indirect impact on patient care: "patient care is the core of a doctor's job, so patients are likely to benefit even if patient care is not the presenting problem." Another felt that the coach-mentoring had improved his attitude to his work, which inevitably impacted on patients: "Happy doctors make for better doctors."

### Improved work-life balance

Both clients and coach-mentors said that coaching had improved the work-life balance of mentees. For example, "Where a doctor was struggling, feeling overwhelmed by the workload and working long hours, addressing this has had a knock-on effect on patients including appropriate limitations on the time spent with them." One coach-mentor said that coaching had helped to improve patient self-reliance, making them less dependent on the doctor, thus resulting in more effective consultations.

### Improvement of patient safety

One mentee had improved patient safety as a result of coaching by persuading the new A and E clinical director at her hospital to employ a paediatrician on the senior team who could lead on child safety issues. The interviewee said: "I only had the confidence to do this because of the mentoring."

### Doctor retention

Mentoring helped one consultant improve his communication skills which helped to convince others to stay in the health service: "mentoring gave me a vocabulary which enabled me to verbalise these issues and discuss them with colleagues and juniors… Some colleagues have told me 'I was thinking of quitting but you've helped me get hold of something.'"

### Developing better relationships with colleagues

One consultant said that coaching had "provided different lenses" to reflect on and improve internal group dynamics which had prevented colleagues from continuing to work in isolation. A coach-mentor said that clients had been able to improve relationships with colleagues and develop better confidence in their team.

### Improved training

A consultant had used some of the coaching approaches with trainees: "A couple of trainees sought me out because of problems and I used the techniques to be less prescriptive and more facilitative in helping them find solutions." Another consultant had set up training sessions for A and E doctors and had also established an educational website aimed at juniors and GPs which had helped patient care.

### Decision-making

A GP had, through coaching, developed skills in how to make decisions – this had been helpful in running the practice.

### Engaging with 'Coaching for Health'

A GP was inspired to start the "Coaching for Health" development and would not have done that otherwise: "Mentoring was about me being led to make my own choices – that seemed very powerful and it works for patients too."

### Key sections of the questionnaire

The analysis of the interview themes led to the identification of the following key evaluation issues that formed sub-sections of the designed questionnaire:

**a. Impact on patients**

According to their experience interviewees noted the following ways in which coach-mentoring had impacted on patients:

- Improved interactions with patients
- Improved feedback from patients
- Use of coaching/mentoring techniques with patients
- Changes in patients' behaviour, such as reduced dependency, better use of doctors' time.

**b. Impact on colleagues**

Interviewees noted the following ways in which coach-mentoring had impacted on their relationships with colleagues:

- Improved interactions and communication with colleagues

- Use of coaching/mentoring techniques with colleagues.

**c. Impact on self**

Interviewees noted the following ways in which coach-mentoring had impacted on themselves as doctors:

- Improved confidence
- Better time management at work, leading to an improved work-life balance
- Improved capacity to solve problems and make decisions, including career decisions
- Better relationships with family members
- Made them decide to stay within the profession after seriously considering leaving the NHS.

A draft questionnaire was developed from the interviews and reviewed by advisers from the Oxford Brookes team and the Coaching and Mentoring Service representatives. It was piloted internally to check the questions and appropriate adjustments were made following feedback. The final questionnaire SWRQ is part of the Time 2 questionnaires in Appendix 3, appearing as questions 5 to 9.

## Data collection and analysis

The Time 1 questionnaire consisted of demographic questions and three scales measuring Employee Engagement, Self-Efficacy and Self-Compassion. The demographic questions were developed in conjunction with the Coaching and Mentoring Service and captured the respondents' age group, sex, ethnic origin, whether trained inside or outside the UK and career level. The Time 2 questionnaire included the above three scales of the Time 1 questionnaire and the additional questionnaire developed by the researchers. All the questionnaires asked for the unique registration number allocated on application in order to pair the Time 1 and Time 2 responses for each individual, whilst maintaining anonymity.

Once the potential participants of the evaluation research applied for the coaching programme online they were informed about the evaluation study and were given an option to opt out if they did not wish to take part. Once accepted, clients were sent their registration number (CLT number) and then an online link to the Time 1 Survey on Surveymonkey (see Appendix 2). The participants were then rung by one of a small team of matchers, all trained Service Coaches. A structured conversation was held with the client checking their reasons for seeking coaching, their understanding of the process and practical requirements such as venue and time. The participant was then sent an email with the description of three coaches attached for them to indicate their preferred coach. Clients were offered coaches outside their specialty and outside their place of work to ensure externality to the coaching process. The coaching intervention consisted of four sessions of 1-1.5 hours taken over a period of six months. When the coaching was completed participants were sent a link with an invitation to complete the Time 2 questionnaires. The Time 2 questionnaires (see Appendix 3) aimed to capture answers to the 3 scales for Employee Engagement, Self-Efficacy and Self-Compassion and a questionnaire developed through the qualitative analysis of interviews.

The Coaching and Mentoring Service set a cut-off date of Friday 3rd January 2014 for last responses and once this date expired the data was downloaded into Excel and then transferred to SPSS. Missing data was highlighted and replaced with mean values.

The research was conducted with consideration of good practice and strict ethical guidelines established at Oxford Brookes University for every research project that involves human subjects. Special consideration was given to providing anonymity for all people recruited onto the study with informed consent of all the people involved. All the data collected were stored in accordance with the Data Protection Act. The research team of Oxford Brookes University followed ethical guidelines in terms of data analysis and conducting interviews. The Coaching and Mentoring Service conducted the recruitment of participants, satisfying ethical requirements according to their rules and regulations. For example, all potential clients were invited to take part in the evaluation; they were not coerced to participate and could opt out at any stage of the process. To ensure anonymity of the participants it was decided that the questions to measure any resultant effect on patient care were gathered from the clients and not directly from patients. Table 3.4.1 presents the stages in the data preparation and analyses employed in this part of the study. There were four missing values for UWES Item no. 8 - "When I get up in the morning I feel like going to work". These were replaced with the mean score for this item, which was 4. All variables were found to have relatively normal distributions and no transformations were required.

| Data Preparation | Data analysis |
|---|---|
| Checked for accuracy of data entry | Descriptive statistics for demographic data |
| Missing values | T-tests for Hypothesis that coaching would increase mean scores of Employee Engagement, Self-Efficacy and Self-compassion |
| Fit between distributions | Correlations between scales |

**Table 3.4.1 Stages in data preparation and analysis**

# RESULTS

## Results of the statistical analysis

Overall there were 189 Time 1 responses and 137 Time 2 responses. However after matching responses and taking out responses where the clients had not completed the minimum number of sessions, there was a total of 120 matched Time 1 & Time 2 responses. Therefore, the final response rate was 78%.

The demographic data (Figures 4.1.2 – 4.1.5) show that 48.3% of respondents were aged between 30-39, 20.8% were aged between 20-29, 23.3% were aged between 40-49 and 7.5% were aged between 50-59. There were no respondents aged over 60 years old. The majority of respondents were trained within the UK (92%). The majority of respondents were female (66.7%). The majority of respondents (46.7%) were less than 2 years Post Qualification with a further 25.8% more than 2 years Post Qualification and 18.3% Foundation Trainees. The majority of respondents were White British followed by 18.3% who were Asian or Asian British: Indian.

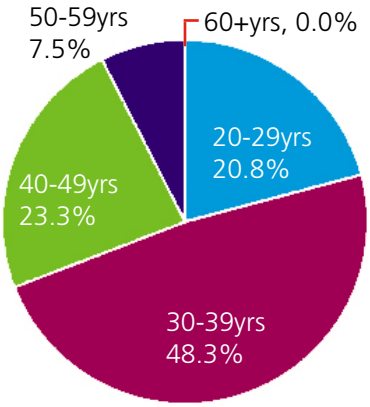



**Figure 4.1.1** **Responses by age group**

| Age Group | Frequency |
|---|---|
| 20-29yrs | 25 |
| 30-39yrs | 58 |
| 40-49yrs | 28 |
| 50-59yrs | 9 |
| 60+yrs | 0 |

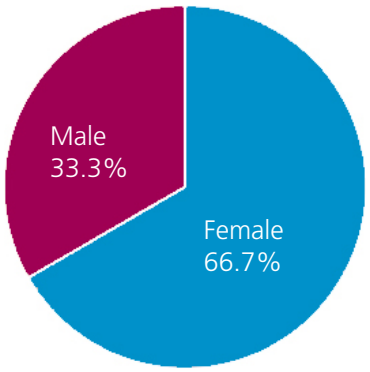



**Figure 4.1.2** **Responses by gender**

| Gender | Frequency |
|---|---|
| Female | 80 |
| Male | 40 |

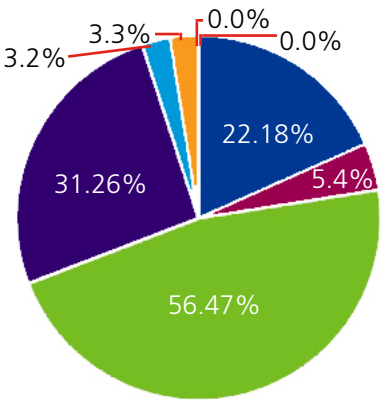



**Figure 4.1.3** **Responses by career level**

| Career Level | Frequency |
|---|---|
| Foundation Trainee | 22 |
| Speciality Trainee | 5 |
| Less than 2 years post Qualification | 56 |
| More than 2 years post Qualification | 31 |
| UCH Leadership Academy (Medical) | 3 |
| UCH Leadership Academy (Non-Medical) | 3 |
| GP Induction or Refresher | 0 |
| Staff, Associate Speciality or… | 0 |

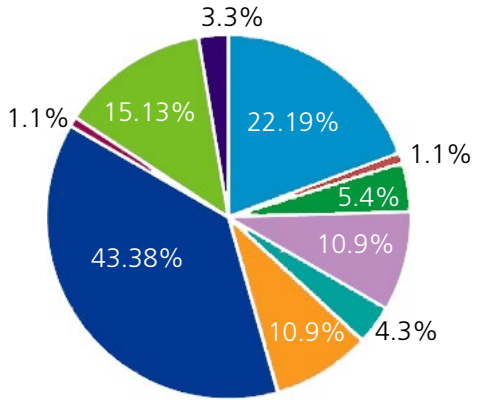



**Figure 4.1.4 Responses by Ethnicity**

| Ethnicity | Frequency |
|---|---|
| Asian or Asian British Indian | 22 |
| Asian or Asian British: Bangladeshi | 1 |
| Asian or Asian British: Pakistani | 5 |
| Other Asian background | 10 |
| Chinese | 4 |
| Black or Black British: African | 10 |
| White British | 43 |
| White Irish | 1 |
| Other White background | 15 |
| Mixed White and Asian | 3 |

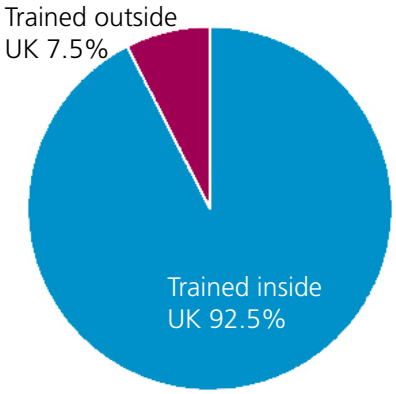



**Figure 4.1.5 Responses by where the participants trained**

| Where trained | Frequency |
|---|---|
| Trained inside UK | 111 |
| Trained outside UK | 9 |

The statistics illustrate a typical profile of the users of the Coaching and Mentoring Service: a 30-39 white female trained in the UK less than 2 years post-qualification and so may indicate the particular needs of this demographic group.

The results of the three selected established measures (table 4.1.1 and 4.1.2) indicate that clients benefited from the programme in relation to each of them.

| | Employee Engagement Time 1 | Employee Engagement Time 2 | Self-Efficacy Time 1 | Self-Efficacy Time 2 | Self-Compassion Time 1 | Self-Compassion Time 2 |
|---|---|---|---|---|---|---|
| Mean/Standard Deviation | 4.13 (0.78) | 4.37 (0.71) | 2.99(0.39) | 3.17(0.39) | 2.98 (0.61) | 3.22 (0.63) |
| Median/Range of scores | 4.2(4.20) | 4.4(3.94) | 3(1.9) | 3.1(1.9) | 2.92(3.17) | 3.25(2.84) |
| Minimum score | 1.60 | 1.93 | 2 | 2.1 | 1.25 | 1.58 |
| Maximum score | 5.80 | 5.87 | 3.9 | 4 | 4.42 | 4.42 |

**Table 4.1.1 Descriptive data from Time 1 and Time 2 questionnaires**

Table 4.1.1 shows the descriptive data for both Time 1 and Time 2 for Employee Engagement, Self-Efficacy and Self-Compassion. The first line of data looks at the means and it is clear that all Time 2 means (average) are higher than the Time 1 means (average).

| | UWES Manual Sample | Coaching and Mentoring Service Sample |
|---|---|---|
| Number | 655 | 120 |
| Mean | 3.10 | 4.13 |
| Coding | "At least a couple of times a month" | "At least once a week" |
| Nationality | Dutch & Finnish | English |
| Background | Completed career counselling questionnaire | Applied to coaching programme |

**Table 4.1.2 Comparing UWES sample and Coaching and Mentoring Service sample**

However, before exploring whether these differences are statistically significant, it is important to consider levels of Employee Engagement, Self-Efficacy and Self-Compassion before the coaching began. Table 4.1.2 describes the differences in results of the sample of doctors that was used in the UWES Manual. These results suggest that the clients in this study had higher levels of employee engagement before they started the coaching than the sample from the UWES manual. However, what is also important to point out are the minimum and maximum scores and the resulting range of scores. Whilst the average employee engagement levels are reasonably high there is a wide range of scores, with the lowest being 1.60 (which equates to " at least once a year") and the highest being 5.80 (which equates to "a couple of times a week or daily"). At Time 2 the range of scores is reduced as is the Standard deviation, which measures dispersion around the average value.

Although Self-Efficacy scores had the largest effect size (see below) the ranges of scores and standard deviation stayed nearly the same. Like Employee Engagement, scores for Self-Compassion showed decreases in range of scores.

| Scale | Standard Deviation | t | Df | Sig. (2-tailed) |
|---|---|---|---|---|
| Employee Engagement | 0.66 | 3.968 | 119 | 0.000 |
| Self-Efficacy | 0.36 | 5.423 | 119 | 0.000 |
| Self-Compassion | 0.47 | 5.586 | 119 | 0.000 |

**Table 4.1.3 Paired sample t-tests to measure whether Time 2 means are higher than Time 1 scores**

From the results of the paired sample t-tests in Table 4.1.3 we can confidently reject our null hypothesis that coaching does not have a positive impact on mean scores of Employee Engagement, Self-Efficacy and Self-Compassion and accept our hypothesis that Time 2 mean scores were higher compared to Time 1 mean scores (at the 0.01 level). We have a highly significant effect for mean scores on all three scales.

Effect sizes were calculated based on Cohen's calculations for paired sample t-tests. Effect size for Employee Engagement is 0.32, effect size for Self-Efficacy is 0.45 and effect size for Self-Compassion is 0.38. Based on Cohen's work effect sizes of 0.2 can be considered small, 0.5 as medium and 0.8 as large. According to this expectation the effect sizes vary from between small and medium (Employee Engagement and Self-Compassion and medium (Self-Efficacy). It is also important to highlight that there is evidence that the UWES is better at measuring lower compared to high levels of employee engagement. It is therefore possible that the coaching had more of an impact on coachees than these effect sizes suggest. The General Self-Efficacy scale is also better at measuring lower scores than higher ones.

This means that all three measures selected for their capacity to illustrate meaningful changes in the clients as the result of their coaching, confirm that these changes were significant. The clients reported higher levels of employee engagement, self-efficacy and self-compassion after being coached in comparison to the levels of these aspects in their lives before they engaged with the coaching programme.

The results were not driven by any particular subgroup and benefit was seen across subgroups in race, gender, stage of career and age.

Another type of analysis was made available by using the SWRQ (specific work-related questionnaire developed for this study). This questionnaire was designed to explore the changes that are perceived by the clients in relation to their work. The results of this analysis are shown in the figures 4.1.6 and 4.1.7 and in table 4.1.4.


**Figure 4.1.6 Changes perceived in working life as the result of coaching**

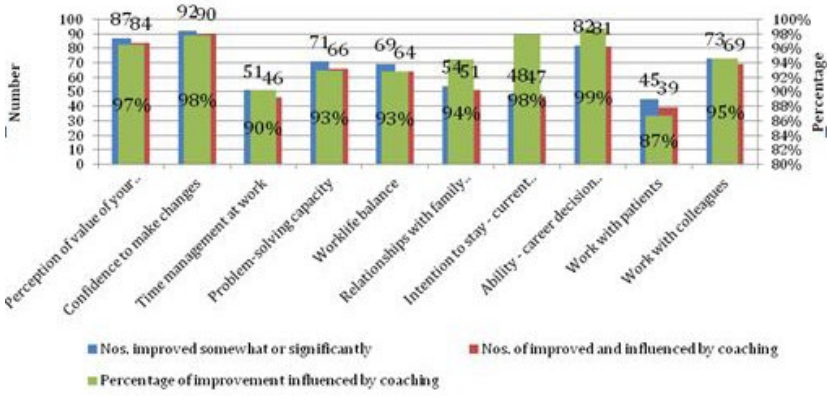
Fig 4.1.6 represents the results of the analysis of the participants' responses to Q.5: "How the following aspects of your work have changed since starting coaching". This figure illustrates how, according to clients themselves, certain aspects of their working life were changing or remained the same after the period when they undertook coaching. There were some missing data in this section and this explains why the totals do not add up to 120. Different colours represent the degree to which the clients perceived the changes. It is clear that dark grey representing "worsened significantly" is not present in the figure. The result suggests that the majority of these aspects improved or improved significantly. Only a very small number of responses (21) indicated that some particular aspects of their working life "worsened somewhat". It is interesting to notice that ten of these responses are related to the 'Intention to stay in the current position' which could be interpreted as a positive outcome in some situations when a radical action is beneficial for both the employee and the employer.

Particularly positive perceptions of changes were demonstrated in relation to Perception of values of the client contribution to their current role, Confidence to make changes in the workplace and Ability to make career decisions. In comparison to other factors it appears that the coaching programme was particularly successful in empowering the clients and improving their perception of themselves at work. This indication of changes corresponds with the data of self-efficacy and self-compassion in the Time 1 and Time 2 questionnaires.

Although the results of changes demonstrated in Table 4.1.3 and Fig 4.1.6 show significant changes in clients who undertook the coaching programme it could be argued that these changes might indicate the influence of a combination of factors other than coaching. Because we had no control group we do not know to what degree the changes that we have seen are due to the coaching that they received. In order to compensate for this issue we included question 6 in our SWRQ which asked this question directly: "Please indicate the extent to which coaching/mentoring contributed to this change". In relation to each change from Question 5 the clients could indicate if the change could be attributed to coaching and the degree they believed the coaching influenced this change.

The results of analysis of responses to this question are demonstrated in Fig. 4.1.7.

**Figure 4.1.7 Perception of participants on how changes occurred are attributable to coaching**




The blue bar in the chart above highlights the number of respondents who felt that there had been some improvement (either somewhat or significant) in the areas highlighted in SWRQ. The red bar highlights the numbers of respondents who felt that the coaching had influenced the positive change that is highlighted by the blue bar. The green bar sitting in front of the red and blue bars highlights what percentage of positive improvement was attributed to the coaching. For example as was already shown in Fig 4.1.6 the three areas of work where respondents felt there had been the most improvement were "Perception of value of your contribution", "Confidence to make changes at work" and "Ability to make career decisions". In these areas of work where there had been improvements, respondents felt that a large percentage of the improvement was due to the coaching that they had received – on average 98% for these three most changed areas of life.

The lowest change is indicated in the area of work with patients, which may indicate that Time 2 responses reflect increased confidence and the way participants felt about themselves, but it may take time to recognise such changes in action particularly with their work with patients. It is also possible that the junior doctors may be fairly remote from patient satisfaction questionnaires (this tends to happen at a departmental level) and therefore find it difficult to notice the effect of their internal changes on patients.

| Q.7 In relation to your work with patients, please indicate which of the following have changed (as many as relevant) | Number |
|---|---|
| Your communication with patients | 34 |
| Feedback from colleagues about your work | 30 |
| Changes in patients behaviour as a result of coaching and mentoring (e.g. reduced dependence) | 21 |
| Feedback from patients about your work | 9 |
| Use of coaching/mentoring techniques when working with patients | 0 |

| Q8 In relation to your work with colleagues, please indicate which of the following have changed (as many as relevant) | Number |
|---|---|
| Use of coaching/mentoring techniques when working with colleagues | 60 |
| Communication with colleagues | 0 |
| Feedback from colleagues about your work with them | 0 |

| Any other: |
|---|
| None of the above |
| My ability to work with middle managers |
| Setting and carrying out goals for identified issues improved significantly |
| Especially with the training |
| Negotiating re: hours and protected CPD time etc |

**Table 4.1.4 Responses to further work-related question**

Questions 7 and 8 in the Time 2 Survey explored in more detail how respondents felt their work with patients and colleagues had changed. The responses above are numbers of responses for each option given (Not all respondents gave an answer to these questions). All options are ordered in size of response. In relation to working with patients, 34 respondents thought that their communication with patients had changed, 30 thought that they had noticed changes in feedback about their work and 21 thought that there had been changes in patient behaviour, e.g. reduced dependence). In relation to working with colleagues, the only option that elicited a response was "Use of coaching/mentoring techniques when working with colleagues". 50% of the total sample marked this as a response.

## Findings from the open question in SWRQ - 'qual'

Question 9 in the SWRQ asked participants in a word or phrase to describe what difference the coaching and mentoring programme had made to them. All participants responded to this question. Three researchers, first independently and then together, analysed these responses and identified the following themes:

- Confidence
- Change/problem solving
- Decision making
- Self-awareness
- Reflection
- Work-life balance
- Seeing things in perspective
- Career development
- Being listened to/sharing
- General positive
- General negative

These themes are described in the order of the number of comments considered as representing each theme (from highest to lowest).

### Confidence (32 comments)

Many participants cited increased confidence as the most significant outcome of coaching, for example, "substantially increased my confidence in the workplace in the context of being a new consultant joining a well-established senior team". Some found that the coaching had provided confidence to make changes, for example, "confidence and tools to address challenges"; "confidence to make some changes and given me a plan"; "confidence, organisation and enthusiasm"; [motivation] "to make changes I was thinking of but not confident enough to pursue". Others found that increased confidence had improved their self-esteem and, for example, "made me believe in myself and realise that I can do whatever I set my mind to"; "given me confidence to believe in my own decisions"; "made me confident of my own capabilities, experience and skills"; "improved my self-esteem and sense of control over my future". In one case this had made the participant a "more resilient, assertive and productive doctor". Another participant wrote: "I am confident that I can lead my colleagues to improve care and patient experience".

### Change/problem-solving (22 comments)

The comments relating to change and problem-solving fell into three broad areas:

**a. Goals**

Participants had found coaching helpful in clarifying and focusing on their goals, for example:

"Helped me to set goals for changing issues that were concerning me"

**b. Strategies**

Coaching had provided participants with appropriate strategies that they could apply at work to solve problems and bring about change, for example:

"I can now confidently formulate strategies to help me achieve my goals"

"It has helped me focus on the changes that I have achieved and helped me with strategies to maintain these changes"

"Enabled me to look at problems in a different light and given new options for solving problems"

"I now have a reliable framework for problem-solving"

c) Decision-making

Participants had found coaching helpful in making decisions, for example:

"I make more conscious decisions in both work and personal life"

"Improved decision-making and thought processes"

"More aware and in control of making decisions"

**Self-awareness (17 comments)**

Coaching had helped to improve some participants' awareness of their strengths, weaknesses, personality and skills. In some cases this had helped individuals to identify their own motivation, commitment and "what I'm passionate about". In other cases participants' self-knowledge had helped them to make changes at work, for example, "gave me insight into the tools I possess myself to change my work and personal life"; "heightened awareness of my own strengths and weaknesses and how to employ this knowledge on a daily basis to increase my performance at work and outside of work". Some participants had learned to value themselves more highly, for example, "helped me see the value of some of my talents". Others had increased their resilience, for example, "learnt techniques to manage the things which caused me stress".

**Reflection (16 comments)**

Participants wrote about the value of reflection during coaching sessions, writing about "a useful mirror", "time to think/reflect", "protected space to reflect on a difficult period of change" and the usefulness of taking a "step back" to think over difficult work issues. Some participants were incorporating the principles of reflection in their work, for example:

"Taught me how to analyse my experiences objectively – reflecting, thinking about things a lot deeper than I usually would"

"I have significantly greater insight and self-reflection about processes rather than focusing on the outcomes"

**Work-life balance (12 comments)**

Several comments referred to an improvement in work-life balance as a result of coaching. This included a "more holistic approach" to work in two cases. The importance of work-life balance was outlined in the following comments:

"It has improved my perspective on what I am able to achieve at work and so improved my work-life balance significantly. I feel better able to cope as a result."

"Given me a greater sense of value and acknowledgement of the need to take care of my well-being and the importance of maintaining a life outside of work… realising that some of my ambitions may need to be put on hold until I have more time, headspace etc… and not beat myself up about this"

Improved time management was mentioned in two comments, including the "use of deadlines to help achieve goals". This seemed likely to impact positively on work-life balance.

**Seeing things in perspective (8 comments)**

A number of participants had found coaching helpful in providing a more balanced perspective, for example, "helped me to see my position, behaviour and current options in better perspective", "remarkable and unexpected change. By permitting me to see things from perspectives I would not have otherwise, I realised that my myopic and pessimistic view of the world was utterly inaccurate".

**Career development (7 comments)**

Coaching had influenced career development for some participants, by helping them to recognise their career goals, encouraging a greater focus on career choices, widening their views of alternative careers, and, in one case, helping them to develop their career in a new direction, for example, coaching "focused my ideas of where I want to be in the future and how to influence and use the resources open to me now to reach these roles".

**Being listened to/sharing (6 comments)**

Participants valued the opportunity to share their concerns with an impartial and constructive listener, for example, "provided a non-judgemental framework to manage issues"; "listening to me without prejudice"; "I was able to safely discuss a very difficult situation at work"; "it was so good to talk to a senior doctor who was not connected with my hospital for impartial reflection and discussion".

**General positives (14 comments)**

A number of participants made generally positive comments about coaching, for example, "encouragement", "insight", "helped me significantly", "invaluable". One had appreciated "awareness of

coaching as a tool", another had found that coaching improved communication with colleagues. Two very positive comments were as follows:

"An immense difference – turned my life around."

"Extremely positive experience – I feel I walk away a happier individual!"

"I have found coaching very valuable. I have found support in my transition to a major change in my working life. My thinking has been challenged and I hope to use these tools in future. I have found it very helpful to think about my possibilities with a very resourceful mentor. I believe I will go through this transition much better supported than I expected. I have found it extremely useful to be able to think outside the box. I think I will be able to reach my full potential and have found my mentor extremely useful – I feel more able to make decisions which are good for me and have also been made aware of habits and thinking which are less useful. I think my work-life balance will improve as a result of mentoring or at least I have felt supported during this process. I also think that I have been enabled or supported in thinking more creatively about my future. This support is greatly appreciated."

**General negatives (7 comments)**

A small number of comments were negative about coaching, stating that it had "limited" or "not much" impact. In one case this was due to "personal circumstances" which the coaching could not address. In two cases it was because coaching did not meet the participants' expectations and they would have preferred a different approach, such as mentoring. One participant wrote "not all problems have a solution".

On the whole the qualitative analysis suggests an overwhelmingly positive impact of coaching on clients and a wide variety of the benefits associated with participation in this programme. The overarching patterns of the benefits are:

- Confidence improvement and increased self-awareness
- Specific areas of working life where there was a significant difference as the result of coaching such as career development and work-life balance
- Acquiring a range of skills that could make participants more capable of addressing potential issues, such as the skills of problem-solving, reflection and seeing things in perspective.
- It would be unusual if the effect of coaching were universally positive. A small percentage of general negative comments illustrate that there are circumstances in which this particular type of intervention is not the best solution. There could be of course other explanations (e.g. not the best match between coach and client); however without further investigation these are only speculations.

# DISCUSSION AND CONCLUSIONS

The overall conclusion of the evaluation described in the report with the support of both quantitative and qualitative methods suggest that the Professional Support Unit's coaching and mentoring programme provides an effective service for their clients. Well validated measures that were selected for this evaluation project seem to support the finding that employee engagement, self-efficacy and self-compassion of the participants significantly improved. The bespoke questionnaire developed for evaluating changes that participants perceived in their working lives also showed improvements particularly to the aspect of self (confidence in their ability). It is important to note that this questionnaire allowed gauging the extent to which clients attributed the above changes to coaching rather than to any other factor. The analysis showed that coaching was a major contributor to the changes that the participants made.

In the conclusion to this report we would also like to discuss the following overarching themes that became apparent at all stages of the evaluation process together with information elicited in the initial interviews with stakeholders of the programme. These are the themes that indicate potential implications of the project and may be considered by the Coaching and Mentoring Service as recommendations. The themes are:

- Issue of terminology
- Methods and design of evaluation
- Feedback to clients
- The purpose of evaluation

## Issue of terminology

It was apparent from the beginning of the project that the programme uses the terms of both coaching and mentoring for this service. In the literature review we suggested that all descriptions of the support process by the Coaching and Mentoring Service closely fit with the description of coaching. Interviews with organisers and other stake-holders also indicate that the service provided is coaching. However, the use of both terms in some materials and a typical confusion that often exists among the general public about these terms may have contributed to unmet expectations of a small number of users of the service. In fact, one of the clients identified the provided service as coaching and indicated that it was mentoring that they expected and needed. Although it appears that for an overwhelming majority of the participants this was not an issue we believe that coaches themselves would benefit from clarification of terminology for their CPD purposes. This would also be beneficial for potential clients who would be able to identify their needs in coaching or mentoring prior to their engagement with the programme.

## Methods and design of evaluation

It appears that the measures selected for this project have been sufficient for the purposes of the evaluation. They appropriately reflect the nature of this programme which is by definition individually focused. It is believed that improvements in employee engagement, self-efficacy and self-compassion contribute to the quality of the working life of the receivers of the coaching programme. These three measures can be used for future evaluations of the programme.

However, as the programme is delivered and paid for by public funding, the benefits for the individuals have to be meaningful in the context of the added value to the ultimate users: in this context, patients. Therefore, an additional

questionnaire SWRQ was developed with a focus on evaluating changes in the context specific to Coaching and Mentoring Service coaching clients. The questionnaire allowed unique information to be elicited about the nature of changes that clients identified as the result of the programme related to their place of work. We believe that this questionnaire has to be part of future evaluations and the data collected in this project can be used for developing the scale for further investigations.

In terms of the design of the evaluation needless to say that projects with features of the randomised control study would be easier to defend. However, considering many issues that constrain the use of RCTs in coaching research (Cavanagh & Grant, 2006; Greif, 2009) this type of design might not be possible to execute. In these circumstances we advocate the use of the SWRQ for evaluation of this coaching programme as it includes a self-estimation by the respondents about the extent to which they can attribute each change to the received coaching.

We also suggest that use of qualitative methods can enrich understanding of the effect of coaching. Some of these methods can include, for example, vignettes constructed around actual experiences, by using situations provided by participants before and after coaching. Another qualitative method that can be used on a reasonably large scale is a sentence completion test that could be tailored for the specific conditions of the relevant context.

## Feedback to clients

In order to improve further the criteria of quality for the evaluation of coaching programmes by the Coaching and Mentoring Service we believe that further effort could be made to create a better connection between the changes in coaching clients and the outcome of their work. For example, it would be possible to utilise the 360 degree feedback that is available about consultants' performance in their annual reviews which includes feedback from patients. However, this is not the case for junior doctors; they may not get to know how patients feel about their work. As a higher level recommendation it would be useful to have access to information about junior doctors and feedback from their patients. It might be useful to consider more differentiated feedback, for example, as part of the criteria for quality for GPs and new consultants because both groups have longer relationships with their patients.

## The purpose of evaluation

This final theme of the report indicates the importance of revisiting the ultimate need for such evaluations in principle and this project in particular. In some respects this project is a piece of research that contributes to a growing pool of the outcome studies that aim to prove that coaching works. It provides a persuasive account of the benefits that coaching clients received as the result of coaching provided to them. Although not a RCT it provides a unique confirmation by the clients themselves that these benefits are attributed to coaching rather than to other factors. This is a good addition to the outcome studies on coaching that adds to the body of knowledge about coaching in this particular context. In terms of further building the theoretical base of coaching the next step for further research into this type of coaching could include the following questions:

- How has the terminology of coaching or mentoring influenced the outcome of the process?
- What elements of coaching in this programme have particularly contributed to positive outcomes?
- Are the changes identified by the clients sustained over a longer period?
- To what type of clients is this programme most suited?
- What difference does the matching process make?
- In what way can the changes identified by the client actually affect their work with patients?
- What factors in the coaches are important, e.g. their training, CPD, number of clients or their engagement with the service?

Research into the effect of the coaching programme on a large scale was on the agenda for the Coaching and Mentoring Service at the start of this project. Although this could be an important and ambitious undertaking we believe that this current project has already provided a very positive answer to the question about the effectiveness of the coaching programme on a reasonable scale. In light of these findings we would argue that the questions that aim at improvement of the service which are of a more precise nature, similar to those listed above, would be no less important and probably more pertinent for the ultimate stakeholders of the Coaching and Mentoring Service.

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# APPENDIX 1: INTERVIEW QUESTIONS

## Questions for mentees

1. Why did you decide to embark on coaching/mentoring?
2. What were your expectations?
3. How did you choose which coach or mentor you wanted to work with?
4. Did you have any contact with the Coaching and Mentoring Service's matcher?
5. Could you describe how the sessions were organised? How long did the coaching/mentoring last? How many sessions did you have? Were they face to face or on the phone? Have you maintained any contact with your coach/mentor since the official sessions ended?
6. Has your practice changed in any way as a result of the coaching/mentoring?
7. Could you give any examples of the effects of coaching/mentoring on patient care (even indirect)?
8. Were there any problems or challenges in undertaking coaching/mentoring?
9. How would you judge the effectiveness of a coach/mentor?
10. Have you anything else you would like to add, or questions you think we should be asking?

## Questions for mentors

1. Why did you decide to become a mentor?
2. What training did you receive? Was it useful?
3. How many doctors have you mentored?
4. Could you describe how the sessions were organised? How long did the mentoring last? How many sessions did you have? Were they face to face or on the phone? Have you maintained any contact with your mentee(s) since the official sessions ended?
5. What (if any) were the outcomes of the mentoring?
6. Could you give any examples of the effects of mentoring on patient care (even indirect)? What would be the signs if patient care were improved by the programme?
7. Were there any problems or challenges in delivering mentoring? What improvements could be made to the programme?
8. How do you think the effectiveness of mentors could be judged?
9. Apart from questionnaires to clients are there any other data that can be used to inform the evaluation?
10. Have you anything else you would like to add, or questions you think we should be asking?

## Questions for matchers

1. What is your involvement in the coaching and mentoring programme?
2. How is the value of coaching/mentoring currently demonstrated?
3. What are the strengths and weaknesses of the coaching and mentoring programme?
4. What would be the signs if patient care were improved by the programme?
5. Apart from questionnaires to clients are there any other data that can be used to inform the evaluation?
6. Who else should be interviewed in order to develop the questionnaires for clients?
7. How is the competence of coach-mentors judged?
8. What improvements could be made to the programme?
9. Is communication effective?

# APPENDIX 2: TIME 1 QUESTIONNAIRES

## London Coaching and Mentoring Evaluation Study

### London Coaching and Mentoring Evaluation

Many thanks for contributing to this study which will evaluate the impact of the overall coaching/mentoring programme. The survey consists of some demographic questions followed by three short questionnaires. Please complete all parts of it. Please be reassured that your responses are completely anonymous and your coaching and mentoring code will only be used to allow us to link data collected pre and post coaching/mentoring.

London Deanery will only be given statistically identified themes and not individual data. All data will be stored and destroyed in accordance with the Data Protection Act. All members of the Oxford Brookes University Business School Team abide by the University Code of Practice setting out Ethical Standards for Research involving Human Participants or the British Psychological Society Code of Ethics, which both ensure that no harm comes to any participants as a result of contributing to projects.

If you have any questions regarding the project please, feel free to contact the evaluation team:

Dr Tatiana Bachkirova, tbachkirova@brookes.ac.uk
Dr Linet Arthur, larthur@brookes.ac.uk
Emma Reading, C Psychol, emma@erop.co.uk

***1. Your Individual Coaching and Mentoring Code (this starts with 'CLT' and was given to you by the Coaching and Mentoring Unit when you joined)**

***2. Your Career Level**

- ◯ Foundation trainee
- ◯ Speciality trainee
- ◯ Less than 2 years post-qualification (CCS, CESR, CEGPR, CCST)
- ◯ More than 2 years post-qualification (CCS, CESR, CEGPR, CCST)
- ◯ Staff, Associate Speciality or Speciality doctor
- ◯ On the GP Induction & Refresher Scheme (GP Returner)
- ◯ UCH Leadership Academy (Medic)
- ◯ UCH Leadership Academy (Non-Medic)

***3. Your age**

- ◯ 20-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60+

***4. Your gender**

- ◯ Female
- ◯ Male

# London Coaching and Mentoring Evaluation Study

***5. Your ethnicity (the groups below reflect the 2001 Census Ethnicity Classification system)**

- ◯ Asian or Asian British: Indian
- ◯ Asian or Asian British: Bangladeshi
- ◯ Asian or Asian British: Pakistani
- ◯ Other Asian background
- ◯ Chinese
- ◯ Black or Black British: Caribbean
- ◯ Black or Black British: African
- ◯ Other Black background
- ◯ White British
- ◯ White Irish
- ◯ Other White background
- ◯ Mixed White and Black Caribbean
- ◯ Mixed White and Asian
- ◯ Mixed White & Black African
- ◯ Other mixed background
- ◯ Any other ethnic group
- ◯ Prefer not to say

***6. Where you trained**

- ◯ UK trained
- ◯ Trained outside of the UK

## Questionnaire 1 - Work and Well-being Survey

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job.

# London Coaching and Mentoring Evaluation Study

## *7. Work and Well-being Survey

| | Never had this feeling | Almost never - a few times a year or less | Rarely - once a month or less | Sometimes - a few times a month | Often - once a week | Very often - a few times a week | Always - everyday |
|---|---|---|---|---|---|---|---|
| At my work, I feel bursting with energy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I find the work that I do full of meaning and purpose | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Times flies when I'm working | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| At my job, I feel strong and vigorous | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I am enthusiastic about my job | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| When I am working, I forget everything else around me | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| My job inspires me | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| When I get up in the morning, I feel like going to work | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I feel happy when I am working intensely | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I am proud of the work that I do | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I am immersed in my work | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I can continue working for very long periods at a time | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| To me, my job is challenging | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| I get carried away when I'm working | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| At my job, I am very resilient, mentally | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| It is difficult to detach myself from my job | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| At my work I always persevere, even when things do not go well | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## Questionnaire 2

# London Coaching and Mentoring Evaluation Study

## *8. GSE - General Self - Efficacy Scale

| | Not at all true | Hardly true | Moderately true | Exactly true |
|---|---|---|---|---|
| I can always manage to solve difficult problems if I try hard enough | ◯ | ◯ | ◯ | ◯ |
| If someone opposed me, I can find the means and ways to get what I want | ◯ | ◯ | ◯ | ◯ |
| It is easy for me to stick to my aims and accomplish my goals | ◯ | ◯ | ◯ | ◯ |
| I am confident that I could deal effectively with unexpected events | ◯ | ◯ | ◯ | ◯ |
| Thanks to my resourcefulness, I know how to handle unforeseen situations | ◯ | ◯ | ◯ | ◯ |
| I can solve most problems if I invest the necessary effort | ◯ | ◯ | ◯ | ◯ |
| I can remain calm when facing difficulties because I can rely on my coping abilities | ◯ | ◯ | ◯ | ◯ |
| When I am confronted by a problem, I can usually find several solutions | ◯ | ◯ | ◯ | ◯ |
| If I am in trouble, I can usually think of a solution | ◯ | ◯ | ◯ | ◯ |
| I can usually handle whatever comes my way | ◯ | ◯ | ◯ | ◯ |

## Questionnaire 3

# London Coaching and Mentoring Evaluation Study

## *9. How I typically act towards myself in difficult times

| | Almost never | Seldom | Sometimes | Generally | Almost always |
|---|---|---|---|---|---|
| When I fail at something important to me I become consumed by feelings of inadequacy | ○ | ○ | ○ | ○ | ○ |
| I try to be understanding and patient towards those aspects of my personality I don't like | ○ | ○ | ○ | ○ | ○ |
| When something painful happens I try to take a balanced view of the situation | ○ | ○ | ○ | ○ | ○ |
| When I'm feeling down, I tend to feel like most other people are probably happier than I am | ○ | ○ | ○ | ○ | ○ |
| I try to see my failings as part of the human condition | ○ | ○ | ○ | ○ | ○ |
| When I'm going through a very hard time, I give myself the caring and tenderness I need | ○ | ○ | ○ | ○ | ○ |
| When something upsets me I try to keep my emotions in balance | ○ | ○ | ○ | ○ | ○ |
| When I fail at something that's important to me, I tend to feel alone in my failure | ○ | ○ | ○ | ○ | ○ |
| When I'm feeling down I tend to obsess and fixate on everything that's wrong | ○ | ○ | ○ | ○ | ○ |
| When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people | ○ | ○ | ○ | ○ | ○ |
| I'm disapproving and judgemental about my own flaws and inadequacies | ○ | ○ | ○ | ○ | ○ |
| I'm intolerant and impatient towards those aspects of my personality I don't like | ○ | ○ | ○ | ○ | ○ |

This concludes the survey. You can review your answers if you wish or click on 'done' to submit. Thank you for taking part in this part of the project.

# APPENDIX 3: TIME 2 QUESTIONNAIRES

## Follow up Survey

Many thanks for contributing to the final part of this study which will evaluate the impact of the overall coaching/mentoring programme. This final survey consists of four short questionnaires. It is important that you complete all parts of it. Please be reassured that your responses are completely anonymous and your coaching and mentoring code will only be used to allow us to link data collected before coaching and mentoring began.

London Deanery will only be given statistically identified themes and not individual data. All data will be stored and destroyed in accordance with the Data Protection Act. All members of the Oxford Brookes University Business School Team abide by the University Code of Practice setting out Ethical Standards for Research involving Human Participants or the British Psychological Society Code of Ethics, which both ensure that no harm comes to any participants as a result of contributing to projects.

If you have any questions regarding the project please, feel free to contact the evaluation team:

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Emma Reading, C Psychol, emma@erop.co.uk

***1. Your Individual Coaching and Mentoring Code (this starts with 'CLT' and was given to you by the Coaching and Mentoring Unit when you joined)**

## *2. Work and Well-being Survey - Follow-up

**The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job**

| | Never had this feeling | Almost never - a few times a year or less | Rarely - once a month or less | Sometimes - a few times a month | Often - once a week | Very often - a few times a week | Always - everyday |
|---|---|---|---|---|---|---|---|
| At my work, I feel bursting with energy | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I find the work that I do full of meaning and purpose | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Times flies when I'm working | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| At my job, I feel strong and vigorous | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I am enthusiastic about my job | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| When I am working, I forget everything else around me | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| My job inspires me | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| When I get up in the morning, I feel like going to work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I feel happy when I am working intensely | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I am proud of the work that I do | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I am immersed in my work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I can continue working for very long periods at a time | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| To me, my job is challenging | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I get carried away when I'm working | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| At my job, I am very resilient, mentally | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| It is difficult to detach myself from my job | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| At my work I always persevere, even when things do not go well | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## *3. General Self - Efficacy Scale - Follow-up

| | Not at all true | Hardly true | Moderately true | Exactly true |
|---|---|---|---|---|
| I can always manage to solve difficult problems if I try hard enough | ○ | ○ | ○ | ○ |
| If someone opposed me, I can find the means and ways to get what I want | ○ | ○ | ○ | ○ |
| It is easy for me to stick to my aims and accomplish my goals | ○ | ○ | ○ | ○ |
| I am confident that I could deal effectively with unexpected events | ○ | ○ | ○ | ○ |
| Thanks to my resourcefulness, I know how to handle unforeseen situations | ○ | ○ | ○ | ○ |
| I can solve most problems if I invest the necessary effort | ○ | ○ | ○ | ○ |
| I can remain calm when facing difficulties because I can rely on my coping abilities | ○ | ○ | ○ | ○ |
| When I am confronted by a problem, I can usually find several solutions | ○ | ○ | ○ | ○ |
| If I am in trouble, I can usually think of a solution | ○ | ○ | ○ | ○ |
| I can usually handle whatever comes my way | ○ | ○ | ○ | ○ |

## *4. Follow-up - How I typically act towards myself in difficult times

| | Almost never | Seldom | Sometimes | Generally | Almost always |
|---|---|---|---|---|---|
| When I fail at something important to me I become consumed by feelings of inadequacy | ○ | ○ | ○ | ○ | ○ |
| I try to be understanding and patient towards those aspects of my personality I don't like | ○ | ○ | ○ | ○ | ○ |
| When something painful happens I try to take a balanced view of the situation | ○ | ○ | ○ | ○ | ○ |
| When I'm feeling down, I tend to feel like most other people are probably happier than I am | ○ | ○ | ○ | ○ | ○ |
| I try to see my failings as part of the human condition | ○ | ○ | ○ | ○ | ○ |
| When I'm going through a very hard time, I give myself the caring and tenderness I need | ○ | ○ | ○ | ○ | ○ |
| When something upsets me I try to keep my emotions in balance | ○ | ○ | ○ | ○ | ○ |
| When I fail at something that's important to me, I tend to feel alone in my failure | ○ | ○ | ○ | ○ | ○ |
| When I'm feeling down I tend to obsess and fixate on everything that's wrong | ○ | ○ | ○ | ○ | ○ |
| When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people | ○ | ○ | ○ | ○ | ○ |
| I'm disapproving and judgemental about my own flaws and inadequacies | ○ | ○ | ○ | ○ | ○ |
| I'm intolerant and impatient towards those aspects of my personality I don't like | ○ | ○ | ○ | ○ | ○ |

## Follow-up Survey

Please see Questions 5 and 6 in combination for each following aspect of your work.

For example, you may choose to indicate that "your time management" 'improved somewhat' (Question 5) and coaching/mentoring 'influenced significantly' this change (Question 6). Another example: "your relationship with family" 'remained the same' (Question 5); in this case response to Questions 6 would be 'not applicable'.

***5. How far the following aspects of your work have changed since you started coaching/mentoring.**

| | Improved significantly | Improved somewhat | Remained the same | Worsened somewhat | Worsened significantly | Not applicable |
|---|---|---|---|---|---|---|
| Your perception about the value of your contribution in your current role | ○ | ○ | ○ | ○ | ○ | ○ |
| Your confidence to make changes in the workplace | ○ | ○ | ○ | ○ | ○ | ○ |
| Your time management at work | ○ | ○ | ○ | ○ | ○ | ○ |
| Your problem-solving capacity | ○ | ○ | ○ | ○ | ○ | ○ |
| Your work-life balance | ○ | ○ | ○ | ○ | ○ | ○ |
| Your relationship with family members | ○ | ○ | ○ | ○ | ○ | ○ |
| Your intention to stay in your current position | ○ | ○ | ○ | ○ | ○ | ○ |
| Your ability to make career decisions | ○ | ○ | ○ | ○ | ○ | ○ |
| Your work with patients | ○ | ○ | ○ | ○ | ○ | ○ |
| Your work with colleagues | ○ | ○ | ○ | ○ | ○ | ○ |

***6. Please indicate the extent to which coaching/mentoring contributed to this change.**

| | Influenced significantly | Influenced somewhat | Did not influence | Not applicable |
|---|---|---|---|---|
| Your perception about the value of your contribution in your current role | ○ | ○ | ○ | ○ |
| Your confidence to make changes in the workplace | ○ | ○ | ○ | ○ |
| Your time management at work | ○ | ○ | ○ | ○ |
| Your problem-solving capacity | ○ | ○ | ○ | ○ |
| Your work-life balance | ○ | ○ | ○ | ○ |
| Your relationship with family members | ○ | ○ | ○ | ○ |
| Your intention to stay in your current position | ○ | ○ | ○ | ○ |
| Your ability to make career decisions | ○ | ○ | ○ | ○ |
| Your work with patients | ○ | ○ | ○ | ○ |
| Your work with colleagues | ○ | ○ | ○ | ○ |

**7. In relation to your work with patients, please indicate which of the following have changed (as many as relevant)**

- ☐ Changes in patient behaviour as a result of coaching and mentoring (for example, reduced dependence)
- ☐ Your communication with patients
- ☐ Feedback from patients about your work
- ☐ Feedback from colleagues about your work
- ☐ Use of coaching/mentoring techniques and strategies when working with colleagues

Any other (please specify)

**8. In relation to your work with colleagues, please indicate which of the following have changed (as many as relevant)**

- ☐ Your communication with colleagues
- ☐ Feedback from colleagues about your work with them
- ☐ Use of coaching/mentoring techniques and strategies when working with colleagues

Any other (please specify)

***9. In a word or phrase, what difference has coaching and mentoring made to you?**

This concludes the follow up survey. You can review your answers if you wish or click on 'done' to submit. Thank you for taking part in the final part of the project - your participation is greatly appreciated.

Professional Support Unit

NHS

Health Education North Central and East London
Health Education North West London
Health Education South London