Nursing Midwifery and Allied Health Professions (NMAHP) Directorate

Phase 2 Impact Evaluation of the Care Home Education Facilitator (CHEF) Role

Final Report

Undertaken for and on behalf of NHS Education for Scotland by:
Claire McGuinness, Project Lead Practice Learning, NMAHP Directorate, NHS Education for Scotland

April 2015

Table of Contents **Page**

Glossary of Terms

CHEF	Care Home Education Facilitator
CNO	Chief Nursing Officer
HEI	Higher Education Institution
NES	NHS Education for Scotland
NMAHP	Nursing, Midwifery and Allied Health Professions
NMC	Nursing and Midwifery Council
NRES	National Research Ethics Service
NSGPL	National Strategic Group for Practice Learning
PEF	Practice Education Facilitator
PEL	Practice Education Leads (Forum)
PLE	Practice Learning Experience
QSPP	Quality Standards for Practice Placements
SG	Scottish Government

Glossary of Operational Terms Used When Discussing Findings

Term	Definition	Application as Part of this Report
Total Number of Care Homes	The total number of care homes in each NHS Board area	Delineates the total of care homes supported by CHEF(s) in each of the NHS Board areas
Active Care Homes	Active in terms of pre-registration student support	Delineates the care homes actively supporting pre-registration nursing education at the time of data collection.
SLA	Service Level Agreement – the number of students placements that each care home has agreed to facilitate	Although SLA has been identified and reported as part of this work, there is recognition that no formal memorandum of understanding exists between HEIs and care homes and, as such, this can fluctuate, sometimes without prior warning. The term is therefore used with this caveat in place.
Active SLA	Active service level agreement	The categorisation of active SLA indicates that the following criteria have been met in full as follows: **(1)** The number of student placements has been agreed (Service Level Agreement) in collaboration with the care home **(2)** Mentor(s) are annotated to the live register and are available to mentor **(3)** Current audit documentation is in place
Mentor Gains	Mentors annotated to the live mentor register	Timeline – during the preceding year (1st April 2013 – 31st March 2014)
Mentor Losses	Mentors removed from the live mentor register	Timeline – during the preceding year (1st April 2013 – 31st March 2014)
Inactivity	Inactivity in terms of pre-registration nursing	Relates specifically to the support of learning and assessment of pre-registration nursing students. Areas which are not currently supporting students but continue to be supported by CHEFs are referred to as inactive.
Suspended	Suspension of student support/SLA	Care homes which have the potential to be active (mentors and SLA in place) but no longer support pre-registration nursing students for a variety of reasons including; **(1)** Care Inspectorate **(2)** Action Plan in place **(3)** Staffing Issues **(4)** No Current Audit (this is not an exhaustive list)
Final Placement Capacity	Capacity to support final placement pre-registration nursing students	Indicates care homes which have a live sign-off mentor annotated to the mentor register and therefore have the capacity to support final placement pre-registration nursing students. Please note; this is however **NOT** indicative of the actual number of final placement students supported in care homes, nor does this indicate that this support actually takes place – only that these homes have the capacity to provide this.

EXECUTIVE SUMMARY

Context

Scotland's legislative direction for health and social care (Public Bodies (Joint Working) (Scotland) Act 2014) is based on the vision that by 2020 everyone will live longer, healthier lives at home or in a homely setting and that health and social care services will be integrated. This increasing focus on health and social care integration, coupled with progressively more complex care requirements for older people, makes the investment in education and workforce development in the care home sector a high priority.

The Chief Nursing Officer's Education Review, Setting the Direction (Scottish Government 2014) identified a range of successful strategies which currently enhance the quality of pre-registration nursing programmes, and the student experience, in Scotland. The identification of these strategies, and their contribution to nursing healthcare education, reinforces that partnerships between the practice and education workforce can make a valid contribution to the development of a nursing workforce that is caring, compassionate and competent. These collaborations also help to assure the quality of the practice learning environment and support adherence to the standards set for Nursing and Midwifery Council approved programmes (Scottish Government 2014).

Despite this, it is acknowledged that practice learning environments are challenged to provide an increasing variety of experiences which will best prepare students and staff to practice within a changing health and social care context. This includes greater demand to access more diverse learning experiences in the community and with third sector and social care providers. The quality of these experiences must be assured if wishing to continue to provide positive experiences for pre-registration nursing students.

Since 2010, mentors in care homes have been supported by Care Home Education Facilitators (CHEFs). This support is designed to assist mentors in fulfilling their role of supporting the learning, teaching and assessment of pre-registration nursing students in the care home setting. CHEFs, through the sign-posting of educational resources and promotion of continuing professional development (CPD), also support mentors in care homes to act as role models for the delivery of safe effective, person-centred care. A key element of this involves CHEFs adopting the role of conduit in terms of national priorities, including the *Promoting Excellence* framework for caring for people with dementia (Scottish Government 2011).

Fourteen whole time equivalent (WTE) CHEFs were recruited between January and July 2010 by NES and 11 NHS Boards across Scotland. Although the role has evolved since its inception, the focus remains rooted in the support and development of practice education across the independent care home sector in Scotland. CHEFs, who are based in 11 NHS boards, work closely with NHS practice education facilitator (PEF) colleagues who are also responsible for practice education, but with a specific NHS remit.

A phase 1 service evaluation of the CHEF role was previously conducted and reported on during 2011/12. This evaluation underpinned the development of the role and also provided evidence to support continued Scottish Government funding of CHEF posts. This Phase 2 service evaluation was therefore designed to longitudinally evaluate the impact of the role (as delineated by the key role functions of the CHEF post) on practice learning support and development in the care home sector.

Evaluation Aim and Objectives
The overall aim of this project was to demonstrate the impact of the CHEF role. The evaluation objectives, outlined below, reflect the project aim, and were mapped to the key functions of the CHEF role (please refer to the full report to review these key role functions) to ensure fit and relevance in terms of the evaluation process:

1. Assess CHEF activity and its impact on the utilisation of care homes as practice learning environments
2. Evaluate the contribution of CHEFs in enhancing the quality of care homes as practice learning environments, including their support and development of mentors
3. Appraise the impact of CHEFs in developing care homes as contributors to the future nursing workforce
4. Identify and explore the implementation and effectiveness of partnership working relationships between Care Homes, NHS Boards and Higher Education Institutions (HEIs)
5. Identify and evaluate CHEF driven initiatives and the way in which they support and enhance staff development in care homes

Project Planning, Ethical Approval and Identifying Stakeholders
Project planning centred on the identification of an evaluation approach that would best consider impact. The Gerrish et al (2011) toolkit, originally designed to measure the impact of the nurse consultant role, was considered as an appropriate framework for the Phase 2 CHEF Evaluation. Although not developed with the CHEF role in mind, the impact evaluation principles highlighted as part of the Gerrish et al (2011) toolkit are arguably transferable, with some adaptation, when considering the key functions of the CHEF role and its subsequent impact.

Planning to measure impact required consideration of multiple stakeholders, most of whom have a vested interest in the role. It was considered important to collect discrete impact data in the first instance from each group as this would not only support discrete stakeholder group analysis, but would also allow for merging of data to generate collective stakeholder viewpoints of impact. Data collection methods identified as suitable for use following distribution of an initial scoping template included; focus groups and qualitative questionnaires. When designing the data collection tools all questions were mapped to CHEF key role functions. The structure and format of the questions reflected the model advocated by Gerrish et al (2011) in that questions centred on the retrieval of data relating to areas of direct and indirect impact.

The project plans were reviewed with reference to the National Research Ethics Service (NRES 2009) guidance documentation *Defining Research.* This helped to confirm the project status as that of service evaluation; NHS Ethic's approval was therefore not required. Despite this, and in light of the national status of the project, the West of Scotland Research Ethics Service (WOSRES) was asked to review the project plans and reaffirmed the project's service evaluation status. The project was logged with all 11 NHS Board Clinical Effectiveness departments. Opportunity for scrutiny of project documentation was also afforded to all HEIs invited to participate in the project, and any subsequent ethical approval recorded as part of project files. Stakeholder groups included; CHEFs, students, HEI academics, NHS Board Leads, Care Home Managers and mentors. Unfortunately however, despite a variety of attempts at recruitment, only 1 student agreed to take part in the project. Consequently, this data could not be used as it was not possible to protect the student's anonymity.

The Literature
As a means of informing this work, a rapid appraisal of literature, including policy and professional standards was undertaken, with a specific focus on the following aspects:

a) Policies and Standards: Caring for Older People and the Implementation and Management of Integrated Practice Learning in Care Homes
b) Potential influences on the delivery and quality of care in care homes
c) The care home environment as a practice learning experience and the attitude of student nurses to this environment and experience

To ensure contemporary care home practice and management was considered, the time span for the rapid appraisal was narrowed to include contemporary literature spanning 2006 – 2014. The search was further focused by narrowing the search parameters to retrieve English language texts only.

It became clear from the literature that the provision of care for older people is multi-faceted in terms of; the changing health and social care landscape; the increasing emphasis on the role of independent sector care; the ongoing development of independent sector staff and the provision of practice learning experiences for pre-registration student nurses in these areas. This combined with national and international recognition of an ageing population, and the challenges and opportunities which this presents, have already spurred moves towards a more integrated health and social care agenda. This in turn has initiated greater recognition of the need to develop shared learning, not only across the healthcare professions, but also across health and social care organisations, an aspect already highlighted as part of the care home education facilitator (CHEF) role.

The literature highlighted that learning and development opportunities in care homes include; opportunities to develop relationships with residents, patients and carers; opportunities to develop skills which are non-reliant on technology and also the provision of individualised holistic care in non-hospital environments.

In terms of caring for older people, there was evidence in the literature that attitudes towards caring for older people can, at times, be perceived as negative, perhaps reinforcing the importance of challenging negative stereotypes which may present. Working to ensure students' gain experience in environments which provide care for older people during their programme of study was however identified as a means of perhaps proactively changing these stereotypes. It was also suggested by some authors that this experience can positively influence post registration career choices when considering future involvement in caring for older people. Although the benefits of theoretically preparing students for care home practice learning experiences are considered by some to be inconclusive, nursing's' professional regulatory body has adopted the stance of advocating the establishment of links between the young and the old can as one way to overcome prejudices which may exist.

Data Collection and Analysis
Gatekeeper access for each group was agreed in advance of commencing the consultation and data gathering process. Approaches to data collection included:

- A preliminary scoping template designed to generate statistical data indicative of the impact of the CHEF role
- Qualitative questionnaires and semi-structured interview/focus group guides to facilitate the gathering of data from which areas of key impact, from the perspective of each stakeholder group, could be garnered. These were developed with reference to CHEF key role functions, the rapid appraisal of the literature and the preliminary CHEF scoping template

A content analysis framework was adapted to support analysis of both qualitative and quantitative data across the stakeholder groups (please refer to Section 4 of the full project report to review this framework). Through triangulation of the data, key areas of CHEF role impact were; identified, statistically analysed and thematically categorised. In keeping with the content analysis method, coding, and counting of coding incidents in each of the thematic categories, supported the depiction of impact frequencies and patterns across stakeholder groups. These frequencies and patterns proved useful when attempting to rank impact in terms of the importance of the CHEF role and CHEF activity to each stakeholder group.

Findings

Four key impact themes emerged during qualitative data analysis. These are detailed as part of the table below, which also delineates the impact, in terms of response frequency, of each aspect of the CHEF role as reported by the stakeholder groups:

Key Impact Themes and Ranking of Response Frequencies

Ranking Key – Participant Responses Coded, Counted, Themed and Ranked (1 – 5) for Pattern Frequency.
1 – Indicates Most Prevalent/Frequent Response
5 – Least Prevalent/Frequent Response

Stakeholder Group	**CHEFs**	**Care Home Mentors**	**Care Home Managers**	**NHS Board Leads**	**HEI Academics**
	Rank	**Rank**	**Rank**	**Rank**	**Rank**
CHEF Role – Key Impact Themes	**Rank indicates Qualitative Response Frequencies for each of the 4 Key Themes for each Stakeholder Group**				
KEY THEME 1 *Collaborative Working and Building Relationships*	**(2)**	**(2)**	**(2)**	**(1)**	**(2)**
KEY THEME 2 *Supporting Attainment of NMC Standards and the Delivery of Pre-Registration Nursing Education*	**(1)**	**(1)**	**(1)**	**(2)**	**(1)**
KEY THEME 3 *Sign-Posting Educational Resources and Supporting Continuing Professional Development*	**(3)**	**(4)**	**(3)**	**(3)**	**No Data Identified**
KEY THEME 4 *Enhancing Safe, Effective, Person-Centred Nursing Practice*	**(4)**	**(3)**	**(4)**	**(4)**	**(3)**
**Miscellaneous Data (not directly related to the CHEF role)*	**(5)**	**No Data Identified**			

Key Impact Theme 1 *– Collaborative Working and Building Relationships*

All stakeholders recognised the integral role of CHEFs in supporting the development of relationships and the implementation of collaborative working. In particular, collaborative approaches have been recognised as being fostered when implementing professional/regulatory requirements, including NMC (2008) *Standards to support learning and assessment in practice* and NMC (2010) *Raising and Escalating Concerns.* Stakeholders indicated that CHEFs, as a direct consequence of their specialised role remit, are better positioned to work across various groups and organisations and are also more able, as a consequence, to develop collaborative working relationships with these stakeholders.

Care Home Managers highlighted that CHEFs not only enhance communication, but also improve overall the perception of the care home environment externally. In addition, the relationships which CHEFs are able to build with care home mentors and managers positively impacts on the way care home staff perceive the support which is available to them – and also the way in which they perceive their role as a care home employee, helping them to feel more valued in their role.

Communication across stakeholder groups was recognised as challenging at times and potentially reduced the ability of CHEFs to build relationships and foster collaborative working. Furthermore, analysis of the data suggests that there remains scope to reconsider how to further enhance current collaborative working strategies and how best to raise the profile of the CHEF role in terms of their support of health and social care integration.

Key Impact Theme 2 – *Supporting Attainment of NMC Standards and the Delivery of Pre-Registration Nursing Education*

Perhaps unsurprisingly, it emerged that mentorship and pre-registration nursing education are intrinsically linked. Stakeholders highlighted the impact of the role in key areas including; mentorship preparation and support; quality enhancement of the practice learning environment and student experience; instilling a sense of mentor competence and confidence and developing placement capacity.

Building mentor capacity in care homes emerged as an area requiring further development as a significant number of care homes were highlighted as having two or fewer mentors at the time of reporting. In light of the propensity for staff movement in this sector, this was recognised as presenting a risk of these areas becoming mentor free zones; a direct consequence of which would be a reduction in care home capacity to support pre-registration nursing students in practice. A similar situation presented when considering final placement capacity and sign-off mentor numbers.

The impact of the CHEF role in the dissemination and actioning of student feedback was confirmed as variable, with both managers and mentors reporting different experiences, and perceptions, of CHEF involvement and impact.

Key Impact Theme 3 *- Sign-Posting Educational Resources and Supporting Continuing Professional Development*

Sign-posting educational resources and supporting CPD for care home staff were confirmed as inter-dependent when delivering the CHEF role. CHEFs themselves expressed concern however that the full impact of their work was not always recognised as mechanisms to capture impact are not always in place.

Evidence of impact remained however including; enhancement of the quality of the practice learning environment, and the student experience, through the education and support of care home staff. It was also evident that work to support CPD in care homes helps to spawn collaborative working with other organisations including; the identification of training needs across the NHS and care home sector and the provision of fee-free education for care home staff in some HEIs.

Mentors reported incidences of active encouragement from CHEFs to continually professionally develop and care home managers are articulated the integral role played by the CHEFs in supporting newly qualified nurses in care homes to engage with Flying Start NHS®.

Key Impact Theme 4 *- Enhancing Safe, Effective Person-Centred Nursing Practice*

Although stakeholders commented with less frequency on the impact of the CHEF role in enhancing care delivery, it became clear that the CHEF role played an integral part. A review of stakeholder comments highlighted that stakeholder feedback often related to the practicalities of CHEF interventions rather than the impact of these. This legitimised concerns expressed by CHEFs around the measurement of impact in terms of their role. This also highlighted that CHEF activity does take place which may well influence care delivery but is perhaps not clearly attributed to the CHEF role.

Despite this, there were examples of explicit CHEF role impact; in particular for one care home manager when relaying a sense of reassurance and confidence that their care home was now proactive and progressive as a consequence of CHEF input. Another also stated that supporting students, alongside access to the CHEF, led to staff development and an enhancement in the quality of care delivered. NHS Board leads also recognised the key role and contribution of CHEFs when citing collaborative policy development as an impact, and also when discussing CHEF input and support of health and social care educational integration and person centred practice. Perhaps more telling in terms of impact, is the concern expressed by one NHS Board Lead about the potential for fragmentation of practice learning in care homes should the CHEF role cease to exist.

Summary and Recommendations for the Future Delivery of the Care Home Education Facilitator Role

As the evaluation progressed, and findings began to emerge, continued fixed term funding for the role was confirmed by Scottish Government in January 2015.

Consultation with stakeholders served to highlight key areas of direct and indirect impact of the CHEF role, formulated as key impact findings in this report. In order to safeguard a future-based focus for the development of the CHEF role, these recommendations have been mapped to both CHEF key role functions and the strategic aims, categorised as *collaborating for the future,* in *Setting the Direction* (Scottish Government 2014); please refer to the full project report to view this mapping. These recommendations have also been developed with a view to both enhancing the strengths of the CHEF role and also further developing aspects of the CHEF role where impact is perhaps less evident:

1. **Recommendation 1 – Support CHEFs to both develop and implement impact measurement strategies.** This should include strategies and data which better define the contribution of CHEFs to the; enhancement of both care home staff CPD and their delivery of safe, effective, person-centred practice; enhancement of the quality of the student practice learning experience

2. **Recommendation 2 – Continue mentor capacity building, in particular targeting this CHEF activity with greater specificity.** This may involve targeting both care homes without mentors and also care homes where mentors numbers are reduced and there is a risk of these areas becoming mentor free zones

3. **Recommendation 3 – Continue to build placement capacity across the care home sector, including final placement capacity.** This should incorporate tripartite collaboration between; CHEFs, care home managers and HEI academics with responsibility for PLE allocation. This work should also consider the potential contribution that the availability of final placements in care homes can have on the recruitment of newly qualified nurses to this sector

4. **Recommendation 4 – Further develop multi-stakeholder collaborations which quality assure the PLE and the practice learning environment.** This should include a review of CHEF involvement in the delivery of annual updates, triennial review, educational audit, action planning and raising and escalating concerns

5. **Recommendation 5 – Define and implement clearer CHEF role parameters in terms of student PLE feedback.** This will help to ensure there is a clearer understanding of the CHEF role in the collation and dissemination of student feedback and their involvement in any subsequent interventions to enhance the quality of the practice learning environment/student experience

6. **Recommendation 6 – Review and refine the CHEF/PEF interface and collaboration parameters.** This work should consider both CHEF and PEF key role functions and priorities. This should also take into account the discharge of both roles and the way in which the strengths of each can be retained to reduce the risk of increased emphasis on either role at the expense of the other

7. **Recommendation 7 – Define CHEF role and responsibilities for practice education as part of the health and social care integration agenda.** The findings from this evaluation would suggest that the CHEF health and social care integration education role is, for some stakeholders, unclear

SECTION 1: INTRODUCTION

1.1 Setting the Project in Context

Scotland's legislative direction for health and social care (Public Bodies (Joint Working) (Scotland) Act 2014) is based on the vision that by 2020 everyone will live longer, healthier lives at home or in a homely setting and that health and social care services will be integrated. This increasing focus on health and social care integration, coupled with progressively more complex care requirements for older people, makes the investment in education and workforce development in the care home sector a high priority.

The Chief Nursing Officer's Education Review, Setting the Direction (Scottish Government 2014) identified a range of successful strategies which currently enhance the quality pre-registration nursing programmes, and the student experience, in Scotland. The identification of these strategies, and their contribution to nursing healthcare education, reinforces that partnerships between the practice and education workforce can make a valid contribution to the development of a nursing workforce that is caring, compassionate and competent. These collaborations also help to assure the quality of the practice learning environment and support adherence to the standards set for Nursing and Midwifery Council approved programmes (Scottish Government 2014).

Despite this, it is acknowledged that practice learning environments are challenged to provide an increasing variety of experiences which will best prepare students and staff to practice within a changing health and social care context. This includes greater demand to access more diverse learning experiences in the community and with third sector and social care providers. The quality of these experiences must be assured if wishing to continue to provide positive experiences for pre-registration nursing students and, perhaps in the future, expand this provision to learners from the allied health professions and social work.

Since 2010, mentors in care homes have been supported by Care Home Education Facilitators (CHEFs). This support is designed to assist mentors in fulfilling their role of supporting the learning, teaching and assessment of pre-registration nursing students in the care home setting. CHEFs, through the sign-posting of educational resources and promotion of continuing professional development (CPD) also support mentors in care homes to act as role models for the delivery of safe effective, person-centred care. A key element of this involves CHEFs adopting the role of conduit in terms of national priorities, including the *Promoting Excellence* framework for caring for people with dementia (Scottish Government 2011).

Strategic Aims 3 and 4 (Setting the Direction, Scottish Government 2014) highlight a continuing national commitment to enhancing and strengthening existing CHEF/PEF (Practice Education Facilitator) structures. The work of CHEFs and PEFs is considered as integral when undertaking work to improve practice learning environments and the experience of students. CHEF/PEF work is also viewed as a key support mechanism when implementing innovative measures to support and improve the delivery of patient care. The importance of this is reaffirmed as a key priority in *Everyone Matters: 2020 Workforce Vision* – Implementation framework and plan 2014-2015' (Scottish Government 2013) wherein it states that all staff need to be effectively educated as well as having access to support for learning and development to meet the 'Quality Ambition' and '2020 Vision for Health and Social Care'.

1.2 Project Brief

Fourteen full time working equivalent (WTE) CHEFs were recruited between January and July 2010 by NES and 11 NHS Boards across Scotland. Although the role has evolved since its inception, the focus remains rooted in the support and development of practice education across the independent care home sector in Scotland. CHEFs, who are based in 11 NHS boards, work closely with NHS practice education facilitator (PEF) colleagues who are also responsible for practice education but with a specific NHS remit. This collaborative working is designed to support a cohesive working system across NHS and independent service areas and to contribute to the development of an integrated practice learning infrastructure across Scotland.

A phase 1 evaluation of the CHEF role was previously conducted and reported on during 2011/12. This evaluation underpinned the development of the role and also provided evidence to support continued Scottish Government funding of CHEF posts. The Phase 2 service evaluation was designed to once more evaluate; the role, and the impact of the role (as delineated by the key role functions of the CHEF post) on practice learning support and development in the care home sector. The *Key Role Functions* of the CHEF role are delineated below:

1. Continue to maximise the contribution that care homes make to the development of the future nursing workforce by positively influencing the student experience of learning. This will include facilitating increased participation in the NES performance management pre-registration student, mentor and manager survey and supporting the development and implementation of local action/development plans.
2. Support the Health and Social Integration agenda through enhancing collaborative cross sector working between the Care Homes, the NHS Boards and HEIs and national, regional and local practice education infrastructures
3. Enhance the quality of the care home learning environment by supporting the education and development needs of staff to effectively support students and newly qualified nurses within this setting, in particular through facilitating the implementation and sustainability of; NMC regulatory standards, Core Curriculum Framework for Mentor Preparation (NES 2013), Quality Standards for Practice Placements (NES 2008) and Flying Start NHS®
4. Contribute to the development of the care setting as a positive learning environment which promotes a values based, person centred approach to care and learning through sign-posting relevant opportunities and resources for nurses and support staff, within the context of Reshaping Care for Older People. This will include building on earlier activities associated with national clinical priorities, for example; National Integrated Tissue Viability, Nutritional Care and Support, Living and Dying Well of national clinical priorities and Care Commission (The Care Inspectorate) quality themes

1.3 Project Aim and Objectives

The overall aim of this project was to demonstrate the impact of the CHEF role. Planning for the project, in terms of impact measurement, focused on the key role functions CHEFs (detailed above) and also associated aspects of the role specifically related to these key functions including:

1. The pre-registration nursing student experience of the care home setting as a learning environment

2. The quality of the care home learning environment, including both the role and development of mentors when supporting pre-registration nursing students
3. The contribution of care homes to the nursing workforce
4. Partnership cross sector working between care homes and other organisations
5. The educational development initiatives sign-posted and implemented by CHEFs for care home staff

The evaluation objectives, outlined below, reflect the project aim and have been mapped to the key priorities of the CHEF role to ensure fit and relevance in terms of the evaluation process:

1. Assess CHEF activity and its impact on the utilisation of care homes as practice learning environments
2. Evaluate the contribution of CHEFs in enhancing the quality of care homes as practice learning environments, including their support and development of mentors
3. Appraise the impact of CHEFs in developing care homes as contributors to the future nursing workforce
4. Identify and explore the implementation and effectiveness of partnership working relationships between Care Homes, NHS Boards and Higher Education Institutions (HEIs)
5. Identify and evaluate CHEF driven initiatives and the way in which they support and enhance staff development in care homes

1.4 Measuring Impact – Adapting the Gerrish et al (2011) Nurse Consultant Toolkit

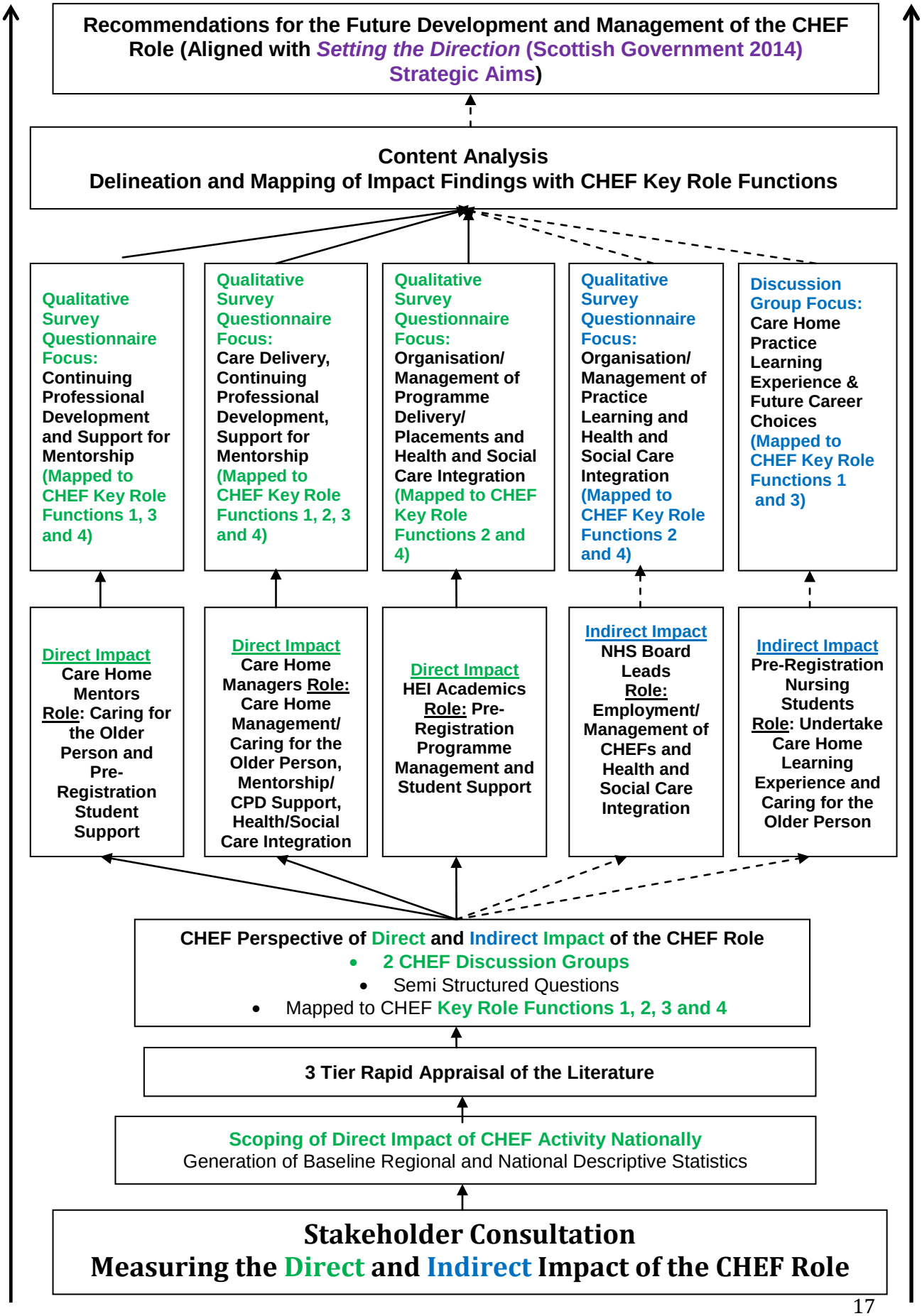
Project planning centred on the identification of an evaluation approach that would best consider impact. The Gerrish et al toolkit, originally designed to measure the impact of the nurse consultant role, was reviewed as a potential framework for the Phase 2 Evaluation. Gerrish et al (2011) define impact as *'the influence or difference brought about by providing a service or having specific healthcare professionals in post..... it might also be useful to view impact as the 'added value' that you, with all your experience and expertise, bring to the organisation.....thinking about what is unique to the role'.* Although not developed with the CHEF role in mind, the principles highlighted as part of the Gerrish et al (2011) definition and toolkit are arguably transferable when considering the key functions of the CHEF role and its subsequent impact. Consequently, the Gerrish et al (2011) toolkit was adapted to provide a core framework best suited to collecting data indicative of the CHEF role impact.

The work of Gerrish et al (2011) provides instruction when planning stakeholder consultation. An aspect of the toolkit, perhaps tellingly entitled '*Who are the stakeholders for your post and what impact is important to them*?' not only delineates who potential stakeholders might be, but also highlights the importance of appropriate stakeholder selection when capturing data. Gerrish et al (2011; p4-5) state *'In addition to your views about what aspects of impact are important to capture, it is also useful to explore the perspectives of other stakeholders.....it is a good idea to identify a variety of stakeholders in order to look at different perspectives, for example junior and senior staff, internal and external to your organisation..... it is therefore important to identify the key stakeholders who are best placed to contribute to an understanding of your impact.'* This guidance confirmed the transferability of the Gerrish et al (2011) toolkit as the CHEF role is recognised as spanning multiple stakeholders, further legitimising an impact measurement approach founded in the adaptation of the Gerrish et al (2011) toolkit.

Planning to measure impact required consideration of multiple stakeholders, most of whom have a vested interest in the role. It was considered important to collect discrete impact data

in the first instance for each group as this would not only support discrete stakeholder group analysis, but would also allow for merging of data to generate collective stakeholder viewpoints of impact. Data collection methods identified as suitable for use following distribution of the initial scoping template included; focus groups, interviews and qualitative questionnaires. The design of data collection tools was recognised as key to the successful retrieval of meaningful data. To ensure CHEF role alignment, all questions included in data collection tools were mapped to CHEF key role functions. The structure and format of the questions reflected the model advocated by Gerrish et al (2011) in that questions centred on the retrieval of data relating to areas of direct and indirect impact. As recommendations for the future of the CHEF role would stem from this, it was agreed that these would be mapped to the relevant strategic aims outlined in *Setting the Direction for Nursing and Midwifery Education in Scotland* (Scottish Government 2014). Figure 1, page 17, represents the overall project planning process and mapping of data collection tools/questions.

Figure 1 – Phase 2 CHEF Evaluation Planning



SECTION 2: RAPID APPRAISAL OF THE LITERATURE

2.1 Aim of the Rapid Appraisal of the Literature

To consider what is known about:

d) Policies and Standards: Caring for Older People and the Implementation and Management of Integrated Practice Learning in Care Homes
e) Potential influences on the delivery and quality of care in care homes
f) The care home environment as a practice learning experience and the attitude of student nurses to this environment and experience

2.2 Search Strategy and Scope of the Rapid Appraisal

Relevant primary research studies and reviews formed the basis of this rapid appraisal alongside policy, guidance and regulatory literature. The search strategy encompassed the 3 aims previously delineated as key to the rapid appraisal. This involved; searching for literature to address each of the aims in isolation and, thereafter, collectively reviewing the literature gathered to support merging and identification of areas of disparity and commonality. This approach also enabled the identification of links between research, policy and standards.

To ensure contemporary care home practice and management was considered, the time span for the rapid appraisal was narrowed to include contemporary literature spanning 2006 – 2014. Recognition that it may be necessary to broaden the search remained at the fore however as, when considering policy and standards, *The Regulation of Care (Scotland) Act* (2001) proved pivotal in determining that there were no legal differences between residential care homes and nursing care homes. This Act directly impacted on the potential movement of care home residents between homes and also introduced the requirement that care homes and their staff must be able to adapt accordingly to the changing needs of those in their care (Scottish Government 2007); a point of pertinence when considering the implementation of an integrated practice learning infrastructure.

The search was further focused by narrowing the search parameters to retrieve English language texts only. The search databases which were accessed are detailed below and a combination of key search terms, also detailed below, supported targeted retrieval of the literature. A search of Google Scholar was also undertaken:

Databases

- Applied Social Sciences Index and Abstracts (ASSIA)
- CINAHL
- EBSCO
- MEDLINE
- OVID

Key Search Terms

- Care home staff education
- Care home practice learning experience
- Care home placement experience
- Students perception + care homes
- Students attitudes + care homes

2.3.1 Policies and Standards: Caring for Older People and the Implementation and Management of Integrated Practice Learning in Care Homes

Policy and standards implemented across the United Kingdom (UK) were reviewed. In particular, 10 documents spanning 2007 – 2014 were deemed relevant when considering the establishing of integrated practice learning in care homes. Specific focus was afforded to policy and standards set within a Scottish context and these were explored with reference to the student practice learning experience of the care home environment.

A common theme which emerged from the literature was recognition of the UK's ageing population (Audit Scotland 2014, Age UK 2012, Royal College of Nursing (RCN) 2012, British Geriatric Society 2011). In particular Audit Scotland (2014) predicts that by 2035, 25% of the population of Scotland will comprise of older people. This assumes significance when considering the development of services for older people and the associated staffing of these services across both NHS and independent sectors. Audit Scotland (2014) discuss the need for service development, recommending that the Scottish Government (SG) work closely with NHS boards, councils and others to ensure both the quality and sustainability of these services. They also highlight the need to expedite the sharing of good practice (Audit Scotland 2014) – a factor which relates directly to practice learning and the integration of this when caring for older people.

The Orchid View Serious Case Review (Georgiou 2014) and the *Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry* (Francis 2013) both make recommendations which emphasise the importance of developing structures which will support and manage continuing professional learning and development for staff. In particular, Georgiou (2014) recognises that those working in more isolated settings, of which care homes are considered an example, require additional support and the implementation of associated measures to facilitate their ongoing professional development. Francis (2013) similarly recommends that the education and training of those responsible for healthcare delivery be enhanced.

A report commissioned by the Joseph Rowntree Foundation (JRF) (2012) following a 3 year study designed, in part, to explore the development of leadership in the care home sector, alludes to the importance of integration across wider health and social care community. In particular, they identify the need to foster positive relationships as well as suggesting that care home managers must encourage and support learning and innovative practice in the workplace. They refer to this as *'supporting, nourishing and enabling staff'* (JRF 2012; P5). The British Geriatric Society (2011; p3) previously highlighted however that care of older people continues to be viewed as a *'Cinderella service'* in the NHS, linking this to the fact that education and training opportunities for staff working in care homes can be less than adequate. They emphasise the need to shift to a more integrated health and social care system which better supports; information sharing, shared assessment and integrated training and learning, suggesting that all of these elements have the potential to enhance the overall quality of care received by older people.

The Age UK (2012) report *Delivering Dignity: Securing Dignity in Care for Older People in Hospitals and Care Homes* is underpinned by the argument that increased life expectancy should be viewed positively, as opposed to the negative connotations that are often presented when discussing care of the older person. This report highlights the presence of ageism in British society, suggesting that establishing and enhancing links between older and younger people can often help to overcome these prejudices where they exist. The Nursing and Midwifery Council (2009) document, *Guidance for the Care of Older People*, similarly alluded to both the problem of ageism and, in fact elaborated to suggest that nurses attitudes to care of the older person also contributed to the risk of delivering poor quality care. This is perhaps of interest when considering both the viewpoints expressed in this

literature and the placement of nursing students in care homes. Pre-registration programme students are commonly 17 years of age and upwards and, as such, these placements provide an opportunity to build the older-younger people links within the nursing profession as suggested by Age UK (2012). This will perhaps also instil a more positive attitude towards care of the older person in the nursing professionals of the future. Age UK (2012) are also clear that those who care for older people must lead and guide by example to help eradicate these negative attitudes, further emphasising the relevance of this point. They provide a series of recommendations with recommendation 6 relating specifically to dementia and the need for an integrated approach to staff development. This confirms that all health and social care staff must be supported to develop the skills necessary to provide the appropriate quality of care. Should an integrated approach to this practice learning be adopted across the professions, it could be argued that it has the potential to enable all staff responsible for caring for older people to lead by example.

The RCN (2012) and The British Geriatric Society (2011) both highlight the difficulty of recruiting staff to care for older people. In particular, RCN (2012) discuss the risks this presents in relation to inappropriate delegation of care when staff skill mix is not at the optimal level. They also state that poor educational preparation worsens this problem and propose that *'appropriate training in the knowledge and skills to care for older people must be available to all nurses – both at pre and post registration levels'* (RCN 2012; p 10). When considering the placement of student nurses in care homes, the relevance of this recommendation is emphasised.

The report *Commission on the Future Delivery of Public Services* (Scottish Government 2011) perhaps provides the most obvious steer when considering integration of practice learning. This report considers the range of public services across health and social care and identifies specific priorities including; the delivery of integrated public services and the implementation of cross-profession education, in effect suggesting that this can help to drive the service integration agenda.

2.3.2 Potential Influences on the Delivery and Quality of Care in Care Homes

When considering potential influences on the delivery and quality of care, 10 papers were reviewed spanning 2008 - 2014. The most recent of these, published in 2014, highlights that positive views of working in the care home sector are relatively rare. The authors, Carlson et al (2014) do however present work which focuses on the positive perceptions of staff that practice in environments where older people are cared for. They cite a number of factors which are viewed positively by staff and which can potentially influence the delivery of care in these environments including; the opportunity to develop relationships with users and carers and the opportunity to deliver individualised care. Carlson et al (2014) also consider benefits for staff which stem directly from practising in this environment, including the opportunity to develop and challenge nursing practice beyond the provision of technical care.

Nurse-patient ratios and retention of staff are issues discussed by a number of authors (McGilton et al 2014, Rose and Adam 2012, Spilsbury et al 2011, Haggstrom and Bruhn 2009 and Nolan et al 2008). In particular, McGilton et al (2014) conducted a qualitative study designed to explore the factors which influence staff to remain employed in long term care units. Factors identified as negatively impacting include; general lack of funding, absence of supportive leaders, less than optimal working environments and, perhaps most crucially, feeling unable to deliver good quality care as a direct consequence of these factors. When considering the implementation of an integrated practice learning infrastructure, it was also useful to review the findings from this paper which highlight aspects which could potentially enhance job satisfaction and staff retention. These include; the provision of ongoing opportunities for CPD and recognition that a diverse approach to the delivery of holistic patient care, as delivered in the care home environment, also provides opportunities for

learning. In addition, job satisfaction could also be enhanced through recognition of the fact that patients and families can be an invaluable source of learning in terms of communication skills, relationship building and the provision of care delivery and quality of care feedback. In terms of the latter, Board et al (2012) similarly highlighted the importance of carer feedback when evaluating the role of education in improving care for patients with dementia, reporting that carers' stories of their experiences contributed to enhancing staff knowledge and understanding of dementia.

The value of staff education and CPD has also been afforded particular focus in the literature reviewed (McGilton et al 2014, Board et al 2012, Haggstrom and Bruhn 2009, Nolan et al 2008 and Hasson and Arnetz 2008). A qualitative study presented by Haggstrum and Bruhn (2009) focuses on the attitudes of those who care for older people and the provision of education in the workplace. The findings from this study, involving 12 participants, suggest that the provision of learning opportunities in the workplace not only contribute to job satisfaction but also positively impact on staff retention. Findings also suggest however that staff must be supported to determine what and how to learn as this maximises the benefits of workplace learning.

Although Haggstrum and Bruhn (2009) propose that educational interventions should be targeted to reflect the care delivered in the workplace, Nolan et al (2008), when reviewing education and training literature previously in terms of achieving change in care homes, suggest that the evidence linking education and improved quality of life for care home residents remains open to interpretation. Despite this however, Nolan et al (2008) are clear, when elucidating the findings of the literature review, that; staff of all levels and from all professions must engage in ongoing education, education must be planned and implemented with regularity and that education delivered on-site helps to cultivate a sense of staff ownership. When considered in terms of an integrated practice learning infrastructure, these recommendations, founded in the literature, provide a source of evidence for consideration.

2.3.3 Care Homes as Practice Learning Environments and the Attitude of Student Nurses to this Experience and Caring for Older People

Thirteen papers were reviewed with a focus on pre-registration nursing students' attitudes to both the care home environment and the provision of care for older people.

A quantitative comparison study conducted by Xiao et al (2013), involving both Australian (n=256) and Chinese (n=204) pre-registration nursing students, was designed to explore the influence of culture when caring for older people. This study also considered student attitudes to caring for older people and factors which could potentially influence this. The findings suggest that Chinese students were less reluctant to work with older people than their Australian counterparts; of those, sampled 8.8% of Chinese students indicated that this would be their least favoured option versus 37.9% of Australian students. However, only 1.6% of Chinese students and 4.4% of Australian students indicated that caring for older people would in fact be their first choice of employment – a much narrower gap when considering actual employment choice. In light of this, this study concluded that ageism remains evident across both eastern and western cultures although also suggests that the collective nature of eastern culture is more receptive to supporting and caring for older people. The authors also conclude that all educationalists must work to improve student attitudes towards caring for older people (Xiao et al 2013).

Neville and Dickie (2014) explored evidence relating to student attitudes to caring for older people by conducting a review of the literature. Through this review, which incorporated both national and international literature spanning 2008 – 2013, the authors arrived at the

conclusion that the majority of pre-registration students have a positive attitude towards older people and caring for older people; in effect adopting a somewhat alternative stance to that voiced in the previous study conducted by Xiao et al (2013). They do however recognise, as does Koh (2012), that culture and personal experience can influence attitude and cite; own family, own community and own workplace as having the power to influence the positivity, or negativity, with which caring for older people is viewed. Since the production of this literature review, Carlson and Edvall's (2014) qualitative study involving year 3 student nurses reached a similar conclusion, suggesting that student nurses generally view the care home learning environment positively.

Of the literature sourced, a number of authors have alluded to the influence, or potential influence, of theoretical preparation for practice when caring for older people (Neville and Dickie 2014, Carlson and Edvall 2013, Xiao et al 2013, and Haron et al 2013). Viewpoints remain conflicted however. Some suggest that nurse educationalists must work harder to positively influence student preparedness and attitudes towards caring for older people (Carlson and Edvall 2014, Xiao et al 2013) whilst others suggest that this effort can often be negated by poor placement experiences (Neville and Dickie 2014). Koh (2012) reviewed the literature and contributes to this discussion, stating that preparation of students to engage with care of older people is crucial. Koh (2012) cites orientation and the support of an academic tutor as key elements of this preparation and also suggests that a focus on improving quality of life may also positively influence students' perception of caring for older people.

Conflict is similarly evident when reviewing the evidence concerning students' post registration career choices. Haron et al (2013), when reporting the findings of their mixed methods study entitled '*Why do students not want to work in geriatric care?'* concluded that there is no evidence to suggest that nursing programmes exert any influence at all on students' choice of employment. A previous study conducted in Finland however by Koskinen et al (2012) concluded that greater emphasis on caring for older people in nursing curricula *could* contribute to enhancing students' interest in this area of practice. Stevens (2011) previously considered career preferences of pre-registration nursing students in a longitudinal study conducted in Australia. Stevens (2011) concluded that negative experiences on placement during nurse education programmes resulted in a similarly negative view of caring for older people. Factors leading to this negative perception of the care home experience included; poor staff knowledge and poor care environments. The work of Stevens (2011) is supported by Shen and Xiao (2012) who conducted a quantitative study designed to identify factors which affect nursing students' intention to work with older people. Shen and Xioa (2012) determined that year 1 students were more receptive to working with older people than any of the other students across a four year programme. This finding led to the conclusion that practice learning experiences with older people can negatively impact on desire to work in this field.

Nolan et al (2008; p 1214) conducted a mixed method study spanning 3.5 years to *'identify the role and influence of students' learning experience on shaping their pre-dispositions to work with older people and to identify the characteristics of a positive learning environment that might promote a more favourable view of gerontological nursing'*. Their findings, although published some time ago in 2008, continue to reflect much of the contemporary literature in terms of the student experience of care homes and caring for older people. One of the conclusions delineated as a consequence of this study is that most students begin nurse education with a positive view of caring for older people. Factors which enhance this positive viewpoint include; being welcomed to the area, clear lines of communication between the university and care homes and a supportive learning environment. Factors highlighted as negatively influencing this are also delineated and include; exposure to poor quality placements; poor care home staff training and lack of resources and equipment.

2.4 Summary of the Rapid Appraisal of the Literature

It is clear from the literature appraised that the provision of care for older people is multi-faceted in terms of; the changing health and social care landscape; the increasing emphasis on the role of independent sector care; the ongoing development of independent sector staff and the provision of practice learning experiences for pre-registration student nurses in these areas. This combined with national and international recognition of an ageing population, and the challenges and opportunities which this presents, have already spurred moves towards a more integrated health and social care agenda. This in turn has initiated greater recognition of the need to develop shared learning, not only across the healthcare professions, but also across health and social care organisations, an aspect already highlighted as part of the care home education facilitator (CHEF) role.

The importance of fostering innovative practice in care homes is clear, as is the importance of enhancing the perception of both staff and students in terms of approaches to care delivery, and the valuable learning to be achieved when working beyond the realms of technical hospital-based care. This is perhaps best articulated in the literature which has highlighted that learning and development opportunities in care homes include; opportunities to develop relationships with residents, patients and carers; opportunities to develop skills which are non-reliant on technology and also the provision of individualised holistic care in non-hospital environments. The key functions of the CHEF role are clearly linked to developing these opportunities for both care home staff and students as they include; sign posting of educational resources, mentor educational development/support and the enhancement of the pre-registration learning environment in care homes. CPD, which links the CHEF role of educational resource sign-posting, has also been linked, in some cases, to both recruitment and retention of staff, an area highlighted at times as problematic in terms of independent sector areas.

The literature reviewed has emphasised that attitudes towards caring for older people can, at times, be perceived as negative, perhaps reinforcing the importance of challenging negative stereotypes which may present. Working to ensure students' gain experience in environments which provide care for older people during their programme of study has however been identified as a means of perhaps proactively changing these stereotypes. It has also been suggested by some authors that this experience can positively influence post registration career choices when considering future involvement in caring for older people. Although the benefits of theoretically preparing students for care home practice learning experiences are considered by some to be inconclusive, nursing's' professional regulatory body has adopted the stance of advocating the establishment of links between the young and the old can as one way to overcome prejudices which may exist.

SECTION 3: PROJECT PLANNING, ETHICAL REVIEW, ACCESS AND PARTICIPANT RECRUITMENT

3.1.1 Project Planning and Project Status

During planning, the project plans were reviewed with reference to the National Research Ethics Service (NRES 2009) guidance documentation *Defining Research.* This helped to confirm the project status as that of service evaluation; NHS Ethic's approval was therefore not required. Despite this, and in light of the national status of the project, the West of Scotland Research Ethics Service (WOSRES) was however asked to review the project plans to re-affirm the project status. In terms of HEI academics and students, it was understood that, irrespective of the project's evaluation status from an NHS standpoint, the ethics committee systems and governance processes of the HEIs would require that the project plans and associated documentation be scrutinised prior to the involvement of either of these groups.

3.1.2 Data Collection Timelines

Phase 2 evaluation data collection timelines were planned to reflect the aim of collecting data with a more longitudinal focus on the CHEF role impact. As the previous phase 1 CHEF evaluation had taken place during defined timelines (2011/12), data collection periods for the phase 2 evaluation were similarly agreed at the outset. In terms of statistical data, a 12 month retrospective period of reference was delineated (1st April 2013 – 31st March 2014). As the collection of qualitative data would, in part, be informed by the statistical data, qualitative data collection was scheduled to take place later from October to December 2014.

3.1.3 Identifying Strategic and Operational Stakeholders

The diversity of stakeholder engagement incorporated as part of the CHEF role was recognised therefore it was considered legitimate to garner data from across the spectrum of stakeholders; this would help to determine the national impact of the role. Stakeholders identified for inclusion included; pre-registration nursing students; care home mentors; care home managers; NHS Board Leads and higher education institution (HEI) academics.

3.1.4 Participant Information and Informed Consent

Irrespective of the research or evaluation status of the project, participant protection remained at the forefront of project planning. Safeguards included:

- An introductory email to all stakeholders to request their participation
- Tailored to each participant group; the provision of an information sheet detailing the project and expectations of their involvement should they choose to take part
- The implementation of an informed consent process
- The protection of confidentiality and the assurance that stakeholders would only be identified in terms of their professional grouping, for example CHEFs, mentors, care home managers, NHS Board Leads and HEI academics
- The adoption of an *opt-in approach* for those asked to become involved in focus groups, helping to protect and maintain stakeholders' right-to-refuse participation or to withdraw at any time

- For those asked to complete an online questionnaire, specific guidance detailing that, once submitted, it would not be possible to withdraw their contribution from the evaluation due to the anonymous nature of the questionnaire

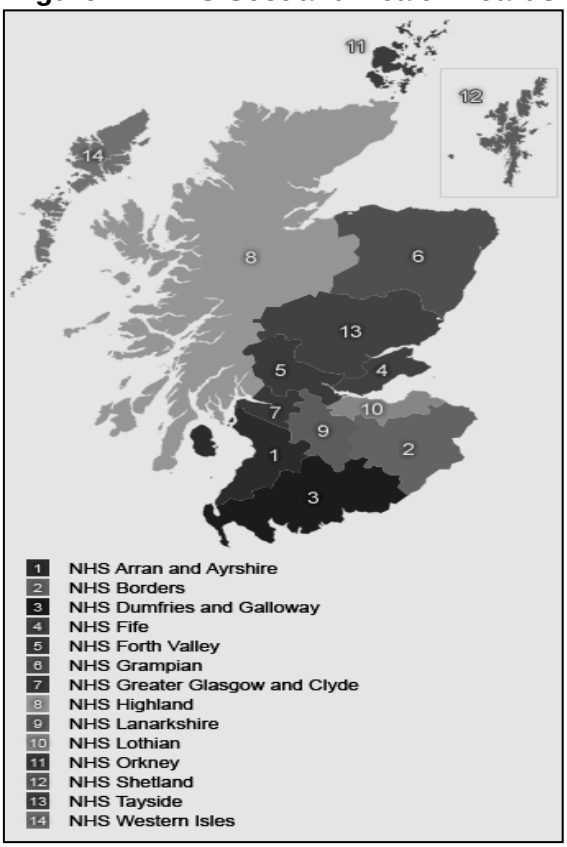
3.2 NHS Education for Scotland Research Governance

The project plans were reviewed and approved by the appropriate NES programme director. This included approval of the project monitoring process and consideration of the rapid appraisal literature which, in tandem with the adapted Gerrish et al (2011) toolkit, had served to inform the development of the project data collection tools. The project was also discussed and reviewed with a representative of the NES NMAHP research advisory group. This review included discussion of plans to seek ethics approval from identified HEIs. The research advisory group representative was informed of the review of project plans in line with the 'Defining Research' (NRES 2009) guidance. Finally, an update was provided regarding the outcome of the subsequent ethical review undertaken by the West of Scotland Research Ethics Service (WOSRES) which confirmed the service evaluation status of the project. Following this activity, and in keeping with the organisation's research governance requirements (NES 2013), the project was logged to the NES Research Register.

3.3.1 NHS Scotland Health Boards

The national focus of the CHEF role required that all NHS Boards (in which CHEFs were employed) be offered the opportunity to participate. Figure 2 depicts the 14 NHS boards in Scotland however, it is worthy of note that NHS Orkney (11) and NHS Shetland (12) do not have an allocated CHEF, and that the NHS Highland CHEF supported care homes in NHS Western Isles (14).

Figure 2 – NHS Scotland Health Boards



3.3.2 NHS Scotland Ethics Review

The NRES (2009; p1) *Defining Research* guidance document has been designed to help those undertaking projects to decide *'if a project is research, which normally requires review by a Research Ethics Committee (REC), or whether it is some other activity such as audit, service evaluation or public health surveillance*.' As identified previously, a review of the project documentation against the *Defining Research* algorithm confirmed the project's status as that of service evaluation, as did the additional review undertaken by WOSRES. In light of this, no further NHS ethics review was required.

3.3.3 NHS Scotland Clinical Effectiveness Registration, Gatekeeper Access and Participant Recruitment

NHS Board Practice Education Leads were identified as the NHS stakeholders most likely to be able to provide some insight into the impact of the CHEF role. The project's service evaluation status required that the Clinical Effectiveness Departments of each participating NHS Board be contacted and gatekeeper permission sought to access the Leads. There was cognisance that each NHS Board also requires evaluation projects involving NHS staff or an NHS service be registered with the Board's clinical effectiveness department and the outcomes/findings of the project be fed back upon completion. In line with these requirements, the project was logged with the Clinical Effectiveness Departments of each of the 11 participating NHS Boards. It is however pertinent to note at this point that the process proved challenging due to variance in process and documentation across NHSScotland Board areas. It became clear that there was no standardised procedure in place across Scotland and, as a consequence, confirmation of Clinical Effectiveness registration and permissions took almost 4 months to finalise nationally.

Upon completion of the above, invitations to participate in the project were circulated to NHS Board Leads via both the National Strategic Group for Practice Learning (NSGPL) and the Practice Education Leads (PEL) Forum.

3.4.1 Scotland's Higher Education Institutions (HEIs)

11 HEIs are responsible for the delivery of pre-registration nursing education in Scotland:

1. Abertay University (AU)
2. Edinburgh Napier University (ENU)
3. Glasgow Caledonian University (GCU)
4. Queen Margaret University (QMU)
5. Robert Gordon University (RGU)
6. The Open University (OU)
7. University of Dundee (UoD)
8. University of Edinburgh (UoE)
9. University of Glasgow (UoG)
10. University of Stirling (UoS)
11. University of the West of Scotland (UWS)

At the time of planning the project the Open University did not engage with CHEFs nor did they place students in care home practice learning environments (PLEs) and, consequently, academics and students from this HEI were unable to take part. The remaining 10 HEIs were however contacted to request access to academics and pre-registration nursing students with a view to participation in the project.

3.4.2 HEI Ethics Review

Each HEI independently undertakes ethics review for any projects potentially involving academics and/or students from their own institution. As a consequence, representatives of the 10 HEIs identified as potential participants in the project were contacted via the National Strategic Group for Practice Learning (NSGPL) and Practice Education Leads (PEL) Forum. One HEI (GCU) undertook preliminary scrutiny of the project proposal and a 3 stage approach to ethics approval was agreed. This agreement supported intermittent review and approval of documentation by GCU as the project progressed – including consideration of any project amendment requests. Due to variance across HEIs in Scotland in terms of ethics committee requirements, it was also necessary to circulate the project documentation to the remaining 9 HEIs; supporting documentation and confirmation of GCU ethics approval (as appropriate) following review of each stage of the project was also provided - as relevant to each HEI. This approach afforded each HEI the opportunity to independently review and approve the stages of the project which would directly impact on academics and students from their own institutions.

3.4.3 HEI Gatekeeper Access and Participant Recruitment

It was agreed that both HEI academics and pre-registration nursing students, the latter with experience of a care home PLE, would be invited to participate in this project. These invitations were extended via 2 routes:

- *Pre-registration Nursing Students* – In cognisance of the geographical spread of the 10 HEIs, it was agreed that students from 1 HEI in the North, 1 HEI in the South/East and 1 HEI in the West of Scotland would be invited to take part. The HEI representatives on NSGPL confirmed that they would be willing to relay the request for student participation to the appropriate HEI gatekeeper, most often the Head of Department (HOD). Upon receipt of gatekeeper access confirmation, students were invited to participate via announcements on each HEI's online learning site and, in some case, posters were displayed providing information about the project with the relevant contact details
- *Academics* - 1 academic from each HEI with expertise in practice learning, of working collaboratively with CHEFs, and also with experience of facilitating student PLEs in care homes, was invited to take part. The representatives of each HEI on NSGPL and PEL Forum were emailed with this invitation to allow HEIs to decide who would be best placed to participate

3.5.1 Scotland's Independent Service Care Homes

Not all independent service care homes were eligible to participate in the project – only those who had previously or currently supported pre-registration nursing students and had previously or were currently being supported by CHEFs. Again, the geographical spread of care homes nationally was considered in an attempt to ensure appropriate representation across the regions; particular care was taken to ensure both remote/rural and urban representation. As CHEFs are managed by NHS Boards, it was agreed that the most efficient way to ensure representation across Scotland would be to invite approximately 5 care homes from each NHS Board area to take part.

3.5.2 Ethics Review

As independent service care homes tend not have ethics committees or ethics review panels it was important to make contact with each care home individually to:

- Provide detailed information about the Phase 2 CHEF Evaluation Project and how this relates to care homes supported by CHEFs in Scotland
- Appraise care home managers of the NHS and HEI ethics review process and permissions, confirming appropriate scrutiny to ensure the protection of potential participants
- Identify care home staff who could potentially be eligible to participate, including care home managers, mentors and sign-off mentors

3.5.3 Gatekeeper Access and Participant Recruitment

Part of the initial telephone contact with each care home involved ascertaining the gatekeeper for each care home. In the main, care home managers identified themselves as the gatekeeper although for some of the larger organisations a regional manager invariably assumed this role. Those identified as gatekeepers were furnished with information relating to the project and ethical review by email and were asked to respond by return mail to both acknowledge receipt of this information and also to confirm access to care home managers and mentors/sign-off mentors. These confirmatory emails were thereafter logged with the primary HEI ethics committee (GCU) as evidence of gatekeeper access.

3.6.1 Care Home Education Facilitators

CHEFs were recognised as a key source of intelligence around the impact of the role in practice; mainly due to the practical nature of their work and the ongoing collaboration with care home managers, mentors, NHS Board managers, PEFs and HEI academics. At the time of project commencement, 19 CHEFs were employed nationally in a variety of capacities including; 0.2, 0.3, 0.5 and whole time equivalent (WTE) posts. Furthermore, some CHEFs were undertaking the joint role of PEF/CHEF. In light of this variety, it was considered important to ensure that all CHEFs had the opportunity to contribute to the evaluation of the role. It is important to note however that CHEF numbers fluctuate at times due to vacancy and recruitment processes and, consequently, at the time of CHEF focus groups, 16 CHEFs were in post.

3.6.2 Ethics Review

CHEF posts are funded by the Scottish Government/NES, but employed by NHS Boards. Their objectives for, and delivery of, the role are managed locally by NHS Board Leads, in collaboration with the NES Practice Education Leads. Consequently, there is a requirement for dual consideration in terms of ethics review and approval at both host NHS Boards, and nationally from NES.

To address this, not only was the project scrutinised by WOSRES but it was also reviewed by the NES NMAHP Research Advisory Group. NHS Board Leads responsible for the management of the CHEF role were kept abreast of the ethics process and were also party to decisions regarding the registration of the project with each NHS Boards' Clinical Effectiveness Department

3.6.3 Gatekeeper Access and Participant Recruitment

As NES act on behalf of the Scottish Government in terms of CHEF funding, access to CHEFs, and information held by CHEFs, was accessible for this project however, it was also considered important to recognise the role and remit of NHS Boards and NHS Board Leads. Consequently, NHS Board Leads were provided with regular updates regarding project planning and were also involved in negotiations regarding gatekeeper access and CHEF participation in the project.

3.7 Summary

Project planning for the Phase 2 CHEF evaluation incorporated 3 key elements; a review of the Phase 1 CHEF Evaluation report; a rapid appraisal of the literature and the review and adaptation of the Gerrish et al (2011) impact toolkit. Identification of key operational and strategic stakeholders at the outset, as part of this process, allowed for consideration of how best to collect and analyse data – discussed in more detail in Section 4 of this report. Perhaps the most fundamental element of project planning involved the steps taken to ensure both appropriate ethical scrutiny and necessary gatekeeper access in advance of making contact with prospective participants. To achieve this end it was necessary to engage with each NHS Board, HEI and care home on an individual basis, ensuring the provision of accurate and timely information in advance of all project involvement.

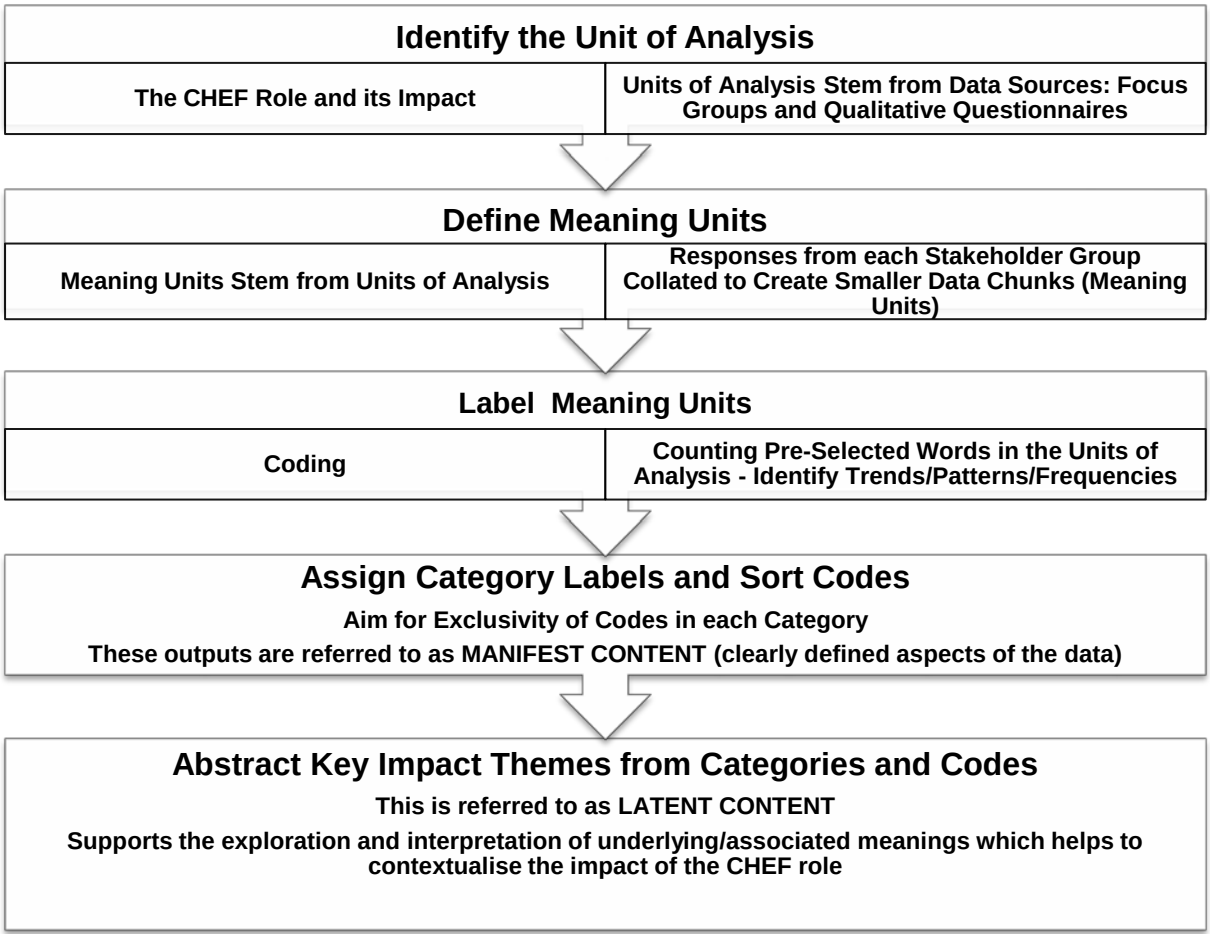
SECTION 4: DATA COLLECTION, RESPONSE RATES AND ANALYSIS

4.1 Determining the Method of Data Analysis

In terms of measuring impact, there was recognition that qualitative data from a variety of stakeholders could lead to the generation of multiple subjective perspectives and interpretations of the impact of the CHEF role. It was therefore considered necessary to identify a method of analysis which would not only generate impact themes based on qualitative data, but could also support the identification of trends and patterns across stakeholder groups. It was anticipated that this mix of subjective experience and pattern/trend identification would more accurately present the perspectives of each individual stakeholder group. Adopting this analysis approach would also support cross-group comparison of stakeholder's perceptions of impact, helping to delineate, in a more meaningful way, the multi-faceted nature of the CHEF role and the way in which the impact of the role is perceived by each stakeholder group.

The work of Wheeler (1988), Graneheim and Lundman (2004) and Gerbic and Stacey (2005) was reviewed to inform the development of a framework for content analysis. An adaptation of the approach advocated by Graneheim and Lundman (2004) ultimately informed the method of analysis chosen and is detailed in Figure 3:

Figure 3 – Framework for Content Analysis



4.2 Response Rates – All Stakeholders

Table 1 summarises the response rate across all stakeholder groups. Unfortunately, despite a variety of attempts to encourage pre-registration nursing students' participation in the project across 3 HEIs, only 1 student chose to take part. Consequently, it was recognised that the data collected from this student could not be used as part of the evaluation as it would be impossible to protect the student's anonymity. Furthermore, there was cognisance that one student's viewpoint/experience would not necessarily be an accurate representation of the student population as a whole.

Table 1 – Response Rates across Stakeholder Groups

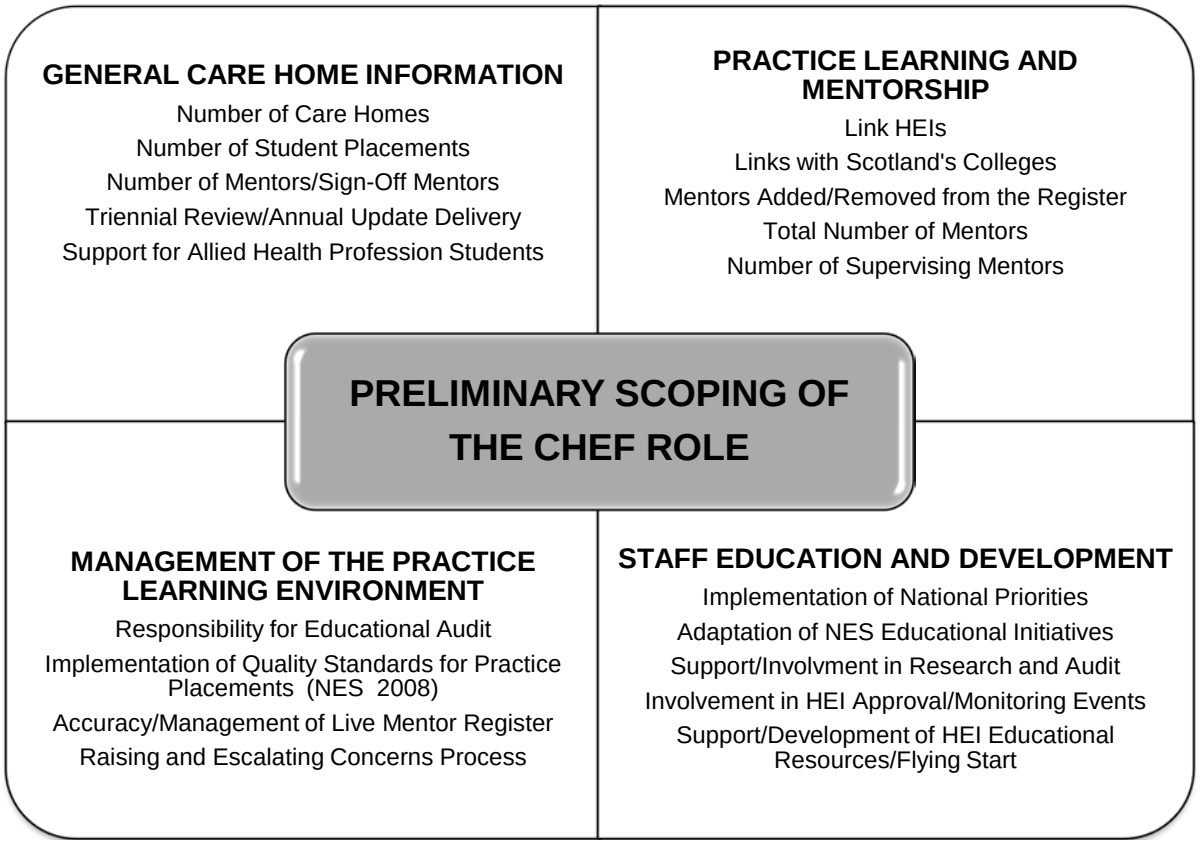
Preliminary Scoping of CHEF Activity (Template)		**Response Rate**
NHS Board Area Completion	11	N = 11 (100%)
Questionnaire Distribution		**Response Rate**
Care Home Managers	44	n = 22 (50%)
Care Home Mentors/Sign-Off Mentors	62	n = 22 (35%)
HEI Academics	11	n = 8 (73%)
NHS Board Leads	11	n = 10 (91%)
CHEF Focus Group Attendance		**Attendance Rate**
CHEF Focus Group 1	5	Total Number of CHEFs in Post – 16 n = 11 (69%)
CHEF Focus Group 2	6	
Student Focus Group Attendance		**Attendance Rate**
3 HEIs		1 student Unable to protect anonymity therefore data not included)

4.3.1 Care Home Education Facilitators – Preliminary Scoping Data

Although delineating the impact of the CHEF role would mainly stem from dialogue with stakeholders, it was recognised that the collation of statistics around mentorship and pre-registration nursing education support, signposting of educational resources and in, particular the support of Flying Start NHS® would provide baseline information and would also facilitate the development of further questions for stakeholders around impact. The statistical data generated from the scoping template would also support any future reporting of the CHEF role in that it would provide a baseline for measurement against.

The scoping template was created with reference to the key functions of the CHEF role and PEF/CHEF priorities and was critically reviewed, prior to circulation to CHEFs for completion, by an NHS Board Lead and a HEI Academic. The question categories, and some examples of the questions, are depicted in Figure 4:

Figure 4 – Scoping Template Categories and Questions



When sourcing information for the template, CHEFs were advised to collaborate and collate the information on one template for each NHS Board area. CHEFs were also advised to limit their review of records to incorporate 1st April 2013 to 31st March 2014; this helped to ensure that all CHEFs, irrespective of geographical/NHS Board area, were working within agreed parameters and that descriptive statistical analysis would be informed by like-for-like data.

Using descriptive statistical analysis, the results generated from the scoping, which have been incorporated as part of Section 5 of this report, facilitated simple interpretation and measurement of the activities undertaken by CHEFs. As expected, it was not possible to reach definitive conclusions regarding the impact of the CHEF role based on this data alone, rather subsequent engagement with stakeholders, and CHEFs, would be required to provide additional detail to support the generation of more definitive findings. The scoping template data did however provide the expected baseline information and also helped to identify aspects of the role which would require further exploration with stakeholders to delineate impact more fully.

4.3.2 Care Home Education Facilitator Focus Groups

All CHEFs were invited to attend an audio recorded focus group to discuss their perceptions of the role; 11 of the 16 CHEFs currently in post took part. Two focus groups were scheduled (n = 5 and n=6) and each group were asked like questions which had been previously mapped to the CHEF key role functions (Appendix 1, page 69), helping to ensure the collection of relevant data. CHEFs were provided with an opportunity at the end of each focus group to highlight any additional aspects of the role which they felt had not been explored or considered and participants from each focus group were also asked to consider

what recommendations they would have in terms of the future development of the CHEF role.

The audio recordings from each focus group were transcribed and analysed using the content analysis method previously outlined. As the aim was to retrieve data representative of the CHEF perspective nationally, the analysis of both focus groups was combined to produce one set of findings.

4.3.3 Care Home Education Facilitator Led Initiatives

The CHEF focus groups highlighted that they undertake a variety of activities and work based interventions designed to support the delivery of safe, effective person centred care and also the enhancement of staff development. Following the focus groups, CHEFs were provided with an additional template for completion; this was designed to capture the specifics of these interventions and also to identify the rationale for implementation and subsequent outputs. As for the preliminary scoping template, CHEFs were asked to collaborate in each NHS Board area and to submit a collective response. They were also asked to ensure that NHS Board line managers had reviewed and sanctioned the submission of this information as part of the impact evaluation project. Selected activities have been included as part of Section 5 of this report and are highlighted in text boxes alongside the discussion of relevant key impact themes.

4.4 HEI Academics and NHS Board Leads – Qualitative Questionnaire

The questionnaire developed for HEI Academics and NHS Board leads focused on more strategic considerations of the CHEF role. Appendix 2, page 70, details the questions asked of these stakeholders. Although both stakeholder groups were asked identical questions, each groups' responses were collated separately via the electronic survey system Questback®. This supported identification of each group's perceptions of the role and role impact and also afforded the opportunity for content analysis of the data from each discrete group in the first instance. Thereafter, if required, it would be possible to merge the findings from both groups to establish a joint strategic perspective of the CHEF role.

4.5 Care Home Managers and Mentors – Qualitative Questionnaire

The questionnaires developed for care home managers and mentors focused on more operational support provided by CHEFs and also on the support provided for continuing professional development in care homes. Appendices 3 and 4, pages 71 and 72 detail the care home manager and mentor questionnaire respectively. The questionnaires were distributed in both paper (pre-paid envelope provided) and electronic form, depending of the preference of care home staff; paper questionnaires were required on a number of occasions due to the absence of IT access for mentors in some care homes. The electronic questionnaires were created using the Questback® survey system. Responses from care home managers and mentors were collated by the system separately through the allocation of a discrete URL link for each stakeholder group. Paper copies of the questionnaire were returned in a pre-paid envelope directly to NES. Those completing the paper questionnaire were instructed not to include any personal identifiers on this documentation.

Discrete analysis of care home manager and mentor responses was undertaken as it was recognised that the perceptions of the impact of the CHEF role may differ. There remained however the potential to combine the analysis to establish joint findings indicative of the CHEF role from the perspective of care home staff generally if required.

4.6 Summary: The Data Collection and Analysis Method

In keeping with the mixed method data collection and analysis approach outlined, discussion of findings incorporates both quantitative and qualitative data; this has been garnered through descriptive statistical analysis of the preliminary CHEF scoping template data and through the application of the content analysis framework (refer to page 30 to view this framework) to data retrieved from stakeholder focus groups and qualitative questionnaires. Through triangulation of the data, key areas of CHEF role impact have been; identified, statistically analysed, thematically categorised and discussed. In keeping with the content analysis method, coding, and counting of coding incidents in each of the thematic categories, has supported the depiction of impact frequencies and patterns across stakeholder groups. These frequencies and patterns have proved useful when attempting to rank impact in terms of perceived importance to each stakeholder group.

SECTION 5: THE CHEF ROLE IMPACT - DISCUSSION OF FINDINGS

5.1 Introduction

Four key impact themes emerged during qualitative data analysis. These were used as a framework to support the discussion of findings indicative of both CHEF role activity and impact:

- ***Key Impact Theme 1****: Collaborative Working and Building Relationships*
- ***Key Impact Theme 2****: Supporting NMC Mentorship Standards and the Delivery of Pre-Registration Nursing Education*
- ***Key Impact Theme 3****: Sign-Posting Educational Resources and Supporting Continuing Professional Development*
- ***Key Impact Theme 4****: Enhancing Safe, Effective Person-Centred Nursing Practice*

Table 2 outlines impact ranking for each stakeholder group for each key impact theme. Discussion of impact incorporates both statistical and qualitative data. Contextualisation has been achieved by referencing pertinent literature and also through the inclusion of stakeholder and CHEF comments.

Table 2 – Key Impact Themes, Sub-Themes and Ranking of Response Frequencies

Ranking Key – Participant Responses Coded, Counted, Themed and Ranked (1 – 5) for Pattern Frequency.
1 – Indicates Most Prevalent/Frequent Response
5 – Least Prevalent/Frequent Response

Stakeholder Group	**CHEFs**	**Care Home Mentors**	**Care Home Managers**	**NHS Board Leads**	**HEI Academics**
	Rank	**Rank**	**Rank**	**Rank**	**Rank**
CHEF Role – Key Impact Themes	**Rank indicates Qualitative Response Frequencies for each of the 4 Key Themes for each Stakeholder Group**				
KEY THEME 1 *Collaborative Working and Building Relationships*	**(2)**	**(2)**	**(2)**	**(1)**	**(2)**
KEY THEME 2 *Supporting Attainment of NMC Standards and the Delivery of Pre-Registration Nursing Education*	**(1)**	**(1)**	**(1)**	**(2)**	**(1)**
KEY THEME 3 *Sign-Posting Educational Resources and Supporting Continuing Professional Development*	**(3)**	**(4)**	**(3)**	**(3)**	**No Data Identified**
KEY THEME 4 *Enhancing Safe, Effective, Person-Centred Nursing Practice*	**(4)**	**(3)**	**(4)**	**(4)**	**(3)**
**Miscellaneous Data (not directly related to the CHEF role)*	**(5)**	**No Data Identified**			

5.2.1 ***Key Impact Theme 1*** *– Collaborative Working and Building Relationships*

Collaborative Working and *Building Relationships* emerged as a strong theme, evidenced by the consistent '1' and '2' ranking (Table 2) across all stakeholder groups. This also reflects *key role function 2* of the CHEF role which is dedicated to the enhancement of collaborative/cross sector relationships. This role function states that CHEFs must *'Support the Health and Social Integration agenda through enhancing collaborative cross sector working between the Care Homes, the NHS Boards and HEIs and national, regional and local practice education infrastructures'.*

Prior to the discussion of the findings relating to collaborative working and collaborative roles it is perhaps also pertinent to consider the way in which CHEFs and PEFs work together. When speaking to CHEFs, consensus was absent when asked whether or not there should be more collaboration between both groups of educators, with some CHEFs indicating that they felt collaborations and joint roles worked well – especially in terms of joint PEF/CHEF appointments. Others however suggested that greater integration would potentially present challenges and could lead to care home being viewed as less important overall. Interesting, the view of strategic stakeholders (NHS Board Leads and HEI academics) was largely in favour of a more integrated practice learning infrastructure.

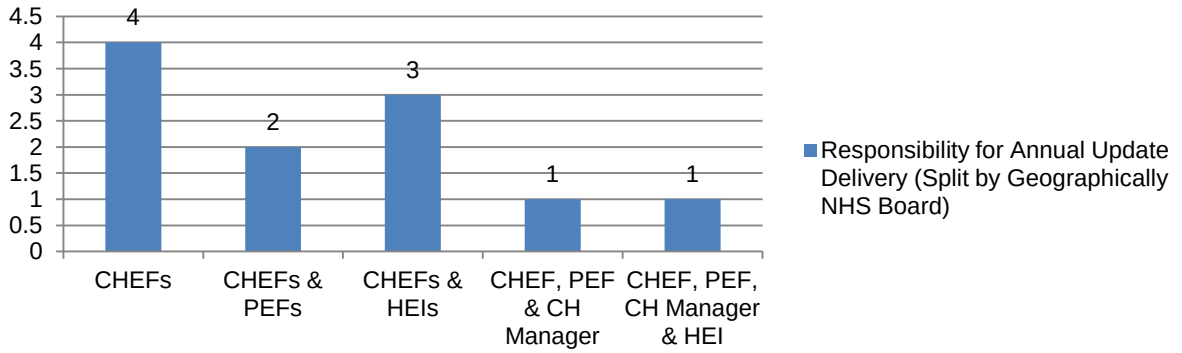
Two sub-themes have been used to delineate and present the findings of this key impact theme.

5.2.2 *Sub-Theme A: Collaborating to Safeguard and Enhance Pre-Registration Practice Learning*

Work to both safeguard and enhance the quality of pre-registration practice learning is recognised as an integral requirement of NMC (2014) *Quality Assurance Framework.* NMC (2014) similarly accede however that this work must be undertaken collaboratively by HEIs and their practice partners.

It was possible to statistically measure some elements of collaborative working when analysing CHEF role activity and impact around pre-registration practice learning in care homes. Using NHS Board areas as a means of geographical split (n=11), Figure 5 highlights CHEF collaborations with a variety of stakeholders when delivering mentorship annual updates. The collaborations are variable in that they involve different stakeholder groups, depending on the NHS Board area. It is also evident that, in some geographical areas (n=4), CHEFs are the sole providers of annual updates; an aspect for consideration when recommending the way forward for future delivery nationally of care home annual updates.

Figure 5 – National Overview: Collaborative Working and the Delivery of Mentorship Annual Updates



Despite this variability of collaboration, the impact remains clear in that, CHEFs nationally, were involved in the delivery of a significant number (n=386) of annual updates during the defined 12 month scoping period.

The authenticity of the impact of the CHEF collaborative role is emphasised by the frequency with which both care home mentors and managers comment on CHEF activity around the delivery of annual updates, and also the sense of reassurance that this provides both mentors and managers. This is best illustrated by these stakeholders:

> *''Prior to the implementation of the CHEF role we always felt like the poor relation in nursing.....now I feel confident that we are up-to-date with mentorship and that we are a progressive and proactive care home'.* ***(Care Home Manager)***

> *'The CHEF keeps us informed about due dates for updates and triennial review – she also facilitates other dates and organises venues out-with scheduled sessions to ensure that we complete on time'.* ***(Care Home Mentor)***

> *'Mentors definitely feel more supported and, as care home manager, working with the CHEF helps me feel more reassured that my mentors are up-to-date and well supported.'* ***(Care Home Manager)***

The maintenance of live mentor registers, and the implementation of triennial review, both of which are integral requirements of NMC (2008) *Standards to support learning and assessment in practice,* and fundamental aspects of the work undertaken to secure practice learning opportunities in care homes, have also been highlighted as collaborative activities. Figures 6 and 7 provide a statistical representation, again geographically split by NHS Board area (n=11), of CHEF collaboration when both working to maintain the accuracy of the live mentor register and to implement triennial review. Here, there is also evidence that collaborative working can at times be variable with CHEFs highlighting in 6 NHS Board areas that they are solely responsible for maintaining the accuracy of the live mentor register; an activity that would normally be collaborative and/or led by the HEI. The importance of the CHEF role is clear for some stakeholders;

> *'The CHEF has fulfilled an important role.....they assist in providing information to maintain the live mentor register'.* ***(HEI Academic)***

Figure 6 – Responsibility for the Accuracy of the Live Mentor

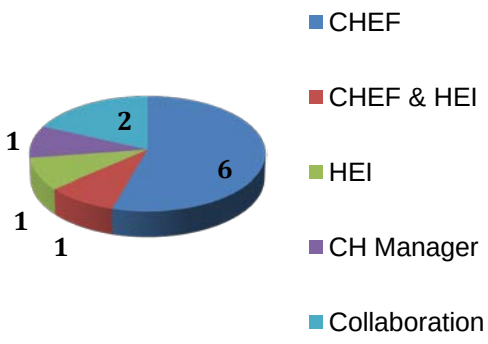
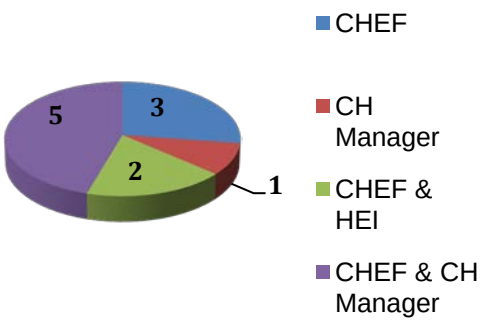


Figure 7 – Responsibility for Triennial Review Register



There is similarly evidence of the central collaborative role discharged by CHEFs when measuring their involvement in educational audit and action planning for interventions/implementation of change in practice learning environments. Figure 8 highlights that in 9 of the 11 geographical NHS Board areas CHEFs undertake educational audit collaboratively with all, or a selection, of stakeholders. Similarly, Figure 9 illustrates that in 10 of 11 geographical NHS Board areas CHEFs work collaboratively to prepare and manage practice learning environment action plans. CHEFs in all NHS Board areas also confirmed, when completing the scoping template, that they work collaboratively to manage the raising and escalating concerns process (NMC 2010).

Figure 8 - Practice Placement Audit Responsibility

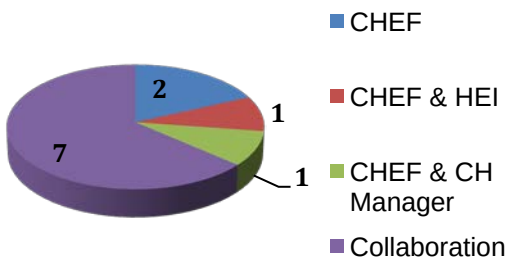
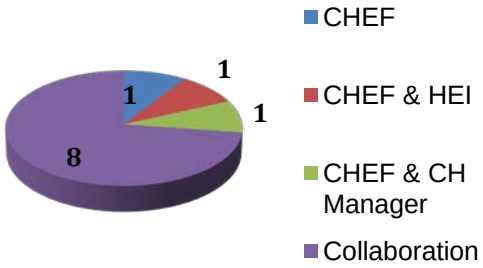


Figure 9 – Practice Placement Action Planning



Qualitative impact findings align with this quantitative interpretation of the data in that both CHEFs and HEI academics recounted similar experiences of the way in which collaborative working supports more effective management of the practice learning environment through educational audit and action planning.

> *'Auditing care homes generally works well but that's mainly because I'm there helping care home managers to get it done - I offer my service and support to complete the documentation. If I wasn't there I'm not sure how well it would work...'* ***(CHEF)***

> *'The CHEF carries out joint audits and these are much more effective because of the CHEF's detailed inside knowledge of the sector'.* ***(HEI Academic)***

The importance of CHEF involvement and collaboration in this area is further highlighted by HEI Academics when they were asked to consider, as part of this evaluation, the potential implications for the future, should the CHEF role cease to exist:

> *'Academic staff would have to take over the role of supporting care homes, care home staff and audit. The resources available in the HEI to take over this role would be limited'.* ***(HEI Academic)***

NHS Board leads were also asked to consider the potential implications should the CHEF role no longer exist; this promoted the expression of similar concerns should collaborative working strategies, currently facilitated by CHEFs, no longer be employed:

> *'From a NHS Boards perspective, communication with the care home sector would greatly diminish'.* ***(NHS Board Lead)***

'There requires to be a model of sustainability and engagement – if the CHEF role did not exist this would not be maintained'. ***(NHS Board Lead)***

Integral to educational audit, CHEFs were asked about their experiences of supporting the completion of the National *Quality Standards for Practice Placements* (QSPP) (NES 2008) educational audit documentation. In particular, the discussion focused on both ease of completion, management of these documents in practice and the impact of the CHEF role as perceived by CHEFs. Although CHEFs expressed concerns about the format of the QSPP documentation, the crucial nature of collaborative working was well articulated when they discussed the support provided by CHEFs to care home managers and HEIs. Some CHEFs also shared their concerns about the potential impact on educational audit in the event of any withdrawal of CHEF support;

'The QSPP is a clunky document - it's easier for care homes to pick up the phone and ask us the specific questions.....no one remembers how to complete it either - sometimes you have to visit 3 or 4 times to help care homes complete it, when really, they want you to just complete it...sometimes I do....and sometimes I just stand back and give them advice.....I'm always involved in some way though....' **(CHEF)**

'Auditing care homes generally works well but that's mainly because I'm there helping care home managers to get it done - I offer my service and support to complete the documentation. If I wasn't there I'm not sure how well it would work...' ***(CHEF)***

5.2.3 Sub-Theme B: Improving Communication and Changing Perceptions through Relationship Building

Contemporary health and social care policy and guidance highlights the need to shift to a more integrated health and social care system (Scottish Government 2011, British Geriatric Society 2011, Age UK 2012, Joseph Rowntree Foundation 2012 and The Kings Fund 2014). Some stakeholders were asked, as part of this evaluation, to consider the impact of the CHEF role in supporting this educational integration. NHS Board leads commented with frequency on the unique link role which CHEFs fulfil, particularly in relation to the implementation of educational interventions and building relationships, through joint working, across Health and Social Care;

'The CHEF role provides an established link between Health and Social Care and fosters the sharing of good mentorship and person-centred care practice....' ***(NHS Board Lead)***

'The CHEF, working jointly with the local authority and the Care Inspectorate, has helped to identify training needs and implement training for all levels of staff. This enhances the learning environment and helps to develop the future care home workforce'. ***(NHS Board Lead)***

For other stakeholders however, the educational role of the CHEF, in relation to Health and Social Care Integration, was less clear. This lack of clarity around impact may require consideration when developing recommendations for the future of the CHEF role and, in particular, when identifying what these educational responsibilities actually are in terms of supporting Health and Social Care Integration.

What *was* apparent however was a fundamental impact of the CHEF role which stemmed directly from CHEF activity to build relationships across stakeholder groups. These outputs include; a greater understanding, across stakeholder groups, of the care home environment,

an improved perception generally of the care home environment overall and enhanced communication for all stakeholders;

> *'The CHEF has definitely helped in building relationships and trying to break down the barriers and the negative attitudes towards care homes that unfortunately still exist. The CHEF actively shares and promotes the good work that goes on in care homes and helps us to liaise with various professionals'.* ***(Care Home Manager)***

> *'There is improved communication with care homes as a result of the CHEF role – they have provided academic staff with an invaluable insight into the care home environment'.* ***(HEI Academic)***

> *'The CHEF is always very enthusiastic and knowledgeable when sharing information about the care home sector – this enhances our reputation within the community and with other professions'.* ***(Care Home Manager)***

CHEFs themselves do however recognise that constraints in communication and different approaches to communicating can, at times, negatively impact on their ability to foster relationships. Constraints include; variation in accepted ways of working across HEIs and also information governance/confidentiality requirements which, at times, preclude the sharing of information;

> *'Sometimes we are the last to know.....I have a really great relationship with my HEI but sometimes I'm not informed of things because of confidentiality – this can be an unavoidable sticking point when you're trying to build relationships and improve communication'* ***(CHEF)***

> *'There is communication but, if its variable, it's harder to make a connection – we meet to discuss this with the HEI though and try to find ways of improving communication between the HEI, care homes and us....'* ***(CHEF)***

Despite this, the impact of the CHEF role remains evident, mainly as CHEFs are considered as fulfilling a key role in helping to improve the overall perception of caring for older people in the care home setting, in turn leading staff to view their role and contribution more positively. This perception, expressed by care home mentors, NHS Board leads and HEI Academics, assumes particular significance when considering the British Geriatric Society (2011; p3) suggestion that care of the older person is often viewed as a *'Cinderella service'* by the NHS.

> *'As a mentor I now feel included and valued – before the CHEF role was in place, care home staff felt as though they were lesser nurses...'* ***(Care Home Mentor)***

> *'In promoting the value of working with older adults in the care home setting, the CHEF has assisted HEIs, NHS Staff and students to now view the care home environment as a valuable practice learning experience'.* ***(NHS Board Lead)***

> *'The CHEF not only promotes care homes as valuable practice learning environments but also promotes care homes as future places of employment'.* ***(HEI Academic)***

> *'.....Thinking about the stigma that has often been attached to employment within the care home sector, the CHEF has made such a difference in preparing students for placements here and also in heightening awareness of the skills that can be learned in this type of area'.* ***(Care Home Manager)***

CHEFs themselves were also able to articulate the impact of this aspect of their role:

'It's about the learning environment – working with HEIs and care homes to develop care home placements and support student practice learning. That's where we make a difference.....' ***(CHEF)***

'It's about changing perceptions.....some 3rd year students are now requesting to be placed in care homes.....they are beginning to see it as an opportunity to deliver care for a vulnerable client group. It's really good to see that change in the way students think'. ***(CHEF)***

CHEFs also shared ways in which they measure impact. Although perhaps more subjective, these impact measurements are none the less tangible and relate to the way in which CHEFs feel they have been able to establish an ethos of trust within care homes;

'We can see the difference we make in the communication we now get from care homes and mentors; they will email you or phone you frequently to ask for help or advice'. ***(CHEF)***

'Things have definitely improved; we aren't viewed as a threat anymore.' ***(CHEF)***

'I benchmark the trust by thinking about how things used to be and the way they are now. At the start we had to make appointments – everything had to be done by appointment. Now, I can drop in any time and be welcomed – care home staff always have time for me now'. ***(CHEF)***

5.2.4 Summary of Key Impact Theme 1

There is evidence which clearly delineates impact specific to the work which CHEFs undertake to support relationship building and the implementation of collaborative working. This evidence often relates specifically to the collaborative approaches fostered when implementing professional/regulatory requirements, including NMC (2008) *Standards to support learning and assessment in practice* NMC (2010) *Raising and Escalating Concerns.* In particular, it is clear that CHEFs, as a direct consequence of their specialised role remit, are better positioned to work across various stakeholder groups and are also more able, as a consequence, to develop collaborative working relationships with these stakeholders. This is particularly evident when considering QSPP (NES 2008) and educational audit as, although the documentation is considered by many CHEFs as cumbersome, completion presents opportunities for collaborative working with both care home managers and mentors.

Care Home Managers have highlighted that CHEFs not only enhance communication, but also improve overall the perception of the care home environment externally. In addition, the relationships which CHEFs are able to build with care home mentors and managers positively impacts on the way care home staff perceive the support which is available to them – and also the way in which they perceive their role as a care home employee, ultimately helping them to feel more valued in their role.

It is however clear that communication across stakeholder groups can be challenging and that this can, at times, reduce the ability of CHEFs to build relationships and foster collaborative working, Furthermore, there is also evidence that there remains scope to reconsider how to further enhance current collaborative working strategies and how best to raise the profile of the CHEF role in terms of their educational support of health and social care integration.

5.2.5 A Thematic Example of a Care Home Education Facilitator Initiative

The following CHEF-led initiative, implemented in one NHS Board area, provides a practical example of the way in which CHEFs are working across care homes to build relationships and to develop an ethos of collaboration:

Care Home Managers' Forum

A Care Home Managers' Forum was established by a CHEF in one NHS Board area to initiate, facilitate and enhance communication and sharing of local/ national educational initiatives and evidence based practice across the care home environment. The overall aim of the initiative was to achieve improvements in the quality of person centred, safe and effective care delivery in care homes. The Forum was considered an optimal platform to raise the profile of care homes and also to discuss the way in which care homes can provide sustainable learning environments for the future workforce. A preliminary evaluation of the Forum has highlighted areas for improvement and has supported the implementation of change improvements.

CHEFs have worked to support the Forum during implementation; this support has included;

- Strengthening working relationships across health and social care and establishing collaborative approaches, recognising that these can take time to evolve
- Guiding and advising external speakers (from NHS and other non-membership care home agencies) in terms of the information the Forum requires and also promoting awareness of the expertise of the members
- Dispelling negative perceptions of the care home environment
- Clarifying expectations of external speakers; this has helped to improve the quality of the information presented by external speakers and has also encouraged more meaningful Forum discussion

The impact of the Care Home Forum includes;

- Recognition of the group at strategic NHS Board and Local Authority level
- Higher Education Institution (HEI) recognition of the currently untapped potential for creating future sustainable learning environments and quality mentorship within the third sector, with CHEF support
- The facility to share concerns and information
- The opportunity to participate in and influence nurse education curriculum development
- The opportunity to access HEI and CHEF support for formal study, projects and research.
- The opportunity to raise the profile of the *Promoting Excellence in Dementia* resource; Care Home Managers have been supportive in providing staff protected time to complete

Plans for the future of this initiative include the planning and provision of workshops, facilitated by CHEFs. Invitations to these workshops will be extended to both care home residents and family members. There are also plans to replicate the Forum model across other areas.

*5.3.1 **Key Impact Theme 2** – Supporting Attainment of NMC Mentorship Standards and the Delivery of Pre-Registration Nursing Education*

When considering the impact of the CHEF role stakeholders tended to discuss pre-registration nursing education and mentorship as one entity, highlighting the relationship which exists between the two. As a consequence, these findings are presented in their entirety as one key theme which aligns specifically with both CHEF *key role functions 1 and 3*. These state that CHEFs should; '*Continue to maximise the contribution that care homes make to the development of the future nursing workforce by positively influencing the student experience of learning. This will include facilitating increased participation in the NES performance management pre-registration student, mentor and manager survey and supporting the development and implementation of local action/development plans'* (*key role function 1)* and *'Enhance the quality of the care home learning environment by supporting the education and development needs of staff to effectively support students and newly qualified nurses within this setting, in particular through facilitating the implementation and sustainability of; NMC regulatory standards and NES (2013) Core Curriculum Framework for Mentor Preparation, NES (2008) QSPP and Flying Start NHS®'* (*key role function 3*).

Table 2, page 35, highlights the importance attributed to supporting NMC standards in the care home environment by stakeholders and CHEFs alike, with ranking confirmed as '1' by CHEFs, HEI Academics, care home managers and mentors and confirmed as '2' by NHS Board leads.

Three sub-themes have been used to delineate and present the findings of this key impact theme.

5.3.2 Sub-Theme A: Supporting Care Home Managers and Mentors to Meet NMC Requirements

In order to understand the importance of this aspect of the CHEF work, and its subsequent impact, it is perhaps pertinent to consider the professional and regulatory drivers which are stipulated as requirements by the NMC and which intrinsically link mentorship and pre-registration nursing education. In particular, NMC (2008, 2010, and 2014) emphasise the importance of quality assuring the practice learning experience for pre-registration nursing students and, in fact, specify requirements which must be met prior to the placement of students in any practice learning environment. These include:

- The presence of sufficient suitably prepared mentors (NMC 2008) to ensure the support of students at a maximum ratio of 1 mentor for every 3 students. These mentors must be annotated to a live mentor register
- Mentors responsible for the supporting the learning, teaching and assessment of pre-registration students in practice must be annually updated to ensure the currency of their mentorship practice and must also undertake a review of their mentorship continuing professional development profile every 3 years, the latter of which is referred to as triennial review (NMC 2008)
- There must be documented evidence that each practice learning environment responsible for providing placements has an up-to-date practice learning audit in place (NMC 2010)
- Evidence of an agreement delineating the maximum number of students that each practice learning environment will support at any one time (usually included as part of the educational audit documentation and sometimes referred to as a *service level agreement)* (NMC 2010)

The descriptive statistical data presented in Figures 10 – 17 illustrate, from a national perspective, the care home landscape in terms of mentorship. These data also delineate specific outputs and the subsequent impact of activity undertaken by CHEFs to develop and sustain the involvement of care homes in the delivery of pre-registration nursing education nationally (please refer to the glossary on page 5 which defines key operational words and terms used as part of this discussion of findings).

Figure 10 illustrates that, during the period of 1st April 2013 to 31st March 2014 a total of 283 care homes were being supported nationally in Scotland by CHEFs. Of these, 200 care homes were actively supporting pre-registration nursing students and 83 were not; the reasons for not supporting pre-registration nursing students are detailed in Figure 11. It is pertinent to note, when reviewing these statistics, that the total number of mentors and sign-off mentors documented in Figure 10 includes those employed in care homes not actively supporting students at the time of reporting.

Figure 10 – National Overview: The Care Home Mentorship/Pre-Registration Nursing Landscape

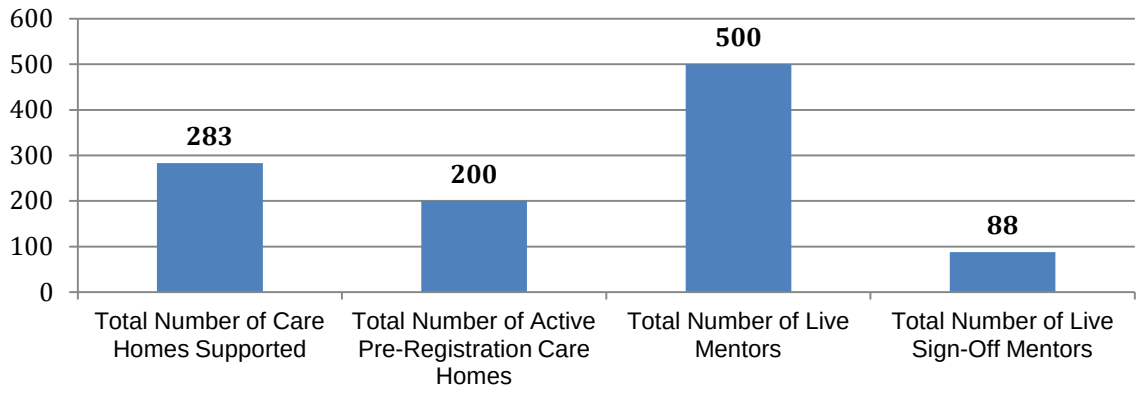
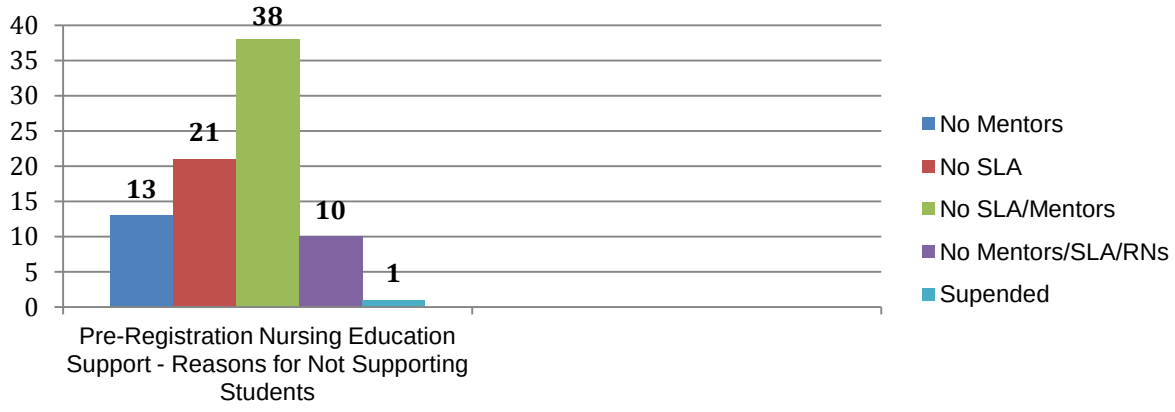


Figure 11 – National Overview: Reasons for Not Supporting Students in Care Homes



When considering this data it is important to note that this provides a snapshot only of care home activity in terms of both pre-registration nursing education support and mentor numbers. The fluidity of the care home setting in particular, when considering staff retention and movement of staff to other care homes and organisations, is well documented (Nolan et al 2008, Haggstrom and Bruhn 2009, Spilsbury et al 2011, Rose and Adam 2012, McGilton et al 2014). It is therefore likely that, as a consequence of this, care home mentor numbers, and the support of pre-registration nursing students, will perhaps fluctuate with greater frequency.

The impact of the CHEF role becomes even more tangible when considering the by-products which stem from their support of mentorship and pre-registration nursing education in care homes. These include; a reduction in the sense of professional isolation which can exist in these areas and also the ability of the CHEF to instil confidence and build competence in those responsible for student support.

> *'The CHEF has been a fantastic source of support and advice for me and fellow mentors. I feel this has translated into more competent and confident mentors in my area.*' ***(Care Home Mentor)***

> *'The CHEF has made a significant difference to the quality of the care home practice learning environment. She consistently keeps us up to date with new practice developments, study opportunities and actively encourages registered staff to consider mentorship. The CHEF has been an excellent source of support and advice generally and is always available when needed'.* ***(Care Home Manager)***

5.3.3 Sub-Theme B: Quality Assuring the Student Experience

There is also evidence that CHEF involvement in the preparation of students prior to the care home practice learning experience can have a significant impact on the students' readiness and ability to engage with this experience. In particular, there is evidence of CHEF involvement in the theoretical preparation of students for the care home practice learning experience, the impact of which has been highlighted as students who are better prepared to care for older people;

> *'The CHEF speaks to our students before their care home experience.....she is able to give information about the forthcoming experience and consequently they have realistic expectations of what that experience will be like'.* ***(HEI Academic)***

> *'Yes, we are involved in HEI module development. In particular, around the delivery of the national dementia champion programme; we teach on that. I have also become a national dementia champion and can pass on skills and share knowledge with the HEI to help prepare the students better for the care home experience'.* ***(CHEF)***

Figure 12 helps to demonstrate the impact of the CHEF role nationally in terms of the development of student placement capacity in care homes. This data confirms that, at the time of reporting, the ratio of available student placements to active care homes was almost 2:1.

Figure 12 – National Overview: Active Care Homes and Total Service Level Agreement

One HEI Academic and two NHS Board Leads, when asked to consider the potential impact should the CHEF role cease to exist, recognised the impact already exerted by CHEFs when undertaking work to develop placement capacity in care homes stating that;

> *'There would be fewer placements in care homes and a lack of understanding of the needs of students and mentors in these care homes'.* ***(HEI Academic)***

> *'The CHEFs have developed care home placements, helping to reduce the pressure placed on NHS placements'.* ***(NHS Board Lead)***

> *'The CHEFs support practice placement agreements and secure adequate provision of quality practice placement experiences for students in care homes'.* ***(NHS Board Lead)***

However, whilst the CHEF role was viewed by some as effective in supporting the development of practice placement capacity, it was also recognised that ways of working could potentially be enhanced to maximise the efficacy of the role. In addition, the health and social care integration agenda, and the changing healthcare landscape, which includes the shift from in-hospital to community based care, serves to emphasise the importance of considering how student placement capacity in care homes can, in the future, be further increased. One HEI academic articulated this viewpoint when stating;

> *'.....We're already starting to think of new ways that we (HEI) can build relationships with care homes for our initiatives and then we can bring them on board as placements.....'.* ***(HEI Academic)***

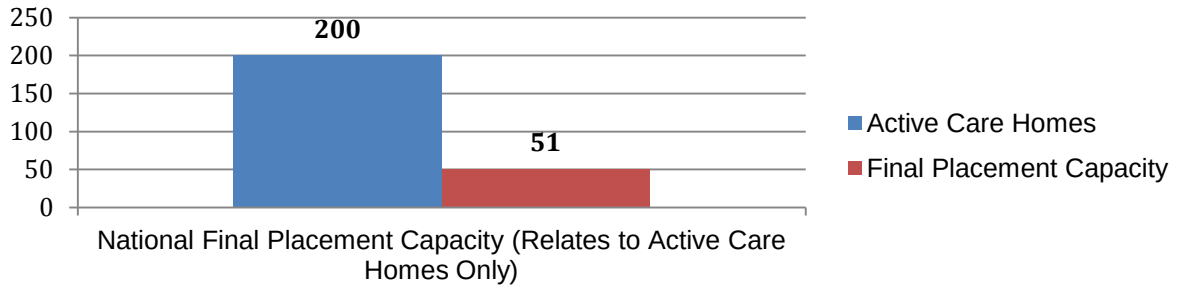
Nolan et al (2008) highlight that it is important to quality assure the student experience. In particular, Nolan et al (2008) suggest that the student experience of caring for older people can influence their perception of this care generally – a potentially significant factor when considering recruitment of newly qualified nurses to the care home sector. The impact of the CHEF role currently is authenticated when reviewing the comments of stakeholders when discussing the quality of the care home practice learning experience in general terms;

> *'Since the implementation of the CHEF role the quality of the care home student experience has improved and there is more consistency in terms of this quality'.* ***(HEI Academic)***

> *'The CHEF role is invaluable.....students are always supported and the work of our mentors has gained 100% satisfaction in relation to student placements; this is attributed to the work of the CHEF. The learning experience is enhanced and, when not on site, the CHEF can easily be accessed if there are questions we are unable to answer for the student'.* ***(Care Home Manager)***

It is therefore perhaps unsurprising that stakeholders recognise the importance of maximising the impact of the duality of the CHEF role, both in terms of developing care home placement capacity and enhancing the quality of the student practice learning experience. The need for this dual role becomes even more apparent when considering the recruitment of newly qualified nurses to care homes. If wishing to stimulate greater recruitment to this environment, increasing the availability of final placements in these areas could potentially help. Figure 13 however illustrates that, at the time of reporting, the ratio of final placements to care homes is relatively low at 1 placement for every 4 care homes.

Figure 13 – National Overview: Pre-Registration Active Care Homes and Final Placement Capacity



This, combined with a fewer sign-off mentors than mentors (88 sign-off mentors versus 500 mentors as illustrated in Figure 10, page 44, has the potential to reduce the availability of final practice learning experiences in care homes. It is important to note when reviewing this data however that HEIs do not always place final placement students in care homes. This has the consequential effect of limiting care home sign-off mentors' access to these students. Furthermore, irrespective of the practice learning environment, mentor numbers can often be greater than that of sign-off mentor numbers. Consequently, whilst recognising the importance of maximising the CHEF impact on increasing final placement availability, the associated influencing factors which contextualise this debate must also be considered. One HEI Academic already recognises the impact of the role however; both now and potentially in the future when stating;

> *'The CHEF not only promotes care homes as valuable practice learning environments but also promotes care homes as future places of employment'.* ***(HEI Academic)***

Similarly, a care home mentor was also able to articulate the impact that CHEFs have in enabling student placements and supporting mentors generally in care homes;

> *'Since having access to the CHEF I now have a greater awareness of what is required within the pre-registration nursing programme and a better idea of how to facilitate student learning'.* ***(Care Home Mentor)***

It is clear that various nuances have emerged around the activity undertaken to; develop care home placement capacity, increase final placement capacity and quality assure the student practice learning experience. These nuances do not detract from the importance of the CHEF role, but rather serve to emphasise the actual impact of the role despite these challenges; particularly when trying to increase the profile of the care home environment. Care home managers and mentors were asked about the CHEF role in relation to student PLE feedback. Although, in line with NMC (2014) *Quality Assurance Framework,* a number of managers were able to articulate the benefits of student feedback, stating that it provides a valuable insight into the students' practice learning support and experience, it was clear that CHEF input was variable. One care home manager indicated that CHEFs actively encouraged students to feedback;

> *'The CHEF has actively encouraged student nurses to complete feedback forms and this has been quite successful – it has increased the amount of feedback that we receive'.* ***(Care Home Manager)***

However, a small number of care home managers indicated that they did not receive student feedback at all and were unable to convey the impact of the CHEF role.

From the care home mentor perspective there was similar recognition of the value of student feedback but a much clearer perception of the CHEF role;

> *'The CHEF makes sure that we receive feedback from the university and encourages us to reflect on our performance and practices as mentors.* ***(Care Home Mentor)***

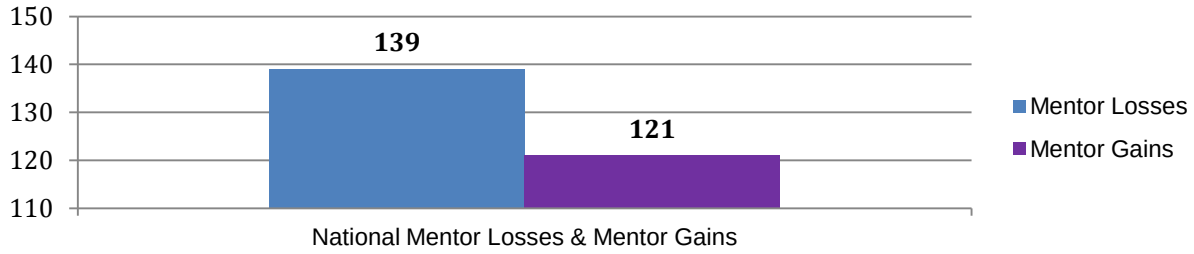
> *'The students meet the CHEF during their placement and she always reminds them to complete an evaluation at the end. The CHEF always gives us feedback about the overall student evaluation at the end'.* ***(Care Home Mentor)***

It is clear, when reviewing all care home manager and mentor responses, that there is variability in the perception of CHEF impact in terms of student feedback and that perhaps this must be considered as part of the recommendations for the future of the CHEF role.

5.3.4 Sub-Theme C: Building Mentor Capacity

Challenges referenced in the literature in relation to care home staff recruitment and retention (Nolan et al 2008, Haggstrom and Bruhn 2009, Spilsbury et al 2011, Rose and Adam 2012, McGilton et al 2014) are perhaps reflected when measuring mentor losses and gains nationally across care homes in Scotland. Figure 14 details mentor losses and gains during the period of 1st April 2013 to 31st March 2014. This highlights a differential of 18 mentors when considering mentor losses versus mentor gains in during this time.

Figure 14 – National Overview: Mentor Losses and Mentor Gains



It is important to contextualise this data however - and to consider the viewpoints of stakeholders when planning next steps around mentor recruitment and retention. Alongside movement of staff, the provision of study time for staff to attend mentor preparation has been highlighted as challenging, although it is clear that CHEFs are beginning to impact positively on this decision making process;

> *'The CHEF is a reliable source of support to staff. They help us to access pertinent training and this has encouraged staff to extend their practice, both in technical and mentorship skills. I have always encouraged staff to develop but having the CHEF has made this easier.....in the last year in particular there has been an upsurge in interest'.* ***(Care Home Manager)***

Maintenance of mentorship status in line with NMC (2008) requirements has also been highlighted as problematic, particularly the delivery of face-to-face annual updates. Despite this, it is clear that CHEFs are positively impacting on the attainment of NMC (2008) mentorship requirements and subsequent mentor gains in care homes nationally (n=121). As a result, CHEFs are making measurable progress in off-setting care home mentor losses across Scotland; a point clearly reflected in stakeholder comments;

'I have just completed the mentorship course and was able to consult with the CHEF to make sure I had a student to mentor and was also able to contact her for advice throughout the student's time on placement. The CHEF was readily available, really approachable and informative!' ***(Care Home Mentor)***

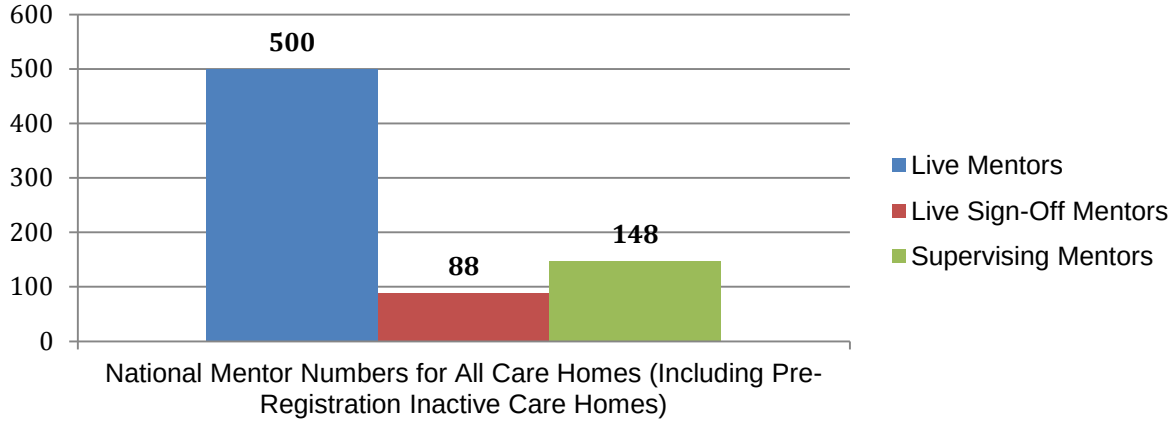
'The CHEF always checks to make sure we are meeting the NMC requirements for mentorship and also makes sure that we have regular access to pre-registration nursing students to mentor to help maintain our mentor status'. ***(Care Home Mentor)***

'Staff feel much more confident that they are meeting NMC requirements for mentorship...' ***(Care Home Manager)***

'There has been an increase in demand for mentor preparation from care homes and there is improved support for both students and mentors'. ***(HEI Academic)***

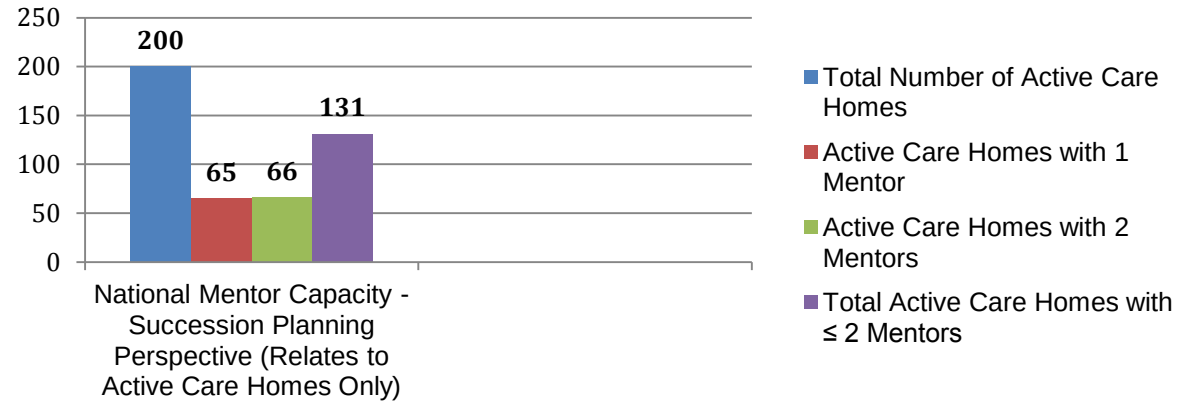
The impact of the CHEF role in supporting the attainment of NMC (2008) mentorship standards is therefore clear. Analysis of impact data has also served to highlight additional mentorship considerations which could potentially influence the future discharge of the CHEF role. Figure 15 highlights the significant work which has been undertaken to develop the supervising mentor role in care homes across Scotland (n=149), ensuring the provision of experienced mentor support for those wishing to prepare for the mentor role. The availability of supervising mentors is considered as integral to the delivery of mentorship preparation therefore work to develop these roles in care homes can be recognised as a key impact of the CHEF role.

Figure 15 – National Overview: Total Number of Mentors



Despite the work undertaken to off-set mentor losses nationally, the need to re-consider strategies for mentorship succession planning in care homes remains. This is perhaps best illustrated in Figure 16 which highlights the number of mentors in each of the 200 pre-registration active care homes. A key finding from this statistical analysis is that, of the 200 care homes actively supporting pre-registration students, 131 of these had 2 or fewer mentors at the time of reporting.

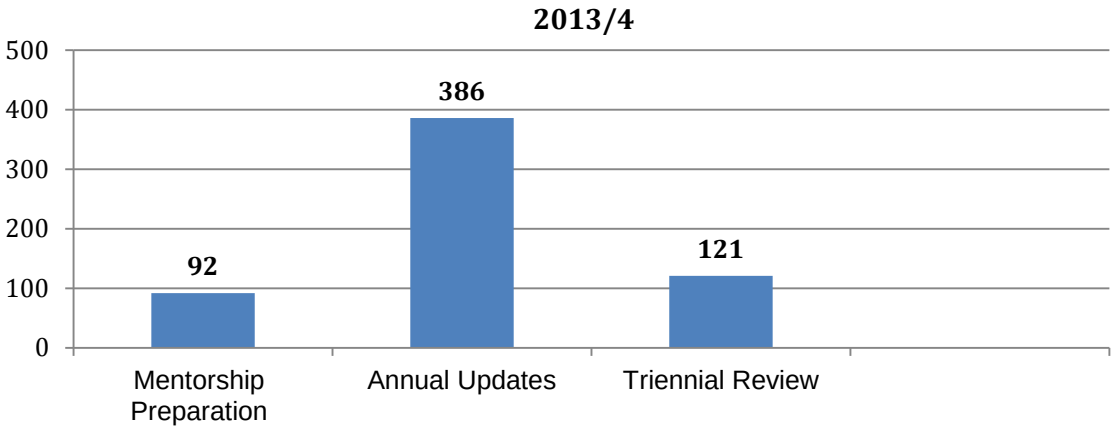
Figure 16 – National Overview: Succession Planning for Mentorship (Active Care Homes Only)



Building capacity by targeting mentor preparation in these areas, whilst continuing to recruit new care homes to support pre-registration nursing students, will not only increase the availability of student placements, but could also potentially decrease the likelihood of care homes becoming *mentor free* in the future. This is of particular importance as mentor free care homes present particular challenges which include; the absence of capacity/capability to prepare new mentors and the negative impact on the care homes' ability to provide support for pre-registration nursing students.

The support of pre-registration nursing students has already been demonstrated as being intrinsically linked to the preparation and maintenance of mentors and mentor status. A key part of this involves the delivery of both mentorship preparation and annual updates, and also the discharge of mentor triennial reviews. Figure 17 below identifies the impact of the CHEF role specifically in these areas, highlighting that, of the 121 mentor gains identified during the reporting period (Figure 14, page 48) 92 of these gains stemmed from the preparation of new mentors.

Figure 17 – National Overview: Mentorship Preparation, Annual Update Delivery and Triennial Reviews



A review of Figure 17 also serves to highlight the impact of CHEF activity in terms of annual updates and triennial review. It is evident that CHEFs have been particularly active in these aspects of the role, delivering 386 annual updates during the reporting period as well as supporting the implementation of triennial review across these areas (n=121). The impact of this aspect of the CHEF role is re-affirmed when reviewing the viewpoints of stakeholders.

'The CHEF helps us to access mentorship preparation – we've had 4 registered nurses complete in the last year and this means we are in a better position to accept more students and to give them a quality learning experience'. ***(Care Home Manager)***

'The CHEF supports us with annual mentor updates and with triennial review and it helps to reduce the risk of taking your eye off the ball when it comes to mentoring. I believe that this has enhanced the quality of mentorship where I work. ***(Care Home Manager)***

'Adherence to NMC requirements has improved generally across the care homes in our area because of the CHEFs'. ***(HEI Academic)***

CHEF activity around annual update and triennial review is also worth considering in light of the logistical challenges which can present as result of care home geographical spread. In some areas, remote and rural in particular, the every-day challenges of the CHEF role can be magnified as a result;

'We do try to get together with the care home manager and the liaison lecturer but as the region is huge this can be very challenging logistically. We have to try to plan carefully and we try to make sure that we achieve as many things as possible at each meeting to make the most of it....partnership working really helps'. ***(CHEF)***

5.3.5 Summary of Key Impact Theme 2

The evidence presented to demonstrate the impact of the CHEF role when supporting the attainment of NMC mentorship requirements and the delivery of pre-registration nursing education in care homes has incorporated the views of all stakeholders, including those responsible for the delivery of the CHEF role. Perhaps unsurprisingly, it has emerged that mentorship and pre-registration nursing education are intrinsically linked. Stakeholders have highlighted the impact of the role in key areas including; mentorship preparation and support; quality enhancement of the practice learning environment and student experience; instilling a sense of mentor competence and confidence and developing placement capacity.

Building mentor capacity in care homes has emerged as an area requiring further development as a significant number of care homes, at the time of reporting, have two or fewer mentors. In light of the propensity for staff movement in this sector, these care homes are potentially at risk of becoming mentor free zones; a direct consequence of which would be a reduction in care home capacity to support pre-registration nursing students in practice. A similar situation presents when considering final placement capacity when, during the reporting period, only 1 in 4 care homes were currently active, or had the capacity to actively support, final placement students.

The impact of the CHEF role in the dissemination and actioning of student feedback was confirmed as variable, with both managers and mentors reporting different experiences, and perceptions, of CHEF involvement and impact. Further investigation may be required to ascertain actual impact nationally and also to enable development of recommendations for the future around this activity.

An additional challenge which potentially impacts on the discharge of the CHEF role is the geographical spread of care homes. It is clear however that CHEFs are now becoming more adept at planning to make best use of time with colleagues across care homes and HEIs.

5.3.6 Thematic Examples of a Care Home Education Facilitator Initiatives

The following initiative, supported by CHEFs in one NHS Board area, provides a practical example of the way in which CHEFs are contributing the selection of potential candidates for a pre-registration nursing programme:

Opening up Education Opportunities

The Open University pre- registration nursing programme provides a route for HCSWs to undertake study to achieve a Bachelor of Science (BSc) Nursing. The programme is 4 years in duration and HCSWs undertake part of the required practice hours for the programme in their workplace. The programme tuition fees are funded by the Scottish Government (SG), and in the past these have only been offered to staff employed substantively by the NHS.

Following an agreement reached with Scottish Government, a pilot project has been planned to support the development of care home support workers to registered nurse status and is due to commence in September 2015. The CHEF in the designated NHS Board area approached all care homes with mentors and provided information, relating to the pilot project, with a view to informing care home staff of the potential availability of this programme of study. Five care homes have subsequently identified support workers who are both willing and enthusiastic to apply for the programme.

This additional initiative describes work led by PEFs and CHEFs to help healthcare support workers to understand their vital role in enhancing the student PLE in the care home setting:

Health Care Support Workers - enhancing practice learning experiences for students

A collaborative initiative to provide education sessions for Health Care Support Workers (HCSWs) was set up by Care Home Education Facilitators and Practice Education Facilitators to help them understand their contribution to the student experience in the care home setting. Four sessions were developed around the learning environment, relationships, culture and conformity, and role modelling and the student journey.

The feedback from participants showed an increased confidence in working alongside, and supporting students; a willingness to share skills and knowledge, and a better understanding of the student journey.

5.4.1 ***Key Impact Theme 3*** *– Sign-Posting Educational Resources and Continuing Professional Development*

The impact of the CHEF role in relation to sign-posting educational resources aligns with both *key role function 3*; *'Enhance the quality of the care home learning environment by supporting the education and development needs of staff to effectively support students and newly qualified nurses within this setting, in particular through facilitating the implementation and sustainability of; NMC regulatory standards and NES (2013) Core Curriculum Framework for Mentor Preparation, NES (2008) QSPP and Flying Start NHS®'* and *key role function 4*; *'Contribute to the development of the care setting as a positive learning environment which promotes a values based, person centred approach to care and learning through sign-posting relevant opportunities and resources for nurses and support staff,*

within the context of Reshaping Care for Older People. This will include building on earlier activities associated with national clinical priorities, for example; National Integrated Tissue Viability, Nutritional Care and Support, Living and Dying Well of national clinical priorities and Care Commission (The Care Inspectorate) quality themes'.

Content analysis for this key theme confirmed ranking as '3' for NHS Board Leads, Care Home Managers and CHEFs and '4' for care home mentors. When considering the ranking of previous key themes, it is clear that this aspect of the CHEF role was, for some, less visible in terms of impact. In particular, HEI Academics, although very clear about the impact of sign-posting and CPD around mentorship preparation and support, made very little reference to the CHEF role in sign-posting other educational resources, or the impact of this on the continuing professional development of care home staff. It is important however to contextualise this finding as most of the HEI academics who participated in this evaluation were principally focused on sign-posting mentors to resources linked to mentorship regulatory requirements and student practice learning.

Despite this, there was evidence of some impact around sign-posting. In particular, both sign-posting and CPD support for care home staff were recognised as contributing to the enhancement of the quality of the practice learning environment. It also became clear that a by-product of this work was and is collaboration with other organisations, mainly to identify staff training needs (this collaborative work has previously been discussed as part of key impact theme 1; collaborative working and building relationships). This is particularly important when considering the comments of The British Geriatric Society (2011; p3) wherein they state that care of older people continues to be viewed as a *'Cinderella service'.* This effectively highlights that there is potential for education and training opportunities for staff working in care homes to be less than adequate, emphasising the importance of the CHEF role in addressing these concerns;

> *'The CHEF, working jointly with the Council and the Care Inspectorate, has helped to Identify training needs and implement training for all levels of staff. This enhances the learning environment and helps to develop the future care home workforce'.* ***(NHS Board Lead)***

Another NHS Board Lead similarly highlighted the positive impact of integrated PEF/CHEF working, stating that this helps to foster a climate of shared learning across care homes and the NHS;

> *'There is improved working with care homes; CHEFs integrate with PEFs and provide opportunities for shared learning with staff across NHS and care home sectors'.* ***(NHS Board Lead)***

Of all stakeholders, perhaps unsurprisingly, care home mentors commented with the most frequency on the impact of CHEFs in terms of their support for care home staff CPD. Some also made reference to the *'active encouragement'* they received from CHEFs to continue to professionally develop, and the impact of this in their workplace;

> *'The CHEF continually points out opportunities for further study and training courses and has actively encouraged us to participate'.* ***(Care Home Mentor)***

> '*The CHEF acts as a stimulus and really helps me to maintain and improve my continuing professional development and evidence keeping'.* ***(Care Home Mentor)***

> *'The CHEF not only arranges in-house training but also keeps us updated about training available at the university – that makes a big difference to us'.* ***(Care Home Mentor)***

In addition, CHEFs in some areas have been able to negotiate flexible education with HEIs for staff who work in care homes, where an agreement exists to support pre-registration nursing students. This is of particular significance when considering the impact of the CHEF role however, of equal significance, is recognition of the challenges which can present in care homes in relation to information technology (IT) access;

> *'We've managed to get reciprocal training in place.....we approached the HEI and asked what training and support they could provide free of charge for care home staff and this is now place.'* ***(CHEF)***

> *'Care home staff don't always have access to the internet or a computer in their workplace; we have to think about that when we're directing them to educational resources and sometimes we have to think of alternative ways to share information'.* ***(CHEF)***

Frequent mention has also been made of CHEF involvement, and their impact, in the support of newly qualified nurses, in particular, support for the completion of *Flying Start NHS®.* Of particular note were the comments of care home managers who recognised the impact of CHEF work in supporting better uptake of this educational resource;

> *'The CHEF doesn't just help staff to register with Flying Start – it's much more than that; she also supports them with the programme, making them aware of not only her support but other support networks that they can join'.* ***(Care Home Manager)***

> *'The CHEF takes a real interest in our newly qualified nurses and provides information tailored to their needs. As a result these nurses have felt supported and more confident in their role'.* ***(Care Home Manager)***

Despite the variety of work undertaken by CHEFs in terms of sign-posting and supporting CPD, CHEFs themselves highlighted that, often, they feel unsure about how to effectively measure the impact of their activity. This is an aspect around which they would value guidance and support to develop impact measurement strategies. They realise that this is crucial to the future development of the CHEF role;

> *'I do get nervous when I'm completing scoping templates and things like that about my activity – I think to myself 'Am I doing things that I'm not writing down and, because of that, the difference it makes isn't being measured?'* ***(CHEF)***

> *'I suppose we have started to record when people contact us in response to newsletters or flyers – that and the fact that there is uptake and interest is a measure of our impact. We also sometimes evaluate care home study days. Other than that, for other things like use of online resources and things like that – no, we don't really measure impact'.* ***(CHEF)***

> *'Being given some direction, or having clear guidance about measuring the impact of what we do would further support the role in terms of longevity'.* ***(CHEF)***

5.4.2 Summary of Key Impact Theme 3

Sign-posting educational resources and supporting continuing professional development for care home staff are confirmed as inter-dependent when delivering the CHEF role. CHEFs themselves have expressed concern however that the full impact of their work is not always recognised as mechanisms to capture impact are currently not always in place.

Despite this, stakeholder comments provide some evidence of broad impact. This includes; enhancement of the quality of the practice learning environment, and the student experience, through the education and support of care home staff. It has also been highlighted that work to support CPD in care homes spawns collaborative working with other organisations including; the identification of training needs across the NHS and care home sector and the provision of flexible education for care home staff in some HEIs.

Mentors refer to the active encouragement they receive from CHEFs to continually professionally develop and care home managers are also clear of the integral role played by the CHEFs in supporting newly qualified nurses in care homes to engage with Flying Start NHS®.

5.4.3 A Thematic Example of a Care Home Education Facilitator Initiative

The following initiative, supported by CHEFs in one NHS Board area, provides a practical example of the way in which CHEFs are contributing to supporting CPD and updating mentors in care homes:

Keeping Care Homes Informed – Signposting

Recognising some of the difficulties of care homes having easy access to practice learning information, the Care Home Education Facilitator and Practice Education Lead from the university produce a quarterly newsletter for mentors and managers. This is designed as a signpost for information on contemporary issues including 'hub and spoke' placements, as well as hyperlinks to help complete mentor updates and triennial reviews. Mentors are encouraged to use updates as evidence of continuing professional development for NMC revalidation. The newsletter also offers information on Flying Start NHS® for newly qualified nurses in care homes. Care homes who do not currently offer student placements are provided with a newsletter to help them understand the process for developing placement capacity in their organisation. This includes guidance around the requirements of practice learning for pre-registration nursing education programmes and also the provision of contact information for the CHEF and the university Practice Education Lead.

Alongside the newsletter, mentor support forums have been established to provide opportunities for networking. The reported benefits are that mentors feel better supported, and have also been encouraged to contribute to the newsletter. As a result of the feedback, the newsletter is now circulated across the region.

5.5.1 Key Impact Theme 4 – Enhancing Safe, Effective Person-Centred Nursing Practice

This aspect of the CHEF role relates to *key role function 2*; *'Support the Health and Social Integration agenda through enhancing collaborative cross sector working between the Care Homes, the NHS Boards and HEIs and national, regional and local practice education infrastructures'* and *key role function 4*; *'Contribute to the development of the care setting as a positive learning environment which promotes a values based, person centred approach to care and learning through sign-posting relevant opportunities and resources for nurses and support staff, within the context of Reshaping Care for Older People. This will include building on earlier activities associated with national clinical priorities, for example; National Integrated Tissue Viability, Nutritional Care and Support, Living and Dying Well of national clinical priorities and Care Commission (The Care Inspectorate) quality themes'.*

Frequency analysis of stakeholder narrative resulted in a ranking of '3' for both care home mentors and HEI Academics with a ranking of '4' confirmed for CHEFs, NHS Board Leads and care home managers. As suggested by the ranking, stakeholders appeared to comment with less frequency on the impact of the role in enhancing the delivery of care for older people. This finding is unexpected when considering the recognition, and frequency of comment, afforded to the impact of CHEF role in other areas of CHEF activity, in particular CHEF support for care home staff CPD which would normally influence care delivery.
In light of this, further exploration of stakeholders' comments was undertaken and this served to highlight that significant sections of the feedback received relate to the practical processes of sign-posting and offering support rather than the impact of this activity in terms of caring for the older person. This finding not only reflects the concerns voiced by CHEF who, during focus groups, indicated that they recognised the general absence of mechanisms at their disposal to measure the impact of CHEF interventions and activity. It also highlights the broader challenges which can present when attempting to delineate the impact of practice education roles generally.

As well as being recognised as a potential recommendation for the future of the role, this demonstrates that CHEFs have considerable insight regarding how the role must develop in the future. It also demonstrates that they have given some thought as to how impact measurement would allow them to better demonstrate the efficacy of the CHEF role in enhancing care delivery.

Despite the low frequency of comments regarding impact, evidence remains that CHEFs do make a difference to nursing practice and the effective delivery of care for older people. In particular, although not explicitly linked to care delivery, implicit links are evident when discussing CHEF input and the development of nursing knowledge and skills;

> *'The CHEF has enabled me to gain access to resources that have been really useful in maintaining and developing my nursing skills and knowledge'.* ***(Care Home Mentor)***

Some care home managers were more explicit about their perception of the impact of the CHEF role on the delivery of safe, effective, person-centred nursing care;

> *'Since having students in our care home, and having access to the CHEF, the quality of care has been enhanced through the education and development of existing staff'.* ***(Care Home Manager)***

> *'The CHEF team have given guidance and support to ensure that we have the knowledge required to deliver a high standard of care'.* ***(Care Home Manager)***

One care home manager was particularly explicit when asked to consider the impact of the CHEF role on the delivery of care;

> *'.....now I feel confident as a manager that we are as up to date as possible with practice and that we are a very proactive and progressive care home'.* ***(Care Home Manager)***

NHS Board Leads referred to the work of CHEFs around; health and social care integration, partnership working and shared learning, suggesting that this impacts both directly and indirectly on the care provided for older people;

> *'CHEFs promote partnership working between the NHS Board and independent sector, in particular around communication regarding care home residents within the acute sector'.* ***(NHS Board Lead)***

'The CHEF role provides an established link between health and social care and fosters the sharing of good mentorship and person centred care practice. It promotes the value of working with older adults. It has assisted in laying the foundations for shared learning in preparation for health and social care integration'. ***(NHS Board Lead)***

NHS Board leads also reference the development of joint NHS/Private Sector policy and the promotion of role modelling and evidence based practice in care homes. They indicate that this work impacts positively on communication across the sectors, particularly when providing care after death;

'CHEFs support the collaboration of NHS, care home and private sector in designing the "Care after Death Policy", enhancing communication across these sectors'. ***(NHS Board Lead)***

'The CHEFs have contributed to the promotion of evidence based practice and role modelling within the independent sector'. ***(NHS Board Lead)***

The impact of the CHEF role is perhaps best articulated when reviewing the response of one NHS Board Lead asked to detail the potential implications, should the CHEF role cease to exist;

'Support for practice learning in care homes would become fragmented, with the potential risk of the overall quality of the learning and care within the independent sector deteriorating'. ***(NHS Board Lead)***

5.5.2 Summary of Key Impact Theme 4

Although stakeholders commented with less frequency on the impact of the CHEF role in enhancing care delivery, it is clear that, for those who did comment, the CHEF role has played an integral part. A review of stakeholder comments has highlighted that many of these comments relate to the practicalities of CHEF interventions rather than the impact of these; both legitimising CHEF concerns around the measurement of impact in terms of their role and also highlighting that CHEF activity does take place which may well influence care delivery but is perhaps not attributed to this.

Despite this, there are however examples of explicit CHEF role impact; in particular for one care home manager when stating that they feel reassured and much more confident that their care home is now proactive and progressive as a consequence of CHEF input. Another has also stated that supporting students, alongside access to the CHEF, has led to staff development and an enhancement in the quality of care delivered. NHS Board leads also recognise the key role and contribution of CHEFs when citing collaborative policy development as an impact and also when discussing CHEF input and support of health and social care educational integration and person centred practice. Also perhaps more telling, in terms of impact, is the concern expressed by one NHS Board Lead about the potential for fragmentation of practice learning in care homes should the CHEF role cease to exist.

5.5.3 A Thematic Example of a Care Home Education Facilitator Initiative

The following initiative, supported and implemented by CHEFs in one NHS Board area, provides a practical example of the way in which CHEFs work collaboratively with care homes to enhance the delivery of safe, effective, person-centred care:

Active Resident Care

One regional CHEF team has implemented the *Active Resident Care* (ARC) initiative. This work stemmed from an *Active Patient Care* (APC) initiative which is a local interpretation of *intentional rounding* (please click on the link to access explanatory information relating to intentional rounding produced by Kings College London: https://www.kcl.ac.uk/nursing/research/nnru/policy/By-Issue-Number/Policy--Issue-35final.pdf

CHEFs viewed this as an appropriate intervention in care homes in the region as current evidence suggests that intentional rounding has led to significant reductions in; the use of call bells; the number of patient falls and the incidence of pressure ulcers. In addition, evidence also suggests that the implementation of intentional rounding has led to an increase in care satisfaction levels.

Consequently, CHEFs believed that the adaptation and implementation of this approach, to meet the needs of residents in care homes, would not only be innovative but would, most importantly, make a significant difference to quality of life for these residents.

CHEFs worked to support care home staff during implementation; this involved;

- The provision of targeted education sessions to enhance care home staff, family members and care home residents knowledge and understanding of person care approaches
- Emphasising the importance of; working as a team; defining roles within the team and encouraging a less task orientated approach to care
- Working to enhance communication with care home residents, families and staff

Measurable benefits from the implementation of ARC include;

- A reduction in falls, which has been recognised by the *National Falls Team*
- An increase in care inspectorate grades for quality of care and support
- A *Continence Award* presented to one of the care homes
- A reduction in the cost of continence aids
- More time available for staff to support residents to engage in interests and activities of their choosing

The CHEF team plan to continue to measure the impact and success of this intervention through the collation of emotional touch point stories (more information on emotional touch points can be located by clicking on this link - http://myhomelife.uws.ac.uk/scotland/wp-content/uploads/2014/07/Using-Emotional-Touchpoints.pdf) from staff, family members and residents. This will also help to increase care home staff awareness and confidence in the application of this evidence based approach.

5.6 Summary of Key Impact Findings across all Themes

Data retrieved and analysed from key stakeholders, including CHEFs, served to highlight both direct and indirect impacts of the CHEF role. Four key impact themes emerged and have been ranked, through the application of a content analysis framework; this supported the identification of areas of greatest importance for each stakeholder group.

Collaborative working and relationship building has been highlighted as an important aspect of the CHEF role in terms of impact. In particular, the way in which CHEFs work to achieve collaboration across stakeholder groups to safeguard and enhance practice learning experiences for pre-registration nursing students. It has also been demonstrated that they play a significant part in the completion of educational audit documentation. This is of particular importance as this can be viewed by some, at times, as cumbersome and labour intensive to complete.

CHEFs, with their specialised role remit, have been found to have a significant impact in both changing perceptions of the care home environment and enhancing communication across stakeholder groups. Care home staff have indicated that their relationship with CHEFs has also helped them to recognise the value of the role they fulfil in caring for older people in the care home setting. Challenges remain however, particularly in terms of information governance and sharing of information as this can, at times, negatively impact on the discharge of the CHEF role. Furthermore, there is a suggestion that the work to measure the impact of the CHEF role in supporting health and social care educational integration must develop further to achieve greater visibility.

Key impacts of the CHEF role have also been demonstrated through the educational element of CHEF activity. This activity is multi-faceted and includes; promotion and delivery of mentorship annual update and triennial review; collaborative completion of educational audit and action planning; identification of cross-sector training and education opportunities; sharing of good practice across care homes and other health and social care organisations and encouraging/supporting staff to value the role they fulfil in caring for older people in these settings. In fulfilling these activities CHEFs play an essential role in preparing the workforce of the future.

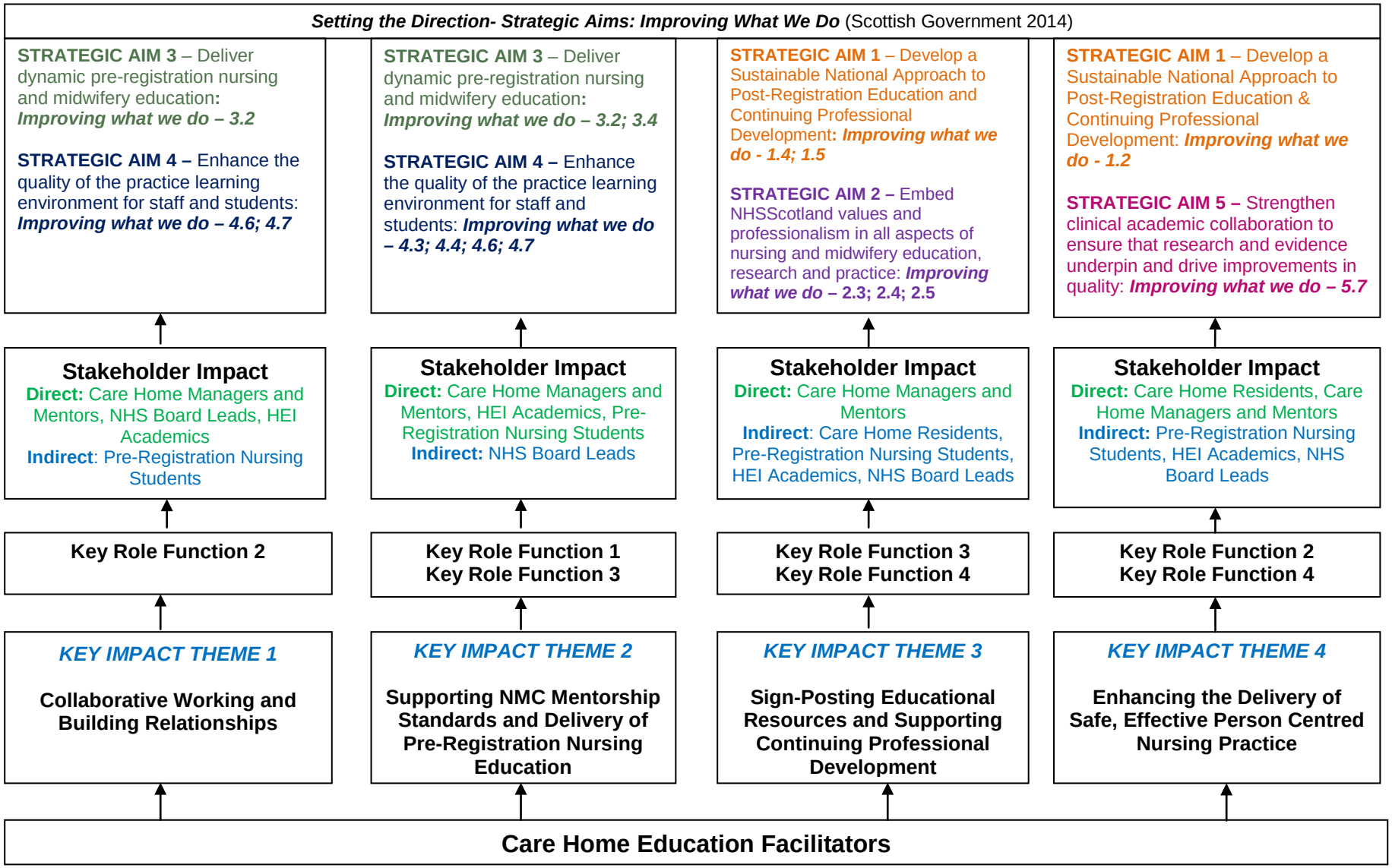
NMC requirements form the foundation of nursing education and practice, emphasising the key role and impact fulfilled by CHEFs when working with care home managers and mentors. CHEFs have made a significant impact in supporting the attainment of NMC mentorship and pre-registration nursing education requirements through; their work to develop new practice learning environments in care homes and their efforts to build mentor capacity. Both of these aspects however continue to present challenges when considering the complexities which often present in relation to care home staff recruitment and retention. On a similar note, final placement capacity has been highlighted as an area requiring further development in care homes, as has the CHEF role in disseminating/actioning student practice learning feedback. Despite these issues however, it is clear that for existing mentors, the CHEF role has demonstrated significant impact in terms of enhancing and instilling care home mentor competence and confidence.

Although CPD is the responsibility of mentors and their employing organisations, CHEFs recognised that the mechanisms to assess their contribution to this are not always evident. Sign-posting of educational resources and support for continuing professional development does however take place and this has the potential to lead to missed opportunities in terms of delineating the impact of the role in this area. Despite this, broad evidence of impact has been demonstrated as part of this evaluation. This includes; the active encouragement mentors receive to continue to professionally develop and the support offered to newly qualified nurses to engage with Flying Start NHS®.

The enhancement of care delivery/nursing practice, although commented on with less frequency, remains evident as an impact of the CHEF role. It is perhaps once again telling however that many of the stakeholders' comments relate to process rather than outputs of CHEF involvement in the enhancement of care delivery and nursing practice and this perhaps requires further exploration.

Figure 18 (page 61) provides a visual depiction of the way in which the 4 key impact themes align with both the CHEF key role functions and the strategic aims articulated as part of *Setting the Direction* (Scottish Government 2014) *'improving what we do'*. Figure 18 also helps to demonstrate the way in which the operational impact of CHEF activity contributes to broader strategic goals, as well as demarcating direct and indirect impact for stakeholder groups.

Figure 18 – The Phase 2 Evaluation and the Current Impact of the CHEF Role



SECTION 6: SUMMARY AND RECOMMENDATIONS FOR THE FUTURE DELIVERY OF THE CHEF ROLE

6.1 Project Work Summary

This Phase 2 Evaluation was designed to evaluate the national impact of the CHEF role, with particular reference to the key functions of the role. Preparation and planning for the evaluation was multi-factorial and included;

- A rapid appraisal of contemporary literature and professional regulatory policy/guidelines to define the landscape within which CHEFs discharge the role
- Ethical review and permissions of project documentation across NHS Boards, independent service areas and HEIs
- The identification and adaptation of an impact measurement framework to maximise the likelihood of engaging with appropriate stakeholders and also to delineate areas of direct and indirect impact
- Comprehensive engagement with both strategic and operational stakeholders, including those responsible for the delivery of the role
- The identification and adaptation of a framework for analysis to maximise the rigour of data analysis and presentation of findings

As the evaluation progressed, and findings began to emerge, continued fixed term funding for the role was confirmed by Scottish Government in January 2015. Stakeholder support for the evaluation process, and the continuation of the CHEF role, remained consistent throughout the consultation period. This was particularly evident when discussing with stakeholders the work being undertaken as part of the Phase 2 Evaluation to delineate the impact of the role with a view to securing further funding.

The *findings* (section 5, page 35) stemming from this evaluation not only relate to the CHEF key role functions, but also align with aspects of *Setting the Direction* (Scottish Government 2014); in particular, Figure 18, page 61,helps to illustrate the relationship between the impact of the CHEF role and the strategic aims categorised in *Setting the Direction* (Scottish Government 2014) as '*improving what we do'*.

6.2 Recommendations for Future Delivery of the Care Home Education Facilitator Role

Consultation with stakeholders has served to highlight key areas of direct and indirect impact of the CHEF role. The subsequent recommendations for the future have been developed with a view to both enhancing the strengths of the CHEF role, as delineated in the findings, and also further developing aspects of the CHEF role where impact is perhaps less evident:

> **Recommendation 1 – Support CHEFs to both develop and implement impact measurement strategies.** This should include strategies and data which better define the contribution of CHEFs to the; enhancement of both care home staff CPD and their delivery of safe, effective, person-centred practice; enhancement of the quality of the student practice learning experience
>
> **Recommendation 2 – Continue mentor capacity building, in particular targeting this CHEF activity with greater specificity.** This may involve targeting both care homes without mentors and also care homes where mentor numbers are reduced and there is a risk of these areas becoming mentor free zone

Recommendation 3 – Continue to build placement capacity across the care home sector, including final placement capacity. This should incorporate tripartite collaboration between; CHEFs, care home managers and HEI academics with responsibility for PLE allocation. This work should also consider the potential contribution that the availability of final placements in care homes can have on the recruitment of newly qualified nurses to this sector

Recommendation 4 – Further develop multi-stakeholder collaborations which quality assure the PLE and the practice learning environment. This should include a review of CHEF involvement in the delivery of annual updates, triennial review, educational audit, action planning and raising and escalating concerns

Recommendation 5 – Define and implement clearer CHEF role parameters in terms of student PLE feedback. This will help to ensure there is a clearer understanding of the CHEF role in the collation and dissemination of student feedback and their involvement in any subsequent interventions to enhance the quality of the practice learning environment/student experience

Recommendation 6 – Review and refine the CHEF/PEF interface and collaboration parameters. This work should consider both CHEF and PEF key role functions and priorities. This should also take into account the discharge of both roles and the way in which the strengths of each can be retained to reduce the risk of increased emphasis on either role at the expense of the other

Recommendation 7 – Define CHEF role and responsibilities for practice education as part of the health and social care integration agenda. The findings from this evaluation would suggest that the CHEF health and social care integration education role is, for some stakeholders, unclear

In order to safeguard a future-based focus for the development of the CHEF role, these recommendations have been mapped to both CHEF key role functions and the strategic aims, categorised as *collaborating for the future, Setting the Direction* (Scottish Government 2014), illustrated in Table 3, page 64. Mapping to strategic aims has been undertaken to demonstrate the potential contribution of CHEF operational activities, should these recommendations be fully realised.

Table 3: Mapping of CHEF Role Recommendations to Key Role Functions and Establishing Links to *Setting the Direction* (Scottish Government 2014) *Strategic Aims – Collaborating for the Future*

CHEF Role Recommendations	CHEF Key Role Functions	Scottish Government (2014) ***Setting the Direction for Nursing and Midwifery Education in Scotland: Strategic Aims – Collaborating for the Future***
Recommendation 1 – *Support CHEFs to both develop and implement impact measurement strategies*.	1, 2, 3 and 4	• Strategic Aim 3 – Deliver dynamic pre-registration nursing and midwifery education: *Collaborating for the Future: 3.9* • Strategic Aim 4 – Enhance the quality of the practice learning environment for staff and students: *Collaborating for the Future: 4.12*
Recommendation 2 – *Continue mentor capacity building, in particular targeting this CHEF activity with greater specificity.*	3	• Strategic Aim 4 – Enhance the quality of the practice learning environment for staff and students: *Collaborating for the Future: 4.11; 4.14* • Strategic Aim 6 – Develop an infrastructure to deliver efficient, responsive and sustainable education: *Collaborating for the Future: 6.12*
Recommendation 3 – *Continue to build placement capacity across the care home sector, including final placement capacity.*	3 and 4	• Strategic Aim 1 – Develop a Sustainable National Approach to Post-Registration Education and Continuing Professional Development: *Collaborating for the Future: 1.13* • Strategic Aim 3 – Deliver dynamic pre-registration nursing and midwifery education: *Collaborating for the Future: 3.11; 3.14* • Strategic Aim 4 – Enhance the quality of the practice learning environment for staff and students: *Collaborating for the Future: 4.11; 4.14* • Strategic Aim 6 – Develop an infrastructure to deliver efficient, responsive and sustainable education: *Collaborating for the Future: 6.10*
Recommendation 4 – *Further develop multi-stakeholder collaborations which quality assure the PLE and the practice learning environment.*	3 and 4	• Strategic Aim 1 – Develop a Sustainable National Approach to Post-Registration Education and Continuing Professional Development: *Collaborating for the Future: 1.8; 1.13;* • Strategic Aim 3 – Deliver dynamic pre-registration nursing and midwifery education: *Collaborating for the Future: 3.14* • Strategic Aim 4 – Enhance the quality of the practice learning environment for staff and students: *Collaborating for the Future: 4.11* • Strategic Aim 6 – Develop an infrastructure to deliver efficient, responsive and sustainable education: *Collaborating for the Future: 6.8; 6.10*
Recommendation 5 – *Define and implement clearer CHEF role parameters in terms of student PLE feedback.*	1, 3 and 4	• Strategic Aim 2 – Embed NHSScotland values and professionalism in all aspects of nursing and midwifery education, research and practice: *Collaborating for the Future: 2.11* • Strategic Aim 3 – Deliver dynamic pre-registration nursing and midwifery education: *Collaborating for the Future: 3.9; 3.12;* • Strategic Aim 4 – Enhance the quality of the practice learning environment for staff and students: *Collaborating for the Future: 4.11; 4.12*
Recommendation 6 – *Review and refine the CHEF/PEF interface and collaboration parameters.*	1, 2, 3 and 4	• Strategic Aim 1 – Develop a Sustainable National Approach to Post-Registration Education and Continuing Professional Development: *Collaborating for the Future: 1.8; 1.13*
Recommendation 7 – *Define CHEF role and responsibilities for education as part of the health and social care integration agenda.*	2	• Strategic Aim 1 – Develop a Sustainable National Approach to Post-Registration Education and Continuing Professional Development: *Collaborating for the Future: 1.13* • Strategic Aim 6 – Develop an infrastructure to deliver efficient, responsive and sustainable education: *Collaborating for the Future: 6.8; 6.10*

REFERENCES

Age UK, 2012. *Delivering Dignity: Securing Dignity in Care for Older People in the Hospitals and Care Homes* [online]. Available at: http://www.ageuk.org.uk/Global/Delivering%20Dignity%20Report.pdf?dtrk=true [Accessed 6th February 2015]

Audit Scotland, 2014. *Reshaping Care for Older People* [online]. Available at: http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf [Accessed 6th February 2015]

Board M, Heaslip V, Fuggle K and Gallagher J, 2012. 'How education can improve care for residents with dementia'. *Nursing Older People,* Vol 24(5), p29-31

British Geriatric Society, 2011. *Quest for Quality: British Geriatric Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes – A Call for Leadership, Partnership and Quality Improvement* [online]. Available at: http://www.bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf [Accessed 6th February 2015]

Carlson E and Edvall E, 2014. 'Nursing students' experiences of clinical learning environment in nursing homes: A questionnaire study using the CLES + T evaluation scale'. *Nurse Education Today,* Vol 34(7), p1130-4

Carlson E, Ramgard M, Bolmsjo I and Bengtsson M, 2014. 'Registered nurses' perceptions of their professional working in nursing homes and home-based care: A focus group study'. *International Journal of Nursing,* Vol 51(5), p761-67

Francis R, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry* [online]. Available at: http://www.midstaffspublicinquiry.com/report [Accessed 6th February 2015]

Georgiou N, 2014. *Orchid View: Serious Case Review* [online]. Available at: http://www.westsussex.gov.uk/your_council/news_and_events/news/2014_archive/june_2014/orchid_view_serious_case_revie.aspx [Accessed 6th February 2015]

Gerbic P and Stacey E, 2005. 'A purposive approach to content analysis: Designing analytical frameworks'. *The Internet and Higher Education,* Vol 8(1), p45-59

Gerrish K, McDonnell A and Kennedy F, 2011. *Capturing Impact: A Practice Toolkit for Nurse Consultants* [online]. Available at: http://research.shu.ac.uk/hwb/ncimpact/NC%20Toolkit%20final.pdf. [Accessed 6th February 2015]

Graneheim UH and Lundman B, 2004. 'Qualitative content analysis in nursing research: concepts, procedures and methods to achieve trustworthiness'. *Nurse Education Today,* Vol 24(2), p105-112

Haggstrom E and Bruhn A, 2009. 'Caregivers attitudes to education and supervision in work with older people in a nursing home'. *Nurse Education Today,* Vol 29(8), p850-54

Haron Y, Levy S, Albagli M, Rotstein R and Riba S, 2013. 'Why do nursing students not want to work in geriatric care? A national questionnaire survey'. *International Journal of Nursing Studies,* Vol 50(11), p1558-1565

Hasson H and Arnetz JE, 2008. 'The impact of an educational intervention for elderly care nurses' care on care recipients and family relatives' ratings of quality of care: A prospective controlled intervention study'. *International Journal of Nursing Studies,* Vol 13(5), p411-433

Joseph Rowntree Foundation (JRF), 2012. *My Home Life: Promoting Quality of Life in Care Homes* [online]. Available at: http://www.jrf.org.uk/sites/files/jrf/care-home-quality-of-life-full.pdf [Accessed 6th February 2015]

Kings Fund, 2014. *Making our health and care systems fit for an aging population* [online]. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf [Accessed 20th March 2015]

Koh LC, 2012. 'Student attitudes and educational support in caring for older people – a review of the literature'. *Nurse Education in Practice,* Vol 12(1), p16-20

Koskinen S, Hupli M, Katajisto J and Salminen L, 2012. 'Graduating Finnish nurse students' interest in gerontological nursing – a survey study'. *Nurse Education Today,* Vol 34(4), p356-360

McGilton KS, Boscart VM, Brown M and Bowers B, 2014. 'Making tradeoffs between the reasons to leave and the reasons to stay employed in long-term care homes: Perspectives of licensed nursing staff'. *International Journal of Nursing Studies,* Vol 51(6), p917-926

National Research Ethics Service (NRES), 2009. *Defining Research* [online]. Available at; http://www.hra.nhs.uk/documents/2013/09/defining-research.pdf [Accessed 29th January 2014]

Neville C and Dickie R, 2014. 'The evaluation of undergraduate nurses' attitudes, perspectives and perceptions toward older people'*. Nurse Education Today,* Vol 34(7), p 1074-79

NHS Education for Scotland, 2013. *National Approach to Mentor Preparation Core Curriculum Framework (2nd Edition)* [online]. Available at: http://www.nes.scot.nhs.uk/media/2071831/national-approach-to-mentor-preparation-2nd-edition.pdf [Accessed 6th February 2015]

NHS Education for Scotland, 2013. *NES Research Governance* [online]. Available at: http://intranet.nes.scot.nhs.uk/help-me-with/governance/research-

governance/?openFAQ=How%20is%20research%20monitored%20in%20NES?&openFAQId=9245 [Accessed 6th February 2015]

NHS Education for Scotland, 2008. *Quality Standards for Practice Placements (QSPP)* [online]. Available at: http://www.nes.scot.nhs.uk/media/323817/qspp_leaflet_2008.pdf [Accessed 20th March 2015]

Nolan M, Davies S, Brown J, Wilkinson A, Warnes T, McKee K, Flannery J and Stasi K, 2008. 'The role of education and training in achieving changes in care homes: A literature review'. *Journal of Research in Nursing,* Vol 13(5), p411-433

Nursing and Midwifery Council (NMC), 2014. *Quality Assurance Framework* [online] http://www.nmc-uk.org/Documents/EdandQA/Quality%20assurance%20framework.pdf [Accessed 20th March 2015]

Nursing and Midwifery Council, 2010. *Raising Concerns: Guidance for Nurses and Midwives* [online]. Available at http://www.nmc-uk.org/documents/nmc-publications/nmc-raising-and-escalating-concerns.pdf

Nursing and Midwifery Council, 2009. *Guidance for the Care of Older People* [online]. Available at: http://www.nmc-uk.org/documents/guidance/guidance-for-the-care-of-older-people.pdf [Accessed 6th February 2015]

Nursing and Midwifery Council, 2008. *Standards to support learning and assessment in practice* [online]. Available at: http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-to-support-learning-assessment.pdf [Accessed 20th March 2015]

Public Bodies (Joint Working) (Scotland) Act 2014 [online]. Available at: http://www.legislation.gov.uk/asp/2014/9/contents/enacted [Accessed 21st January 2015]

Regulation of Care (Scotland) Act, 2001 [online]. Available at: http://www.legislation.gov.uk/asp/2001/8/contents [Accessed 6th February 2015]

Rose E and Adam J, 2012. 'Using a practice development project to improve standards of care for people with dementia'. *Nursing Older People,* Vol 24(8), 24-31

Royal College of Nursing(RCN), 2012. *Safe Staffing for Older People's Wards: RCN Full Report and Recommendations* [online]. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0009/476379/004280.pdf [Accessed 6th February 2015]

Scottish Government, 2007. *National Care Standards: Care Homes for Older People.* [online]. Available at: http://www.nationalcarestandards.org/files/care-homes-for-older-people.pdf [Accessed 6th February 2015]

Scottish Government, 2011. *Standards for the Care of Dementia in Scotland* [online]. Available at: http://www.scotland.gov.uk/Resource/Doc/350188/0117212.pdf [Accessed 6th February 2015]

Scottish Government, 2013. *Everyone Matters: 2020 Workforce Vision* [online]. Available at: http://www.scotland.gov.uk/Resource/0042/00424225.pdf [Accessed 6th February 2015]

Scottish Government, 2014. *Setting the Direction for Nursing and Midwifery Education in Scotland* [online]. Available at: http://dera.ioe.ac.uk/19343/1/00443655.pdf [Accessed 6th February 2015]

Shen J and Xiao LD, 2012. 'Factors affecting nursing students' intention to work with older people in China'. *Nurse Education Today,* Vol 32(3), p219-223

Spilsbury K, Hewitt C, Stirk L and Bowman C, 2011. 'The relationship between nurse staffing and quality of care in nursing homes: A systematic review'. *International Journal of Nursing Studies,* Vol 48(6), p732-750

Stevens JA, 2011. 'Students' career preferences for working with older people: A replicated longitudinal survey'. *International Journal of Nursing Studies,* Vol 48(8), p944-951

Wheeler DR, 1988. 'Content Analysis: An analytical technique for international marketing research'. *International Marketing Review,* Vol 5(4), p34-40

Xiao LD, Shen J and Paterson J, 2013. 'Cross-Cultural Comparison of Attitudes and Preferences for Care of the Elderly among Australian and Chinese Nursing Students'. *Journal of Transcultural Nursing,* Vol 24(4), p408-416

Appendix 1 - Semi-Structured Focus Group Topic Guide for CHEFs

Question Focus and Specific Questions	**Mapping to CHEF Key Role Functions**
Question 1 Focus – Developing the Care Home Practice Learning Environment a. Describe your overall experience of developing the pre-registration practice learning environment in care homes. b. Describe how you work with higher education institutions (HEIs) as part of this development work	**Key Functions 1 & 3**
Question 2 Focus – Quality Standards for Practice Placements (NES 2008) a. How are the QSPP and Audit Tool being used in care homes? b. What are the positives associated with the use of these tools? c. What are the challenges associated with the use of these tools?	**Key Functions 1 & 3**
Question 3 Focus – Supporting Mentors and Students a. What does this entail in care homes - mentors? b. What does this entail in care homes - students?	**Key Functions 1 & 3**
Question 4 Focus – Supporting Recruitment and Retention of Care Home Staff a. What do you feel your impact is – if any - in terms of recruitment and retention of care home staff?	**Key Functions 1 & 3**
Question 5 Focus – Sign-Posting and Educational Development a. Describe how you direct staff to educational resources b. Explain the way in which you measure and record the effectiveness of this activity	**Key Functions 1, 3 & 4**
Question 6 Focus – Health and Social Care Integration Thinking of this, what is your role across health and social care sectors including; NHS Boards, Health and Social Care teams and other allied health professionals *(including the way in which you work with PEFs).*	**Key Functions 2 & 4**
Question 7 Focus – Delivery of Care What evidence – if any – do you have that your role has influenced the delivery of safe, effective, person centred care?	**Key Function 4**
Question 8 – Impact Indicators How do you know that your role makes a difference in care homes?	**Key Functions 1, 2, 3 & 4**
Question 9 – Mentorship Preparation What is your role in terms of mentorship preparation for care home staff and what challenges do you encounter?	**Key Functions 1, 3 & 4**
Please provide any additional information which you think may be pertinent to the evaluation of the CHEF role.	

Appendix 2 – NHS Board Lead/HEI Academic Questionnaire

Questions	**Mapping to CHEF Key Role Functions**
Question 1 Thinking about your organisation, what do you feel the main impacts of the CHEF role have been?	
Question 2 What do you feel the main benefits of the CHEF role are – both generally and in terms of your organisation?	
Question 3 What do you feel the main challenges of the CHEF role are – both generally are in terms of your organisation?	
Question 4 How do you feel the CHEF role has contributed to Health and Social Care Integration and how can this contribution be enhanced?	**Key Functions 2 & 4**
Question 5 What would practice learning support look like if the CHEF role did not exist?	
Question 6 How would you like the CHEF role to develop in the future?	
Please provide any additional information which you think may be pertinent to the evaluation of the CHEF role.	

Appendix 3 – Care Home Manager Questionnaire

Questions	**CHEF Key Role Functions**
Question 1a. What difference, if any, has the CHEF role made to the quality of the care home practice learning environment overall in terms of: a. Supporting Learning and Assessment in Practice (Mentorship)	**Key Functions 1, 3 & 4**
Question 1b. What difference, if any, has the CHEF role made to the quality of the care home practice learning environment overall in terms of: b. Staff Education and Development	**Key Functions 3 & 4**
Question 2a. From your perspective, how has the CHEF role supported the development of: a. Newly Qualified Nurses	**Key Functions 3 & 4**
Question 2b. From your perspective, how has the CHEF role supported the development of: b. Mentors	**Key Functions 1, 3 & 4**
Question 3 Thinking about student feedback: *a.* Please describe the role of the CHEF in terms of sharing student practice learning experience (PLE) feedback (received from the universities) *b.* Please also tell us how this student feedback benefits the care home.	**Key Functions 1, 3 & 4**
Question 4 It is recognised that care homes work closely with other healthcare professional and healthcare sectors: a. Describe the way in which the CHEF in your area supports this partnership working b. What difference has this made?	**Key Functions 2 & 4**
Question 5 In what way – if any – has the role of the CHEF influenced the delivery of safe, effective and person centred care?	**Key Function 4**
Question 6 How would you like the CHEF role to develop in the future?	
Please provide any other information below which you think may be pertinent to the evaluation of the CHEF role:	

Appendix 4 – Care Home Mentor Questionnaire

Questions	**CHEF Key Role Functions**
Question 1 What difference has the CHEF role made, if any, to a) Your continuing professional development generally? b) Your knowledge and understanding of pre-registration nursing programmes/	**Key Functions 1, 3 & 4**
Question 2 What impact has the CHEF role had in terms of maintaining your mentor status, including; annual update, triennial review and access to pre-registration nursing students to mentor?	**Key Functions 1, 3 & 4**
Question 3 What difference has the CHEF role made in terms of the way in which you, as a mentor, support, teach and assess pre-registration students in your care home?	**Key Functions 1, 3 & 4**
Question 4 Thinking about student feedback: a) Please describe the role of the CHEF b) Please also tell us how this feedback benefits you as a mentor	**Key Functions 1, 3 & 4**
Please provide any other information below which you think may be pertinent to the evaluation of the CHEF role:	

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

NHS Education for Scotland
Westport 102
West Port
Edinburgh EH3 9DN
Tel: 0131 656 3200
www.nes.scot.nhs.uk

April 2015