Service evaluation of Leading Better Care

NHS Education for Scotland

April 2015
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**Glossary**

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<th>Term</th>
<th>Definition</th>
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<tr>
<td>Agenda for Change (AfC)</td>
<td>National pay band system applicable for the majority of NHS staff.</td>
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<tr>
<td>Band 5</td>
<td>Agenda for Change Band 5 roles typically include entry level Staff Nurse, Community Nurse, Midwife, Theatre Nurse (and others).</td>
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<tr>
<td>Band 6</td>
<td>Agenda for Change Band 6 roles typically include Charge Nurse, Specialist Community Nurse, higher level Theatre Practitioner, Health Visitor, Community Midwife (and others).</td>
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<tr>
<td>Band 7</td>
<td>Agenda for Change Band 7 roles typically include Senior Charge Nurse, Senior Charge Midwife, Team Leader, Specialist Nurse / Midwife / Health Visitor (and others).</td>
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<tr>
<td>Career Framework for Health</td>
<td>Designed to support workforce planning and staff career development, the framework describes nine levels of 'roles' grouped according to their level of complexity and responsibility and the level of experience and knowledge necessary to carry them out.</td>
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<tr>
<td>Clinical Quality Indicators (CQIs)</td>
<td>Evidence–based process indicators, which measure aspects of nursing care such as assessment and interventions.</td>
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<tr>
<td>Education and Development Framework (EDF)</td>
<td>NHS Education for Scotland resource designed for Senior Charge Nurses, Senior Charge Midwives, Team Leaders and their managers to identify learning and development needs and opportunities related to the revised SCN, SCM and TL role framework and to demonstrate the evidence and impact of their role.</td>
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<tr>
<td>Effective Practitioner</td>
<td>NHS Education for Scotland education resource designed to support nurses, midwives and allied health professionals (NMAHP), who are practitioners and senior practitioners, in achieving the best in their work.</td>
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<tr>
<td>Healthcare Quality Strategy for NHSScotland</td>
<td>The 2010 strategy set out the improvement interventions required to deliver the national Quality Ambitions related to achieving person–centred, safe and effective care.</td>
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<tr>
<td>Knowledge and Skills Framework (KSF)</td>
<td>Continued professional development (CPD) framework linked to annual development reviews and personal development plans of NHS staff.</td>
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<tr>
<td>Knowledge into Action</td>
<td><em>Getting Knowledge into Action to Improve Healthcare Quality: Report of Strategic Review and Recommendations</em> (Healthcare Improvement Scotland and NHS Education for Scotland, 2010) sets out a vision for...</td>
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embedding evidence-based approaches to care within NHSScotland. It emphasises the need for Boards to adopt models that both deliver education in actionable formats and support a greater exchange and dissemination of knowledge among practitioners and patients (including peer learning and communities of practice).

**Nursing and Midwifery Workload and Workforce Planning Toolkit**
NHS Education for Scotland work-based guide published in 2008 to support the workforce planning issues that are relevant to SCN s, SCMs, TL s and others who contribute to nursing and midwifery workforce planning.

**Plan Do Study Act (PDSA) cycle**
A quality and service improvement tool based on the principle of testing an idea by temporarily trialling a change and assessing its impact.

**Releasing Time to Care (RTC)**
Developed by the NHS Institute for Innovation and Improvement, the RTC initiative aims to enable nurses to improve and streamline hospital ward processes and spend more time on direct patient care. Participating staff have access to an education package and tools to analyse their working environments.

**Review of the Senior Charge Nurse**
Scottish Government review undertaken in 2008 that resulted in a revised role framework and LBC programme of support. The aim of the SCN Review was to create a modern clinical leadership role to enable frontline senior charge nurses to maximise their contribution to delivering safe and effective care by developing their leadership capacity and capability.

**Revised role**
The Review of the SCN highlighted the need for greater standardisation of the role, with a key set of responsibilities, skills, knowledge and behaviours. It resulted in the development of a standard framework for the SCN with four key role domains and associated capabilities linked to the Knowledge and Skills Framework (KSF).

**Scottish Executive Nurse Directors (SEND)**
Strategic group representing senior Nurse Directors from across NHSScotland.

**Scottish Patient Safety Indicator (SPSI)**
A measure used to support the Scottish Patient Safety Programme (Acute Adult Programme). It focuses on the occurrence of specified harm in relation to Cardiac Arrest, Catheter Associated Urinary Tract Infections (CAUTI), Falls with Harm, and Pressure Ulcers (Grade 2–4).

**Scottish Patient Safety Programme (SPSP)**
Introduced in 2008 the SPSP aims to reduce avoidable harm to patients by improving the safety of patient care at all points of care delivery and supports Boards to test and implement processes to improve care.
delivery and bring about a patient safety culture within teams.

**List of abbreviations**

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<th>Description</th>
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<tr>
<td>AND</td>
<td>Associate Nurse Director</td>
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<tr>
<td>CNO</td>
<td>Chief Nursing Officer</td>
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<td>CQI</td>
<td>Clinical Quality Indicator</td>
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<td>END</td>
<td>Executive Nurse Director</td>
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<td>KSF</td>
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<td>LBC</td>
<td>Leading Better Care</td>
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<td>NES</td>
<td>NHS Education for Scotland</td>
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<td>RTC</td>
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<td>SCM</td>
<td>Senior Charge Midwife</td>
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<tr>
<td>SCN</td>
<td>Senior Charge Nurse</td>
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<tr>
<td>SEND</td>
<td>Scottish Executive Nurse Directors</td>
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<tr>
<td>SPSI</td>
<td>Scottish Patient Safety Indicator</td>
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<td>SPSP</td>
<td>Scottish Patient Safety Programme</td>
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<tr>
<td>TL</td>
<td>Team Leader</td>
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Acknowledgements

A note of sincere thanks to all the NHS staff and other individuals who gave up their time to contribute to this evaluation by providing information and participating in interviews, surveys and focus groups. Thanks also to Vicky Thompson, former National LBC Lead, to members of the Evaluation Steering Group and to the network of LBC facilitators in NHS Boards for supporting the research team throughout the study and providing access to consultees.
Executive Summary

In March 2013, Blake Stevenson was commissioned to undertake a two-year service evaluation of phases 1 and 2 of Leading Better Care (LBC) across NHSScotland.

Background to Leading Better Care

LBC emerged as a direct consequence of the Senior Charge Nurse (SCN) Review\(^1\). In 2008, this review identified the key role of the SCN in determining the quality of care within wards and settings and a need to enable these clinical leaders to fulfil their role consistently and effectively.

The wide variation in the functions and responsibilities of SCNs across NHSScotland highlighted the need for greater standardisation of the role, with a key set of responsibilities, competencies and skills. It resulted in the development of a standard framework for the SCN with four key role dimensions\(^2\) linked to the Knowledge and Skills Framework (KSF). This is often referred to as the ‘revised role’.

Published alongside the Review in June 2008 was the outcome of a parallel programme of work to develop Clinical Quality Indicators (CQIs) for nursing and midwifery. A core set of three CQIs were developed as a means to demonstrate the nursing and midwifery contribution to care and clinical outcomes.

The first phase of LBC set clear objectives for all NHS Boards, so that by December 2010:

- all SCNs working in hospitals across NHSScotland will be working within the context of the revised role; and
- Boards will have Clinical Quality Indicators (CQIs) in place in the majority of inpatient areas.

In 2010 LBC was expanded to community-based staff (Senior Charge Midwives and Team Leaders) that managed a service or led a team. This second phase set new objectives that by March 2013:

- all SCNs, SCMs and TLs will be able to demonstrate that they are working in the context of the LBC components; and
- nurses and midwives will be able to demonstrate the contribution they make to the quality and experience of care that patients receive under the three Healthcare Quality Strategy themes of safe, effective and person-centred.

\(^1\) Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project (2008)

\(^2\) Ensure safe and effective clinical practice, enhance the patient’s experience, manage and develop the performance of team, contribute to the delivery of the organisation’s objective
The implementation of LBC was reinforced with a programme of support that included a National Lead, a network of facilitators, national materials and annual, unrestricted, funding for each Board.

**Management of LBC**

At a national level, governance of LBC is overseen by the Chief Nursing Officer’s (CNO) Directorate. Since March 2014, lead responsibility for LBC has been with NES. Prior to that date, the National LBC Lead had day-to-day management, supported by a Programme Board and the Chair, which reported to the Scottish Executive Nurse Directors (SENDs). This enabled this group of Executive Nurse Directors to have ownership of the programme and shape the strategic direction of LBC.

At a local level, the management and introduction of LBC was Board led so that implementation was appropriate and relevant to local conditions and needs. This meant that the governance and infrastructure arrangements varied significantly across NHSScotland which had implications for collecting systematic and consistent data about the progress of LBC at a national level.

Since 2008, a number of key strategies and policy drivers have been introduced which have directly affected the roles of SCNs, SCMs and TLs and this changing policy and practice landscape has influenced the implementation and enactment of LBC.

When LBC was introduced the focus was on the transition of staff into the revised role and working within the context of the LBC components. Reporting often focused on outputs, reinforced by case studies of staff experiences that articulated some of the outcomes of LBC but did not provide a comprehensive account of the wide range of work and approaches undertaken by Boards to support role development and the outcomes of working in the revised role.

**The evaluation**

There were four main evaluation objectives, the operation of LBC, the implementation of LBC, the impact of LBC and the sustainability of LBC principles and practice.

The evaluation was managed by an Evaluation Steering Group who the Blake Stevenson team worked closely with in designing the evaluation tools and providing progress reports at regular intervals.

The evaluation involved two visits to the territorial and special boards over the two year period and interviews, focus groups and surveys with staff from the individual Boards and interviews with national stakeholders. The network of LBC facilitators and the National Lead played a key in identifying and facilitating contact with the evaluation participants and this report is based on the analysis, using Nvivo software, of the discussions with 360 staff from 14 territorial and three
Special Boards, 26 interviews with national stakeholders and 900 survey responses from Board staff.

**Operation and implementation of LBC**

In each Board the approach to introducing and implementing LBC was informed by a range of factors: strategic direction from the END or AND, organisational structures, the learning needs of staff, experience of working with the staff group, experience of implementing other educational development programmes, and logistics and practicalities. As a result there was significant variation in the ways in which Boards introduced and raised awareness about LBC; engaged with staff and management about LBC and the content and delivery of the support to help SCNs, SCMs and TLs to work within the revised role;

In most Boards the support was delivered through an LBC course or training programme or workshops that varied in length from half a day to 11 days. The content of the support also varied significantly, for some the four role domains shaped the content linking relevant policy and practical tools to address the skills and knowledge being developed and then the learning was applied in the workplace. This approach was often reinforced with activities like peer learning and refresher events. In contrast some Boards did not focus the support on the role development but on information sharing around elements like the CQIs and with little or no follow up with the SCNs, SCMs and TLs.

When considering the effectiveness of local support to introduce and implement LBC, there was, again, variation between staff from different Boards. Diagram 1 identifies the factors that lead to effective local LBC support.
There were some key resources and tools that were designed to support staff working in the revised role. The Education and Development Framework was one of these, designed to guide and support the SCNs, SCMs and TLs in their development journey and to demonstrate and evidence the impact of their role. Yet, the 2013 survey of 704 staff highlighted that only 45% used this key framework mainly to reflect on personal learning and development. The most common reasons for non-users was because they had not seen it or they were not familiar with the resource.

The impact resource, introduced in 2012, was designed to support Boards to demonstrate locally the impact of their SCN, SCM and TL roles. The resource can be used by post-holders and their line managers and use of this tool was inconsistent across the Boards.

The three Clinical Quality Indicators (CQIs), introduced in 2009 were designed to provide SCNs with their own real time ward level data and were intended as a tool to support the way they assured care in a setting and help identify improvement. When used in this way they were generally valued and considered as part of a suite to evidence the quality of care. When used as a form of audit, they were viewed by some as a time consuming administrative exercise. The CQIs were a regular measurement in inpatient areas across NHSScotland until the national collection of CQI data ended in 2013 when the Scottish Patient Safety Programme rolled out its indicators and measures within different care settings.

Even with access to and use of national resources coupled with the delivery of effective local LBC support, there were some commonly reported barriers preventing SCNs, SCMs and TLs from working within their revised roles. These are highlighted below.

- Having an active caseload
- Lack of support from line manager
- HR and administrative burden
- Staff shortages
- Wider hospital duties
- Lack of clarity about LBC

**The Impact of LBC**

Evaluating the impact of LBC has been challenging. In part because of the nature of the programme, the diverse implementation approaches in the Boards, the expansion of LBC and also the changing policy environment. The focus on LBC objectives at the outset of the national programme has added to these difficulties and to explore the impact of LBC, it was necessary to define a set of potential outcomes.
The research team and the Evaluation Steering Group agreed a set of primary outcomes for the SCNs, SCMs and TLs, secondary outcomes for staff teams, settings and the Boards and tertiary outcomes for patients.

Board-led implementation of LBC resulted in varying content and delivery of the support across localities and settings. The ongoing support and infrastructure to reinforce the role also differed dramatically resulting in SCNs, SCMs and TLs operating in a variety of ways within the role. Inevitably these differences have affected the extent of LBC’s impact. Nevertheless in this evaluation, by far the greatest impact of LBC has been on the skills, confidence and abilities of SCNs, SCMs and TLs and there were many examples of the change in individuals that improved their performance in their role. Examples of reported outcomes for SCNs, SCMs and TLs included:

- Having greater clarity of the SCN, SCM or TL role
- Being more visible and accessible to teams and patients
- Being a more reflective practitioner
- Improved leadership skills and confidence in leading a team
- Better able to identify their own learning and development needs and those of their team
- Better able to identify more effective ways of working and driving improvements in their setting

Whilst there was far more consensus on the achievement of primary outcomes, there were varied views on the impact of LBC on the wider teams, units and settings.

Some respondents felt that the SCNs, SCMs or TLs role modelling as well as their willingness and ability to share knowledge and implement improvements had a positive effect on the way their teams operated and were supported which led to changes in staff morale and staff performance. However, others felt that there had been minimal or no impact on the wider teams, in part due to the SCN, SCM and TL not having the capacity to perform all elements of their role.

The most frequent types of secondary outcomes resulting from LBC were:

- Better and clearer lines of communication within teams and units
- Better supported teams
- Greater cohesiveness and team working
- Greater peer networking and collaboration among SCNs, SCMs and TLs
- Enhanced capacity of managers of SCNs, SCMs and TLs to undertake their role
The tertiary outcomes were the most difficult ones to attribute and evidence, on the whole impact on patients and families was the least commonly observed as this was reliant on SCNs, SCMs and TLs making changes to practice, e.g. introducing care rounding, that contributed to improved patient experience and service quality.

The main impacts on patients and their families were:

- Improved patient experience
- Increased awareness of the care team
- Increased contact time with patients and families
- Improved levels of patient satisfaction.

The evaluation identified that there were common factors, often inter-connected that were important facilitators or barriers to the impact of LBC. A combination of them influenced the way in which LBC was introduced, implemented and reinforced in the individual Boards and ultimately the impact it had in those local settings. These factors are captured in the diagram below.
Sustainability of LBC Principles and Practice

There are sharp differences in the profile and presence of LBC across the Boards and this is heavily linked to the implementation, reinforcement, management and commitment to LBC at a local level and, ultimately has a direct impact on the extent to which LBC principles and practice are being sustained. The report summarises the different approaches and factors in those Boards that continue to engage and support or inhibit their SCNs, SCMs and TLs to work within the role and deliver LBC principles and practice.

National factors also affect sustainability. The Education Development Framework, in particular, and the Impact Resource tool, are still valid, but need to change so that they are used more consistently and effectively. The period of uncertainty around LBC and a sense of drift had affected the priority and focus on LBC in some Boards and the opportunities for a refocused drive from NES was welcomed and there is an appetite to see changes and actions that will revitalise LBC.

Conclusions

As with any national programme that is implemented at a local level there has been huge variation in the approach, content, commitment and resourcing of the LBC support to introduce, implement and reinforce the revised role amongst SCNs, SCMs and TLs.

This two year service evaluation has identified that, even with the wide variety in approaches and a series of barriers to the impact of LBC, the investment in the education and professionalism of the key roles of SCN, SCM and TL has raised the profile and resulted in positive outcomes for this critical staff group.

In the Boards where the LBC support clarified the change in role functions and expectations, where the content of the support was relevant to post–holders and where the opportunities to develop actionable knowledge and apply learning in situ, the SCNs, SCMs and TLs exhibit clinical leadership and role modelling within their setting. Where LBC is still championed and there are systems, structures and a culture that continues to encourage and develop the SCNs, SCMs and TLs they flourish in their revised roles and confidently lead and manage their clinical areas and deliver safe and effective practice.

Nevertheless, the vision of LBC was to enable SCNs, SCMs and TLs to deliver better care in a consistent, measurable and evidence based way. There is still a lack of consistency, a lack of measurement and a lack of evidence in the way care is being delivered across NHSScotland. The SCN review identified aspects of clinical coordination that the SCN should not be involved in – a direct clinical caseload, participating in the management of hospital sites, having significant administrative duties. However an active caseload and time consuming administration are still part of the role for many SCNs, SCMs and TLs.
Although there were Boards where there was little evidence of the sustainability of LBC, amongst most local and national stakeholders, there was still a strong belief that LBC principles and the four role domains were appropriate and relevant to delivering high quality patient care. They did however recognise the need to refocus and reinvigorate LBC and crucially to secure Executive level commitment in Boards where this had waned.

Since LBC was introduced there have been many new policies and initiatives – the Quality Strategy, 20:20 workforce vision, SPSP and an increased use of improvement techniques and tools like Plan, Do, Study, Act (PDSA) LEAN, workload and workforce planning tool.

The SCN, SCM and TL post holders play a pivotal role in adapting to new policies and translating them into practice and leading changes and improvements in their setting. To do this, they need the skills, confidence and capacity to fulfil all elements of their role.

The Board discussions, survey responses and national stakeholder contributions showed how important it is to continue to articulate the supervisory role of the SCN, SCM and TL and explore ways in which this can happen in as many sites and teams as possible so that the repositioning of the role as the “guardians of clinical standards and quality of care for patients and families” can be better realised.

**Recommendations for the future sustainability of LBC**

There are eleven recommendations that should be considered in order to help improve the consistency of approach, the accountability and governance of LBC and the focus of support.

**Recommendation 1**: Refocus and reinvigorate LBC by identifying and rationalising priority areas that LBC support should target.

**Recommendation 2**: Identify outcomes that LBC funding should deliver that demonstrably support SCNs, SCMs and TLs to work within their roles and deliver person-centred, safe and effective patient care.

**Recommendation 3**: Develop appropriate and proportionate reporting systems to evidence outcomes and achievements of LBC support.

**Recommendation 4**: Review the governance and monitoring mechanisms to increase national and Board level accountability.

**Recommendation 5**: Consider the relevance of LBC support for those staff not in the SCN, SCM or TL post and identify alternative development opportunities to support career progression.

**Recommendation 6**: Identify ways to encourage and consolidate the gains made by boards that have embraced LBC, e.g. through piloting new approaches to evidencing achievements.
**Recommendation 7**: Explore ways to support those Boards where SCNs, SCMs and TLs are not fulfilling functions and responsibilities within the standardised role.

**Recommendation 8**: Review the existing LBC materials to sense check relevance to different settings and the changing policy environment.

**Recommendation 9**: LBC is not a gateway and there should be offerings throughout duration of the SCN, SCM, TL career.

**Recommendation 10**: Articulate and strengthen the links between career development, clinical leadership programmes, improvement programmes and LBC.

**Recommendation 11**: Champion the supervisory status of the SCN, SCM and TL roles and collect evidence of the impact.
1. **Introduction and Context**

1.1 In March 2013, Blake Stevenson was commissioned to undertake the service evaluation of phases 1 and 2 of Leading Better Care (LBC) across NHSScotland. This report presents the findings of the two-year evaluation.

**Context for the work**

**The rationale for LBC**

1.2 LBC emerged as a direct consequence of the Senior Charge Nurse (SCN) Review conducted by the Scottish Government and professional advisors in 2008\(^3\). The Review identified the large body of evidence that recognised the key role of the SCN in determining the quality of care within wards and settings, and the need to enable those in that role to fulfil this function consistently and effectively.

1.3 The Review of the SCN role found that:
   - all stakeholders – including patients and the public – perceived SCNs to be pivotal to the delivery of high-quality care;
   - there was widespread concern that SCNs spent too much time on administrative duties and in having an active caseload of patients, and therefore were not fully enabled to lead and develop their team; and
   - the SCN role lacked clear expectations, responsibilities and associated development opportunities.

1.4 The wide variation in the functions and responsibilities of SCNs across NHSScotland highlighted the need for greater standardisation of the role, with a key set of responsibilities, competencies and skills. It resulted in the development of a standard framework for the SCN with four key role domains linked to the Knowledge and Skills Framework (KSF). This is often referred to as the ‘revised role’.

1.5 The four domains and key role activities created the standardised role and are depicted in Figure 1.

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\(^3\) *Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project (2008).*
1.6 Published alongside the Review in June 2008 was the outcome of a parallel programme of work to develop Clinical Quality Indicators (CQIs) for nursing and midwifery. A core set of three CQIs were developed as a means to demonstrate the nursing and midwifery contribution to care and clinical outcomes.  

1.7 The Review and CQI projects were viewed as critical to developing the strong and inspirational clinical leadership required to deliver the NHS vision for safe, effective care and enhanced patient experience of services. LBC was introduced in 2008 as the initiative to implement the outcomes of these complementary workstreams, with the aim of

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5 Food, fluids and nutrition; Falls; and Pressure area care CQIs
enabling Band 7 SCNs and SCMs to work within the revised role and embed quality improvement into practice.

“This report from the projects gives us the impetus and the evidence we need to enable us to reposition the senior charge nurse/midwife as the arbiter and guarantor of patients’ experiences in clinical areas. Empowered by their new role definition and equipped with the CQIs, senior charge nurses/midwives will be the guardians of clinical standards and quality of care for patients and families.”


1.8 The first phase of LBC set clear objectives for all NHS Boards, so that by December 2010:

- all SCNs working in hospitals across NHSScotland will be working within the context of the revised role; and
- Boards will have Clinical Quality Indicators (CQIs) in place in the majority of inpatient areas.

1.9 The roll-out of LBC was reinforced with a programme of support that included a network of facilitators, national materials and funding to resource the support needed to enable those working within the revised role to deliver high quality, person-centred, safe and effective care. In addition to the funding and infrastructure provided to Boards, a critical element was the Education and Development Framework (also known as the ‘pink book’). This was developed by NHS Education for Scotland (NES) and detailed the four key areas of responsibilities and competencies linked to KSF. This tool was viewed as an essential component of LBC, designed for SCNs and their managers to identify learning and development needs and opportunities and to demonstrate the evidence and impact of their role.

1.10 In 2010 it was decided to expand the role framework to community-based staff that managed a service or led a team so that they could benefit from leadership development and the support provided by LBC. The second phase of LBC reflected this expansion, with new objectives that by March 2013:

- all SCNs, SCMs and TLs will be able to demonstrate that they are working in the context of the LBC components; and
• nurses and midwives will be able to demonstrate the contribution they make to the quality and experience of care that patients receive under the three Healthcare Quality Strategy themes of safe, effective and person-centred.

1.11 During the roll-out of phase 2 individual Boards were also asked to consider including additional groups within their LBC cohorts: in particular Band 6 staff who aspired to the SCN, SCM or TL roles.

Releasing Time to Care

1.12 The Releasing Time to Care (RTC) initiative was launched in Scotland at the same time as LBC. RTC was initially a six–month pilot in eight NHS Board areas before being rolled out across all boards. Developed by the NHS Institute for Innovation and Improvement, RTC aimed to enable nurses to improve and streamline hospital ward processes and spend more time on direct patient care. Participating staff had access to an education package and tools to analyse their working environments.

1.13 Initially the National Lead managed both LBC and RTC programmes as they were seen as complementary to each other, both aimed at supporting the SCN, SCM or TL to improve patient care and lead and influence change. NHS Boards each developed their own roll-out plans for RTC to reflect local needs. In some Boards RTC was used as a primary vehicle for supporting LBC. LBC facilitators often had responsibility for both RTC and LBC and this shaped the way LBC support was delivered and the level of understanding and distinction between the two programmes. In 2010, due to changes at a strategic management level, the day to day management of LBC and RTC was split and managed by two National Leads in different sponsor organisations.

Intended outcomes of LBC

1.14 When LBC was introduced, the focus was on the transition of staff into the revised role and working within the context of the LBC components. By having the key leader within a ward or community setting ensuring safe and effective practice, managing the performance of the team, enhancing the patient experience and contributing to organisational objectives, there was a generally accepted view that this would lead to improvements within the team and the care that they provided. Ultimately this should lead to positive outcomes for the patients and the care they receive.

1.15 Whilst the aspiration and intent was there, the potential benefits for Band 7 staff, their teams, their Boards and patients and families they cared for was not articulated beyond general service outcomes specifically derived from the LBC programme. This was not unique for a national programme but this lack of specific outcomes created a challenge, which has been widely acknowledged, in identifying and measuring the impact of LBC.
1.16 Therefore, for the purposes of this evaluation it was necessary to define a set of potential outcomes in order to fully explore the impact of LBC. This list was developed by the evaluation team and a subgroup of the Evaluation Steering Group and is discussed in detail in Chapter 3.

Changing landscape

1.17 There has been a fast-changing policy and practice landscape since 2008 which has impacted on LBC and is an important consideration for this evaluation.

1.18 Since LBC was introduced a number of key strategies and policy drivers have been initiated which have directly affected the workforce across NHSScotland as well as having particular implications for the role of SCNs, SCMs and TLs. These include:

- The *Healthcare Quality Strategy for NHSScotland (2010)*. The strategy set out the improvement interventions required to deliver the national Quality Ambitions related to achieving person-centred, safe and effective care. SCNs, SCMs and TLs are key to delivering many of these interventions and play an important role in meeting the national outcome measures.

- *Everyone Matters: 2020 Workforce Vision (2013)*. The national workforce strategy, and associated annual implementation plans, set out a vision for stronger leadership, better workforce planning and more effective ways of working. The strategy placed renewed emphasis on developing leadership, planning and improvement skills and ensuring access to appropriate learning at all levels of the workforce.

- An increased use of improvement techniques and tools such as the Plan, Do, Study, Act (PDSA) cycle, LEAN\(^6\), and the *Nursing and Midwifery Workload and Workforce Planning Toolkit*. This was first published in 2008 and mandated as part of workforce planning processes across NHSScotland in 2012.

- The *Scottish Patient Safety Programme (SPSP)* was first introduced in 2008 in the acute setting and over time has extended to other programme areas. The high-profile programme aims to reduce avoidable harm to patients by improving the safety of patient care at all points of care delivery and supports Boards to test and implement processes to improve care delivery and bring about a patient safety culture within teams. As part of the programme the *Scottish Patient Safety Indicator (SPSI)* was introduced, with data collection and reporting that, in 2013, replaced two\(^7\) of the three CQIs that had been introduced alongside LBC.

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\(^6\) Adopted by NHS Institute for Improvement and Innovation

\(^7\) Falls and Pressure Area Care CQIs
1.19 While to some extent LBC has been integrated and aligned with these policy and strategic agendas, this shifting policy and practice environment has presented challenges and opportunities both to implement and reinforce LBC but also to identify and attribute specific impact to it.

**LBC support and governance structure**

**National management of LBC**

1.20 Whilst governance of LBC has always been overseen by the Chief Nursing Officer’s (CNO) Directorate, from 2008 to March 2014 the Scottish Executive Nurse Directors (SENDs) were the executive sponsors of LBC. As a group, they received reports from an LBC Programme Board and were the final sign off for strategic decisions relating to the programme. This ensured that SEND had full influence over the national LBC programme and a clear understanding of how LBC could be implemented in their individual Boards. At that time the LBC Programme Board, chaired by Professor Angela Wallace, Nurse Director of NHS Forth Valley, oversaw the implementation of the programme and Vicky Thompson, the LBC National Lead, had day to day management.

**Figure 2. LBC reporting structure 2008–2014**

1.21 Since March 2014 lead responsibility for Phase 3 of LBC has been placed with NES. This transfer was designed to support the continuation of this development journey by embedding LBC within the Post Registration Career Development Framework and refocusing activity and investment on Level 7 (Career Framework for Health) SCNs, SCMs and TLs across Scotland. The NES Programme Director, Dr Stuart Cable is leading an LBC
team, supported by a newly constituted advisory group with Executive Nurse level representation.
Local management and delivery of LBC

1.22 Whilst LBC provides a national framework within which all SCNs, SCMs and TLs should be working, the implementation of LBC was Board–led to allow local delivery that was fit for purpose across settings and different clinical areas. This allowed Executive Nurse Directors (ENDs) to shape LBC in a way that suited their Boards and that best emphasised the pivotal role that SCNs, SCMs and TLs played in delivering safe, personalised and effective care.

1.23 A network of LBC facilitators provides a vital role in co–ordinating the delivery of LBC at a local level. They are supported in their role by their local structures, reinforced by the advice and guidance from the LBC team, their peers, the network of LBC facilitators as well as access to LBC resources.

1.24 At a local level the management and governance arrangements vary and have changed dramatically since LBC was introduced in 2008. At that time some facilitators reported into local LBC steering groups with senior staff representation, others fed into existing structures like clinical governance committees and others worked with their strategic lead in consultation with staff to manage local arrangements. By the end of phase 2 of LBC the governance arrangements had changed for most facilitators with some simply reporting to line managers and others still feeding into Board committees and Senior Executives.

Funding and reporting mechanisms

1.25 Throughout phases 1 and 2, quarterly progress reports were submitted by the majority of Boards and information about the number of staff supported through LBC along with CQI data and case study examples. The reporting proved challenging because of the:

- different approaches to implementation;
- different IT systems in and across each Board area;
- varying level of detail provided by each Board; and
- lack of clarity regarding governance and commitment to national reporting.

1.26 Together, these factors led to the reluctance to mandate Board submission of monitoring information.

1.27 Most of the reporting focussed on outputs, such as the numbers supported by LBC and CQI data. Where case studies were submitted these provided a richer picture of staff experiences and captured some of the outcomes of LBC. Nevertheless a comprehensive account of the wide range of work and approaches undertaken by Boards to support role development and the outcomes of working in the revised role was not collected.
1.28 Since 2008 the Boards have each received annual funding to support facilitation and implementation of LBC. Between 2008/09 and 2010/11 over £850,000 was disbursed to the Boards. From 2011/12, LBC funding was allocated within nursing bundles, alongside other programmes. For example in 2012–13 the ‘nursing bundle’ encompassed funding for LBC and Tissue Viability and in 2013–14 for LBC and Patient Safety work.

1.29 Boards could use the funding flexibly to deliver the agreed outcomes described for programmes within the scope of the bundle. For LBC this was that all SCN, SCM and TLs in clinical settings will be working in the context of the LBC components and able to demonstrate this.

Table 1. Annual funding bundle allocation for LBC

<table>
<thead>
<tr>
<th>Year</th>
<th>Total spend on LBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008–09</td>
<td>£438,500</td>
</tr>
<tr>
<td>2009–10</td>
<td>£138,000</td>
</tr>
<tr>
<td>2010–11</td>
<td>£287,700</td>
</tr>
<tr>
<td>2011–12</td>
<td>bundle £2,220,000</td>
</tr>
<tr>
<td>2012–13</td>
<td>bundle £2,071,975</td>
</tr>
<tr>
<td>2013–14</td>
<td>bundle £2,041,600</td>
</tr>
</tbody>
</table>

1.30 Although the original release of monies was triggered when the Boards submitted their programme plans, in phase 2, under the bundling approach, delivery against agreed programme outcomes was monitored via established Board arrangements. Under both approaches there was no detailed requirement to evidence spend or restrict spend to certain activities. This provided Boards with the flexibility to use the funding in a way that best suited their planned activities. However, it has resulted in inadequate knowledge about how the funding has been spent to support SCNs, SCMs and TLs in their role or the outcomes of this support and no framework to challenge Boards where there was limited evidence of LBC–specific activity.

**Evaluation aims**

1.31 The overall research aim was to undertake a service evaluation of the operation and impact of LBC. The detailed evaluation aims and components are set out below:

Aim 1: to evaluate the operation of the LBC initiative focusing on the key structures and processes involved in its enactment.
• Appraise the effectiveness of the national LBC governance approach including the implementation and action plan, national/board level facilitation, project management activities and funding/expenditure

• Analyse the nature and effectiveness of partnerships with stakeholders, organisations, and integration with other national projects/programmes

Aim 2: to evaluate the transition and enactment of the Senior Charge Nurse (SCN), Senior Charge Midwife (SCM) and Team leader (TM) role framework to date.

• Establish the nature and extent of local and national achievement of the initiative’s key aims that: “All Senior Charge Nurses in hospital settings will be working in the context of the revised role (2008–10) and all SCNs, Senior Charge Midwives and Team leaders will be working in the context of the LBC components:
  – to ensure safe and effective clinical practice
  – to enhance the patient experience
  – to manage and develop the performance of the team
  – to ensure effective contribution to the delivery of the organisation’s objectives
by March 2013 and able to demonstrate this.

• Appraise achievement in relation to the four main areas of SCN, SCM and TL responsibility and their associated key result areas with particular focus on clinical leadership, co–ordination and management aspects of the role

• Describe the nature, scope of engagement and application of the SCN, SCM, TL education and development frameworks (NES 2008 and 2011) to date and related impacts

Aim 3: to evaluate the impact of the LBC initiative to date.

• Establish the nature and extent of local and national achievement of the initiative’s key aim that: “The majority of in–patient areas will have Clinical Quality Indicators in place (2008–10) and nurses and midwives will be able to demonstrate the contribution they make to the quality and experience of care that patients receive under the three themes by March 2013: safe; effective; person–centred. (2011–13)”

• Collate and analyse indicators of impact such as performance/improvement measures, CQI impact data, and relevant qualitative data, drawing on material available from NHS Boards (including any local evaluations) and national project databases
Elicit perceptions from SCNs, SCMs and TLs, relevant colleagues in clinical and strategic roles, patients, the public and partners organisations of the impact of LBC in relation to intended, and any unintended outcomes

Aim 4: to inform the future development and sustainability of LBC principles and practice.

• Elicit more junior nurses’ perceptions of the attractiveness of the revised SCN, SCM and TL role and gauge to what extent succession planning is developing

• Identify key lessons for further development of the initiative, with particular reference to educational and practice issues

**Methodology**

1.32 There were three stages to evaluation approach which are summarised in Figure 3.

**Figure 3. Evaluation methodology**

### Stage 1 - Planning and preparation
- Inception meeting
- Discussion with LBC National Lead
- Review all nationally and locally held data
- Finalise evaluation framework
- Check ethics situation with NRES

### Stage 2 - Fieldwork
- First fieldwork visits to all Boards
- First national stakeholder interviews
- Survey to staff supported by LBC (2013)
- Second fieldwork visits to NHS Boards
- Second national stakeholder visits
- Survey to SCNs, SCMs and TLs (2014)
- Survey to nurse managers (2014)

### Stage 3 - Analysis and reporting
- Progress reports
- Ongoing analysis of data
- Deliberative team analysis workshop including members of Evaluation Steering Group
- Draft final report
- Final report with Executive Summary

Planning
1.33 The evaluation was managed by an Evaluation Steering Group\(^8\). The evaluation team worked closely with this group to design the evaluation tools and to report on progress at regular intervals\(^9\).

1.34 The process for progress reporting and discussions with Evaluation Steering Group enabled the methodology to adapt in response to initial findings and changing circumstances since the work was tendered. For example, although one evaluation aim component focused on collation and analysis of national and local data, during the planning stage when this initial activity was undertaken it showed that there was limited nationally held consistent performance and improvement data and wide variation in the nature of locally held data. In the absence of consistent evaluation and monitoring data across all the Boards, the Evaluation Steering Group agreed that the fieldwork should predominantly focus on gathering qualitative information using a range of approaches that would address the evaluation aims.

Fieldwork

1.35 Blake Stevenson worked closely with the LBC facilitators in each Board to recruit participants for the fieldwork. This key group helped to arrange interviews and focus groups with staff within their Board and also disseminated the three surveys that were undertaken as part of the fieldwork.

1.36 Across the two phases, the fieldwork involved in–depth discussions with 360 staff from 14 territorial and three Special Boards, 26 interviews with national stakeholders\(^{10}\). In addition the fieldwork collected 900 survey responses: 704 staff who have been supported by LBC responded to the 2013 survey; 137 SCNs, SCMs and TLs responded to a follow–up survey in 2014; and there were 59 responses to the survey specifically for managers of SCNs, SCMs and TLs.

1.37 Full details of the research tools and consultees involved in the fieldwork are included in the Appendices.

Analysis and reporting

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\(^8\) Appendix 1 lists the members of the Evaluation Steering Group

\(^9\) Three formal progress reports were provided to the Evaluation Steering Group in September 2013, March 2014 and September 2014

\(^{10}\) Phase 1 fieldwork: 229 staff interviews, 17 stakeholder interviews. Phase 2 fieldwork: 131 staff interviews, and 9 national stakeholder interviews.
1.38 The fieldwork produced a large amount of data. The surveys were designed, administered and analysed using SNAP survey software and the interviews were analysed using Nvivo, a qualitative data analysis package. The data from the fieldwork was analysed at regular intervals and observations and key initial findings were presented to the Evaluation Steering Group, along with progress reports in September 2013, March 2014 and September 2014. An exploratory analysis workshop was held with a subgroup of the Evaluation Steering Group in January 2015 prior to the draft final report being produced.

Report structure

1.39 The remainder of this report is set out under the following sections:

- Chapter 2: Implementation and reinforcement of LBC
- Chapter 3: Impact of LBC
- Chapter 4: Sustainability of LBC principles and practice
- Chapter 5: Conclusions and recommendations

1.40 The information contained within this report is not attributed to any individual although anonymised quotes from individuals have been used to illustrate commonly held views. The information is purposefully reported at a national level (with the exception of illustrative case studies in Chapter 3 where, with permission, some individual Boards are identified). This is a national evaluation of LBC and although evidence and data was collected at Board level, the decision to report data at a national level only was taken by the LBC Evaluation Steering Group at the outset of the research and therefore data was collected from respondents on this basis.

1.41 However, it is important to ensure that the findings are of value to both NES and individual Boards planning and implementing phase 3 of LBC. The report therefore sets out to support NES and individual Boards to consider the different approaches taken to date and the issues and critical success factors associated with these approaches so that they can inform next steps at both a national and local level.
2. Implementation and reinforcement of LBC

Sources of information for this chapter

2.1 The first phase of the evaluation sought to explore the first two evaluation objectives: the operation and implementation of LBC, and consider the ways in which Boards had supported SCNs, SCMs and TLs to work within the revised role framework.

2.2 This chapter sets out the findings from the fieldwork in this area and is informed by:

- interviews and focus groups with SCNs, SCMs, TLs and their Band 6 and Band 5 staff;
- interviews with LBC facilitators;
- interviews with managers of SCNs, SCMs and TLs;
- interviews with the Executive Nurse Directors (END) and/or the Associate Nurse Directors (AND);
- a survey of staff supported by LBC (SCNs, SCMs, TLs and Band 6 and Band 5 staff where relevant);
- a survey of managers of SCNs, SCMs and TLs (undertaken in phase 2 of the evaluation); and
- interviews with national stakeholders.

Varied approaches to local implementation

2.3 The fieldwork highlighted that in each Board the approach was informed by a range of factors: strategic direction from the END or AND, organisational structures, the learning needs of staff, experience of working with the staff group, experience of implementing other educational development programmes, and logistics and practicalities.

2.4 As with any local implementation of a national programme, there was significant variation in the ways in which Boards:

- introduced and raised awareness about LBC;
- engaged with staff and management;
- delivered the support and the content of the support to revise the role;
- extended LBC support to wider staff groups; and
- reinforced the LBC approach.
Introduction of LBC and engagement within the Boards

2.5 Interviewees described how in some Boards interest in and awareness of LBC was encouraged through roadshows and launch events. In other Boards specific staff and their managers were briefed about the introduction and purpose of LBC in order to create a shared understanding. In contrast, some units or teams of SCNs, SCMs and TLs reported they were unaware of LBC until the first day of the course or workshop.

2.6 In a handful of Boards, managers of SCNs, SCMs and TLs were invited to attend specific briefing sessions about LBC and their role as a manager in supporting their teams to work within the revised role framework. This was felt to be particularly beneficial by managers and the need for engagement at this level was highlighted by comments from some SCNs, SCMs and TLs who felt that their managers’ lack of interest and awareness of LBC was a major barrier to their ability to work within the revised role.

Delivery of formal and informal support

2.7 The consultations with staff supported by LBC identified the ways in which they received support to refocus their role. The most common response in the 2013 survey was through a formal or facilitated LBC course or training programme, as shown in Figure 4.

Figure 4. Responses to survey question “What support did you receive to refocus your role?” (2013; n=704)

2.8 The interviews and survey responses identified that when LBC courses and workshops were delivered, this was for a time period that ranged from half a day to more than 11 days. Typically the support was delivered over three to five days. For example, in one Board their five day programme involved four one–day sessions themed on the role
domains that were delivered through workshops and action learning sets and a final day to present a work based improvement project.

2.9 In another Board, the support was delivered as a course over a period of months but there were opportunities for the SCNs, SCMs and TLs to draw in members of their team so that they could share the learning and be better placed to support changes or improvements back in their setting.

2.10 As well as variation in delivery, the content of support varied significantly. As already identified, in some Boards, the four role domains and the Education and Development Framework formed the basis of the support, linking in relevant policy and introducing appropriate tools to address the skills and knowledge being developed. For example, in one Board the themed workshops on safe and effective practice were delivered with colleagues from SPSP and RTC so that the role domains of LBC were explicitly linked to measures, CQIs and other quality improvement tools and participants could clearly see the linkages between the initiatives.

Extending LBC to wider staff groups

2.11 A number of Boards made the decision to extend the reach of LBC to staff at other levels. In the majority of cases this meant encouraging Band 6 staff (and in some Boards Band 5 staff) to complete the LBC programme or receive 1:1 LBC support.

2.12 Perceptions about the effectiveness of extending LBC support beyond SCNs, SCMs and TLs were mixed. Some considered it to have been beneficial in providing a basis for succession planning and developing leadership potential of future SCNs, SCMs and TLs. A larger number of consultees felt it had limited effect because although it had raised awareness and knowledge amongst Band 6 and Band 5 staff they had limited opportunity to put the learning into practice. A number of consultees also felt that by expanding the scope of LBC beyond the SCN, SCM and TL roles the support and focus of LBC had been diluted, creating confusion around the purpose of LBC.

2.13 Interviews with Band 6 and Band 5 staff appeared to support these points, as whilst it had been interesting to be involved in LBC and it had raised their awareness of the expectations and role of the SCN, SCM and TL post-holder they were generally far less able to identify any particular benefits to their current role, their leadership development or their practice.

Overall perceptions of the effectiveness of delivery

2.14 When asked, the majority of survey respondents (2013 survey, n=704) felt that the local programme of LBC support had been very or quite relevant and of high or fair quality. When analysed further, 14% felt the support they had received was very high quality and
57% fairly high quality, 23% thought it had been very relevant and 54% felt that the programme of LBC support had been quite relevant. There were patterns in the responses from individual Boards about the quality and relevance of the support and great variation in these responses between the different Boards. Comments that suggested that the delivery had been effective included:

“Good support with informed facilitators and guidance throughout the process. Peer support very important, encouraging and motivational”.

“I am still able to reflect in what had been taught on the course”.

2.15 There were, however, examples of support to refocus the role that were not effective. In these cases the following issues were often present:

- A lack of awareness and understanding amongst staff about LBC so staff felt this was yet another thing to do alongside their role;
- The content was not considered relevant, e.g. too focussed on the acute setting or on CQI elements, regardless of the setting in which the staff worked;
  
  “I had to attend 4 study days, during which I felt I gained nothing useful at all and that my time was wasted” (SCN)

  “No change in work at all as the course was directed totally towards ward staff – issues such as wound care, pressure sore care are not applicable to health visiting. It was simply a tick box exercise so [the Board] can say all senior staff have attended the course” (TL)

- The support was limited, e.g. one or two days, with no follow up:
  
  “I haven’t had any support. My LBC experience has consisted, so far, of a 1 day course and a workbook that I have attempted to complete in my own time” (SCN)

- No clear link was made to pull together relevant policies and programmes.

2.16 When the local support was considered to be effective and successful, it had a marked impact on participants in terms of their understanding of their role, their enthusiasm for their role and their self-confidence in their role.

“The team delivering and leading the course were fantastic and made me feel valued and that my opinions, thoughts and work really did matter. LBC made me analyse myself but I felt safe doing this with the support I had”. (SCN)

2.17 The delivery of effective local LBC support involved a combination of factors, highlighted in Figure 5.
Reinforcing the LBC approach

2.18 It became evident through the survey and discussions with staff in different Boards that again there was significant variation in the extent to which LBC principles and practice were reinforced and how the support continued to assist SCNs, SCMs and TLs to work within the revised role. It also became clear that consultees felt that having multifaceted and long-term support was a critical element in effectively embedding LBC into practice.

2.19 A summary of how respondents perceived the usefulness of different components to reinforce LBC is set out in Figure 6.
Figure 6. Responses to survey question “What supported or reinforced your work?” (2013; n=703)

![Figure 6. Responses to survey question “What supported or reinforced your work?”](image)

2.20 Figure 7 provides a further breakdown of responses to this question by the type of setting respondents worked in. There are a number of clear differences in responses between respondents working in acute and community settings. In particular, a much larger proportion (16%) of community-based respondents felt that none of the listed aspects of LBC had supported their work compared to 5% of those working in an acute setting. Unsurprisingly, given the acute focus of the CQIs, far fewer community-based respondents (14%) felt that the CQIs had support or reinforced their work compared to those working in the acute setting (43%).

2.21 The other key difference highlighted by responses to this question is in relation to the difference that other improvement work has made: 41% of respondents from an acute setting considered it had supported their work compared to 29% of respondents from a community setting.
Figure 7: Responses to survey question “What supported or reinforced your work?” broken down by respondents in acute, community and acute and community hospital settings

2.22 It seems that one of the reasons why LBC was not reinforced in some Boards was because the design and delivery of the support had not focused on the role development and the changes expected in the way SCNs, SCMs and TLs would lead and manage their settings. In these Boards LBC support was often delivered as a one-off programme with limited follow up activity.

2.23 At the other end of the spectrum, there were Boards that recognised that LBC support should continue for staff to keep up to date with policy and practice changes, to enhance particular skills and knowledge for some staff to fulfil the revised role, and for new staff coming into post. In these Boards SCNs, SCMs and TLs are actively encouraged and engaged in a range of activities and support to embed LBC and this includes:

- provision of peer learning or coaching;
• support to use and embed knowledge and tools like improvement methodologies;
• encouraging staff at this level to influence Board policies and processes through representation on strategic groups or meetings with senior managers; and
• ongoing forums, events and workshops to reinforce LBC and link with new or changing local and national initiatives.

2.24 Discussions about the steps taken to reinforce LBC principles and practice frequently resulted in consultees identifying the importance of local Board support for LBC. There was a strong feeling that effective reinforcement of LBC depended heavily on the Board demonstrating clear strategic support at END or AND level that resulted in operational change enabling the SCN, SCM and TL to perform in their revised role.

2.25 The most obvious example of this reinforcement was in those Boards where the SCN, SCM and TL roles have experienced a reduction in or removal of their patient caseload and, whilst not without its challenges (staff shortages reducing its effect, for example), this was felt to be essential by almost all local and national consultees to enabling staff to work effectively within the role framework and embed LBC principles and practice.

Use and value of LBC tools and resources

2.26 LBC was launched with a number of key tools and resources designed to support staff working within the revised role. The evaluation explored the ways in which these resources were used in practice, and perceptions of their relative value to the staff using them.

**Education and Development Framework**

2.27 The Education and Development Framework is intended to be a tool to guide and support SCNs, SCMs and TLs in their development journey, to identify with their managers which areas they need support to develop further, and to demonstrate and evidence the impact of their role.

2.28 Many of the national stakeholders commented that they expected the framework to be used in conjunction with personal development, management and appraisal and whilst this was the case in a minority of the Boards, in most cases the Education Development Framework was used as a standalone reference guide and in a much more limited capacity. This is highlighted by the results of the 2013 survey (n=704) where, as shown in Figure 8, only 45% of the SCN, SCM and TL respondents said that they used the Education and Development Framework (sometimes referred to as the ‘pink book’). A small proportion of survey respondents, 6%, did not know if they had used the resource and 49% said they had not used it.
As shown in figure 9 the most common reason for non-use of the Education and Development Framework was because respondents had not seen it or they were not familiar with the resource.

For the 45% who had used the Education and Development Framework, it had been used as part of the LBC support, to reflect on personal learning and development and as a framework to support staff who they manage.

“This provided me with a valuable resource but also helped me clarify my role and helped me gain confidence”. (SCM)

Consultees strongly believed that the content of the Education and Development Framework was still valid and relevant. However many felt that the Education Development Framework could be more interactive and linked with e-portfolio and eKSF.
2.32 The majority of interviewees recognised the potential of the Education and Development Framework in developing, supporting and managing current and future SCNs, SCMs and TLs. Some of the improvement suggestions included:

- introducing modules for each role component that staff could work through;
- developing different component levels and modules that could be used for other staff who support the SCN/SCM/TL, e.g. with expectations for the registered nurses who work with them and for the line managers who support them; and
- having modules that were accredited.

**Impact Resource Tool**

2.33 In September 2012, a new national tool was tested and then rolled out to Boards keen to use it. The impact resource tool was designed to support Boards to demonstrate locally the impact of their SCN, SCM and TL roles as well as achieving the LBC aim by March 2013. The resource can be used by the post holders and their line managers and the 2013 and 2014 survey responses and interviews with staff showed that the Impact Resource Tool was a useful resource for some individuals, teams and Boards.

2.34 However, use of the tool is inconsistent, as depicted in Figure 10. The 2014 survey (n=95) found that only 34% of SCN, SCM and TL respondents said that they and/or their manager used it, and only 21% of manager survey respondents (n=56) said that they used it to support their staff to work in the revised role.

**Figure 10: Use of the Impact Resource Tool**

2.35 The main reason given for non-use was the perceived difficulty in using it. This difficulty is not evident amongst other respondents, particularly in those Boards who use the Impact Resource Tool as a mandatory tool or strongly encourage staff and managers to use it.

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11 Based on the results from the question “what tools and resources do you and your manager currently use to within the LBC role framework.”
Clinical Quality Indicators

2.36 Between 2009 and 2013, the three CQIs were a regular measurement in inpatient areas across NHSScotland and by December 2011 more than 800 areas each week were recording this data. CQIs were designed to provide SCNs with their own real time ward level data. They were intended to be used as a tool to support the way they assured care or flagged care issues in the setting and help identify improvement. However, recording and collection of CQI data was variable. There was not a national CQI monitoring mechanism in place and, importantly, baseline data was not gathered at the start so the extent of improvements and distance travelled was not possible to capture.

2.37 From the 2013 survey, 55% of respondents (n=384) identified that the CQIs applied to their areas of work. The majority of that group considered CQIs valuable in enhancing clinical practice (77%) and valuable in enhancing the patient experience (70%). Figures 11 and 12 show how respondents from different settings (acute, community, acute and community hospitals) responded to this question.

Figure 11: Responses to survey question “How valuable are the CQIs in enhancing the patient experience?”, broken down by respondents in acute, community and acute and community hospital settings
Interestingly the results show that when CQIs applied in their setting, staff in the community considered CQIs valuable in enhancing the patient experience and clinical practice, more so than their acute colleagues.

Figure 12: Responses to survey question “How valuable are the CQIs in enhancing clinical practice?”, broken down by respondents in acute, community and acute and community hospital settings

In areas where the CQIs were used as a measure to drive improvement, they were generally valued and considered as part of a suite to evidence the quality of care. Many staff commented on how they used them positively:

“They highlight areas where issues are arising so action can be taken to improve and sustain, and I feed results back to staff so that we can identify areas for improvement and ensure they are all clear about their responsibilities”. (SCN)
2.39 For others, the CQIs were too process orientated. They were being used to audit and then evidence poor performance and were viewed by some as a time consuming administrative exercise.

“SCNs were using it for improvement and heads of nursing were using it for judgement, berating staff for poor documentation of good care”. (Nurse Manager)

“CQIs have become a measure of the quality of the paperwork – they were meant to indicate the quality of the experience – it has now become a paper exercise”. (SCN)

2.40 In some areas the CQIs shifted from their purpose as a tool to use as part of implementing LBC to becoming the primary focus of LBC. In these areas, the focus on CQI auditing was felt to have had an impact on the way that Boards prioritised the education and leadership development of those working in the revised role and inevitably in the understanding of those being supported by LBC. This is highlighted by some interviewees in the community setting who felt that LBC was either irrelevant or less relevant to them because they perceived that CQIs only applied in acute settings.

2.41 The aspiration of the national collection of CQI data ended in 2013 when SPSP rolled out its indicators and measures within different care settings and the position of the CQIs as a tool by which all SCNs and SCMs would measure improvement was removed.
3. **Impact of LBC**

**Sources of information for this chapter**

3.1 The second phase of the evaluation sought to explore the third and fourth evaluation objectives: to evaluate the impact of the LBC initiative to date, inform the future development and sustainability of LBC principles and practice.

3.2 This chapter sets out the findings from the fieldwork in this area and is informed by:

- interviews and focus groups with SCNs, SCMs, TLs and their Band 6 and Band 5 staff;
- interviews with LBC facilitators;
- interviews with managers of SCNs, SCMs and TLs;
- interviews with the Executive Nurse Directors (END) and / or the Associate Nurse Directors (AND);
- a survey of SCNs, SCMs, TLs or equivalent postholders;
- a survey of managers of SCNs, SCMs and TLs; and
- interviews with national stakeholders.

3.3 This chapter also contains three case studies identified during the second round of fieldwork that demonstrate particular examples of improvement work linked to LBC that resulted in positive outcomes. These case studies were selected for illustrative purposes and there will be other examples of the impact of LBC related activity within these and other Boards that are not detailed in this report.

**Potential outcomes of LBC**

3.4 As highlighted in the introductory context to this report, evaluating the impact of LBC has been challenging, in part because of the nature of this type of programme, the diverse implementation approaches in the Boards, the expansion of LBC and also the changing policy environment. However, the focus on LBC objectives and an absence of clearly identified outcomes at the outset of the national programme has added to these difficulties.

3.5 In order to identify the potential outcomes of LBC, the research team and the evaluation subgroup used the findings from the initial phase of fieldwork to agree a set of primary outcomes for SCNs, SCMs and TLs and then develop secondary outcomes for staff teams, settings and the Boards and tertiary outcomes for patients. These are detailed in Figure 13.
Figure 13. Range of potential outcomes of LBC

Primary Outcomes

LBC outcomes for SCNs, SCMs & TLS
- Increased confidence
- Improved clarity of role
- Increased clinical co-ordination
- Increased capacity
- Improved knowledge & skills
- Increased job satisfaction
- Improved accessibility & visibility
- Wider engagement with colleagues & peers
- Improved knowledge and use of improvement techniques & tools
- Increased focus on high quality care
- Improved workforce management

Secondary Outcomes

Outcomes for NHS Boards
- Increased contribution of SCNs to strategic policy & practice
- Improved opportunities to influence organisation
- More effective clinical leadership
- Greater ability to drive change

Outcomes for Teams, Units & Settings
- More effective communication
- Improved engagement within & across the team
- Enhanced learning & development across team
- Improved clinical practice
- More effective deployment of resources
- Improved understanding of collective roles & responsibilities
- More responsive to patient needs
- Increased patient contact
- Improved succession planning

Tertiary Outcomes

Outcomes for Patients & Carers
- Improved co-ordination of patient pathway
- Increased awareness of care team
- Increased confidence about care received
- Better care environment
- Improved patient/carer involvement
- Increased staff contact
- More appropriate care received
3.6 Identifying these outcomes formed the basis for the second round of fieldwork, comprising interviews with Board staff and national stakeholders as well as two surveys focused on impact: to SCNs, SCMs, TLS; and to managers of these post-holders. This phase of the evaluation explored:

- expectations of the impact of LBC on staff teams, units/settings, patients or service users and service provision;
- actual impact of LBC on staff teams, units/settings, patients or service users and service provision;
- specific examples of the positive impact LBC has made against the four domains of the LBC role framework – enhancing the patient experience, ensuring safe and effective practice, managing the performance of the team and delivering organisational objectives; and
- other changes that have occurred as a result of LBC.

**Limitations in measuring LBC impact from the patient perspective**

3.7 The original intention was to also gather the views of patients/carers or members of the public and in nearly all Boards we explored ways in which this could be achieved. The first challenge was identifying what changes members of the public or patients might realistically be able to identify (that could be attributed to LBC). In reflecting on the LBC outcomes for patients/carers, these are likely to be:

- increased awareness of the care team;
- improved patient/carer involvement; and
- increased staff contact.

3.8 For a patient, carer or member of the public to be able to identify such changes during the period 2009–2013 they would need to be accessing the service or setting in a regular or repeated way. Whilst Boards do have mechanisms for regularly gathering patient or public opinion, e.g. through the public partnership forum (PPF), the participants in these fora are unlikely to have the detailed knowledge of the setting and the leadership provided by the SCN, SCM or TL and most Boards were uncomfortable about attempting to use this route.

3.9 As a result the evaluation focused on gathering examples and case studies from staff and managers in the Boards and from national stakeholders to draw out conclusions, critical success factors and illustrative examples. The rest of this chapter summarises these key findings around impact and the observed outcomes of LBC.
Areas of impact

3.10 As highlighted in Chapter 2 the Board-led implementation of LBC resulted in varying content and delivery of the support across localities and settings. The ongoing support and infrastructure to reinforce the role also differed dramatically resulting in SCNs, SCMs and TLs operating in a variety of ways within the role. Inevitably these differences have affected the extent of LBC’s impact. However consultees clearly identified several primary outcomes that were a result of LBC support and that led to changes in the skills, confidence and abilities of SCNs, SCMs and TLs.

3.11 Throughout the research there were a number of clear examples of the application of LBC principles and practice which resulted in positive and evidenced changes. A selection of these examples feature as case studies in this chapter, providing a snapshot of the elements identified by those involved as particularly supporting or enabling the SCN, SCM or TL to apply learning into practice and work within the revised role. With permission we have identified the Boards in which these illustrative examples took place.

3.12 While there are several powerful examples of the impact that SCNs, SCMs and TLs, working in the revised role, are having on their staff, settings and the patient experience, the perceived impact of LBC, beyond the individual SCNs, SCM, and TLs was, on the whole, limited and variable.

Impact on primary outcomes

3.13 The primary outcomes focused on outcomes to SCNs, SCMs and TLs.

<table>
<thead>
<tr>
<th>Primary outcomes case study – NHS Lothian example</th>
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<tbody>
<tr>
<td><strong>Board LBC Context</strong></td>
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<tr>
<td>The Board quickly embraced the introduction of LBC and developed a programme that would support the enactment of the revised role and embed learning within the individuals’ settings. Their single system approach allowed colleagues from across departments to learn together and better understand other service areas and the patient journey. LBC support was delivered primarily through six full day workshops at monthly intervals. The workshops were themed around the four role dimensions, involved contributions from local and national stakeholders and offered opportunities for the individual’s team to attend relevant aspects of the support, e.g. if data gathering and improvement techniques was an activity that they would be involved in. The workshops were reinforced with 1:1 support, peer networks and bi-annual forums to reflect on applied learning and share ideas. The Board has evaluated the programme and its impact on several occasions and this has informed development of the programme and the support structures for wider leadership and educational development.</td>
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</tbody>
</table>
Case study context for improvement work
SCNs were supported by the LBC programme to identify improvement projects within their setting. SCNs within the A&E department identified a need for greater uniformity in their approach to patient care, planning and assessment within the context of a high patient flow (300 patients every 24 hours) outpatient setting. They wanted to bring complaints down and to be more joined up with the approaches and initiatives related to care assessment and CQIs within inpatient settings. They identified that a formalised approach to care rounding would be a useful way of incorporating local and national initiatives that they should be more involved in. Prior to this, care rounding was very inconsistent, nursing staff did not think they had the time to do it and questioned the relevance and value of documenting such activity in their busy setting.

Details of improvement work implemented
The A&E SCNs actively consulted with all staff in the department and with colleagues from the wards to plan and redesign a new patient care rounding document and agree the process for care rounding. With support from management they incorporated the process within the Board’s quality information database system (QIDS), enabling them to record practice, assess activity at any time and evidence contribution to national and local targets. They produced a DVD on the care rounding process so that staff at all levels and any new staff joining the department would understand the rationale for the process that had been developed and their role within the process, and to raise awareness with colleagues in other departments.

Measurable outcomes
Primary outcomes
The SCN who managed the project developed significant leadership skills through the LBC programme and her experience of developing the improvement project. As a direct result she moved into a new role in the Board with a specific remit for improvement. Secondary outcomes
The department-wide involvement in the introduction of care rounding has increased staff knowledge and understanding of improvement planning and improvement methodologies. While the SCN who led the project has moved post, the care rounding procedures and audit have continued, with the team and unit enabled with the skills and knowledge to continue to embed the improvement work. There is also closer collaboration between departments with a shared understanding of the patients’ journey. All staff and management are able to assess patient data collected in A&E and this is used to inform care in the inpatient setting. Tertiary outcomes
Patients have a more positive care experience and a smoother transition from A&E to the inpatient departments where the staff have a greater understanding of their care needs. They reported improved satisfaction with their care and the department has seen a
3.14 The above example illustrates how LBC support had a direct impact on the SCN’s knowledge and confidence and ability to plan and implement improvements, ultimately impacting on the team, unit and patient experience. The lead SCN on the project explained that the LBC programme provided the opportunity to reflect on their patients’ experiences and consider the tools they could use to better that experience and drive the change forward:

“The beauty of this course (LBC) was that through talking to other SCNs in A&E we began to realise that we are part of the patient journey, and picking up the national initiatives would have a significant impact on us. Up until this point we hadn’t seen a way we could do it”. (SCN)

3.15 Based on the research findings for this evaluation, by far the greatest perceived impact of LBC has been on the role and abilities of SCNs, SCMs and TLs. However, it should be noted that the impact was considered to be much less on SCMs and TLs working in community settings, with many people commenting that they felt LBC, the role framework and resources were not as relevant in their working environment.

3.16 Figure 14 highlights the main aspects of the SCNs, SCMs and TLs role or skills that were considered to have been consolidated or improved as a result of LBC.

**Figure 14: Main examples of reported impact on the role and abilities of SCNs, SCMs & TLs**

<table>
<thead>
<tr>
<th>Examples of reported primary outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Having greater clarity of the SCN, SCM or TL role</td>
</tr>
<tr>
<td>• Being more visible and accessible to teams and patients</td>
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<tr>
<td>• Being a more reflective practitioner</td>
</tr>
<tr>
<td>• Improved leadership skills and confidence in leading a team</td>
</tr>
<tr>
<td>• Better able to identify their own learning and development needs and those of their team</td>
</tr>
<tr>
<td>• Better able to identify more effective ways of working and driving improvements in their setting</td>
</tr>
</tbody>
</table>

3.17 The majority of managers and other respondents also remarked that there had generally been a positive and noticeable impact in these areas.
3.18 Almost two thirds of the 2013 survey respondents (64%) (n=704) agreed that LBC had made a difference to the way in which they were working, and the remaining 36% said that LBC had not made a difference to the way they were working.

3.19 The question was rephrased in the 2014 survey with additional options to ascertain the extent to which LBC was felt to have made a difference to the way respondents were working. In total 12% of respondents to this question said that it had made ‘a major difference’, 67% said it had made ‘some difference’ and 21% said it had made ‘no difference’. The larger impact identified in the second survey may be partly due to the different audiences for the two surveys: the 2013 survey was issued to anyone who had been supported by LBC (including Band 5 and 6 staff); whereas the 2014 survey was specifically aimed at SCNs, SCMs, TLs or equivalent roles who, as the evaluation has identified, had greater opportunity to implement change and work in the revised role.

3.20 The interviewees and survey respondents consistently identified the clarity it gave to their role and the sense of empowerment that they felt. In the 2013 survey, respondents were asked to select from a list all the changes that they felt were a result of LBC. Figure 15 displays all the responses – role clarity, increased auditing activity and increased use of improvement techniques were the three changes most frequently identified.

Figure 15. Responses to survey question “What has changed for you as a result of LBC?” (2013; n=444)
Respondents and interviewees also provided examples which included changes in the following:

- **presence and visibility in and outwith their areas** – SCNs were spending more time on the ward with patients and staff and were happier to participate and contribute to a broader agenda including issues that did not directly relate to their immediate area. There were examples provided of information and knowledge sharing across sites.

- **practice** – SCNs introducing ward rounds and ‘daily conversations’ with patients to check their needs and the quality of care, working out rota planning to fit the needs of the ward and make sure they can supervise staff and support relatives, and changing team working by streamlining processes that they had worked through as part of their LBC project.

- **improvement and auditing processes** – for some, they were collecting and interpreting their own ward data for the first time which was giving them ownership
and evidence to feedback and use with their teams and line managers, to inform practice and to share with their patients.

3.22 The comments provided by survey respondents also give indications of a positive change in practice for many:

“The confidence to challenge, evidence best practice and demonstrate need for service have all been outcomes of LBC”. (TL)

“It allowed me to focus on different aspects of practice, my role and the role of my team, during a time of enormous change within midwifery”. (SCM)

“I am better at actively seeking feedback from others and I am more organised in the way I work. I feel I am working in a much more positive manner and am better equipped to deal with difficult situations”. (SCN)

“My skills and knowledge have certainly improved. I am more confident in dealing with difficult staff situations. I now feel confident in using emotional touch point and carrying out SWOT analysis to brainstorm changes etc”. (TL)

3.23 Despite this general perception of the positive impact on practice, one third of the 2013 survey respondents (n=704) and one–fifth of the 2014 respondents (n=135) did not think that LBC had made any difference to them. The reasons vary but they are often linked to the quality and relevance of the LBC support and the postholder’s capacity and support received to work within the revised role.

3.24 Team Leaders in community settings often commented that it had had little or a lesser effect on their role.

“It has made me think more about how to achieve a quality service. However, in community it does not seem to have the high profile that it has in the hospital setting”. (TL)

Capacity of SCNs, SCMs and TLs to undertake the revised role

3.25 A lack of capacity to work in the revised role was a very common feature in local and national interviews and surveys over the two–year evaluation and this restricted the impact that postholders could have on their teams, settings and patients.

3.26 In both the 2013 and the 2014 surveys, respondents were asked to consider which if any of the four role dimensions they did not have the time or capacity to deliver. The results are shown in Figure 16.

Figure 16: Responses to the survey question “Which of the four role dimensions do you feel you do not have enough time to undertake?” (2013: n=454; 2014: n=136)
In order to make a meaningful comparison the 2013 results are based on the 454 Band 7 respondents to that survey only.

3.27 In the 2013 survey only a small proportion of respondents (12%) felt they could deliver all four dimensions. Notably, in the 2014 survey a larger number (35%) respondents said that they have the time and capacity to undertake all four role dimensions. In 2013, amongst those who felt that they could not sufficiently deliver all four elements of their role, contributing to the delivery of the organisation’s objectives and managing and developing the performance of the team were the two most challenging dimensions.

3.28 Whilst the response to the 2014 survey was much lower and not all Boards were represented\textsuperscript{12}, this trend was reflected in the 2014 survey. 48% of all respondents said that a lack of time or capacity prevented them from managing and developing the performance of the team, and 41% could not contribute to the delivery of the organisation’s objectives.

3.29 The most common explanations for the lack of ability to deliver on all four elements of the role were a lack of time or resources to plan and implement changes as a result of a heavy patient caseload or covering for staff shortages.

\textsuperscript{12} There were no responses from NHS Ayrshire and Arran, NHS Highland, NHS Orkney, NHS Western Isles or the State Hospital.
“I am still holding a caseload and am seldom in a position to be supernumerary even for the day. So all the plans I have and want to implement are very slow coming into place. So, in essence there is no change in my way of working although I would like that to happen and I have the tools/knowledge to do so”. (SCN)

“I have made safe and effective clinical practice my priority for our unit as I do not have time/resources to focus more on the other elements”. (SCN)

3.30 Boards recognised the challenges for SCNs, SCMs and TLs when the caseloads were not reduced. Some boards have been able to remove the active caseloads of their Band 7 post-holders in particular settings and others have piloted the supervisory role but acknowledged the difficulties in trying to do this and the inequalities across sites and settings when staff have a full caseload, a reduced caseload or no caseload.

“LBC has been a real chance to claw back the SCN’s identity and role in the ward setting. In order to do that they need protected time from direct patient care, that’s the biggest challenge in our Board”. (Nurse Manager)

3.31 Even if there is capacity, there were examples during the board visits and frequent comments from survey respondents that their desire to work in the revised role was being hampered by line managers,

“[Managers] take no collective responsibility in creating the culture in which that person can flourish. You can teach all you like but if you put that person back in the role where they can’t act you will get no difference”. (SCN)

“The LBC principles were relevant however the practicalities of how to implement changes remain much outwith the realms of SCN control and very much based on management agenda”. (SCN)

3.32 Based on the fieldwork discussions and survey responses the critical factors that appear to prevent SCNs, SCMs and TLs from working in the revised role are summarised in Figure 17.

**Figure 17. Commonly-reported barriers preventing SCNs, SCMs, TLs from working within the revised role**
Impact on secondary outcomes

3.33 As highlighted in figure 13, the second level of outcomes of LBC–related activity focused on outcomes for the Boards, and for units, settings and teams. The next case study highlights the outcomes for a group of staff.

Secondary Outcomes case study – NHS Tayside example

Board LBC Context
In this Board, LBC is considered strategically important to ensure the provision of quality patient care. LBC receives visible senior support, reporting to the Senior Executive on a monthly basis. There is a high demand for places on the four day education programme. The fourth day is dedicated to the delegates to enable them to share their improvement project. Each delegate is asked to identify an area they would like to improve. Using the model for improvement, the delegate will develop their idea into their working environment or team. Day four is an opportunity to share the learning and celebrate success. The Board adopted the national job description for the revised SCN, SCM and TL posts. The Education and Development Framework forms the basis of 1:1 meetings with nurse managers and the SCNs, SCMs and TLs. To support this, the LBC impact tool further supports staff to fulfil the responsibilities of their role by identifying areas of achievement and areas where development may be necessary. The diagnostic framework is a further resource to identify the health and performance of the SCN, SCM and TLs’ teams. This considers team dynamics, culture, quality, leadership and relationships to understand where a team might need support and improvement to achieve the expectations of quality patient care.

Case study context for improvement work
In NHS Tayside all SCNs, SCMs and TLs were tasked to undertake an LBC improvement project based on a PDSA (Plan, Do, Study, Act) methodology. For her LBC improvement project a district nurse TL developed a study to trial the use of an ergonomic kneeler by community nursing staff. The issue identified by the TL in her setting was the high risk of staff injury and cumulative damage associated with prolonged static squatting or kneeling.
during nursing procedures involving low working, such as leg ulcer management. By minimising the risk of injury the project aimed to promote staff attendance at work and have a positive effect on staff and the wider team.

**Details of improvement work implemented**
The TL planned how the study would be conducted and developed a questionnaire for use with staff and patients involved in the pilot. Funds were made available to purchase the kneeling device for use in the pilot, and the initial pilot within the district involved six members of staff, some of whom had pre-existing injuries as a result of prolonged low level working. The evidence from the improvement project resulted in the device being used more widely and rolled out to other district teams, alongside a limb support device to further improve both patient and staff comfort.

**Measurable outcomes**

**Secondary outcomes**
Staff within the teams reported a significant improvement to their own comfort when dressing a patient’s lower limb which they felt made them more effective in performing this treatment. The equipment is now used regularly for patients with injury, surgery or leg ulcers requiring dressing.

3.34 In this case study example, the focus of the LBC improvement project was on addressing an issue that was affecting staff when they performed a particular nursing procedure. The TL was able to use the improvement planning tools from the Board’s LBC programme to identify, plan and implement the change in working practice to the benefit of her team.

3.35 Whilst there was far more consensus on the impact of LBC on the role, skills and confidence of SCNs, SCMs and TLs, the responses to the impact of LBC on the wider teams, units and settings were more varied.

3.36 Some respondents felt that the role modelling exhibited by SCNs, SCMs or TLs as well as their willingness and ability to share knowledge and implement improvements had an effect on the way their teams operated and communicated. Some also directly related a positive impact on staff morale and staff performance to the SCN, SCM or TL being more visible and better equipped to manage performance and develop individuals within the teams.

3.37 In the managers’ survey, the majority echoed the view that there had been a positive impact on the way the teams were managed and supported by the SCN, SCM and TL.

“It has led to much stronger leadership and proactive management of their teams”.
(Nurse Manager)
“Team leaders have a clearer understanding of their pivotal role – leading, acting as a good role model, looking at processes and procedures in a critical way... whilst bringing the team alongside them”. (Manager (other))

3.38 However, a significant number of respondents felt that there had been minimal or no impact on the wider teams, explaining that this is in part due to the SCN, SCM and TL not having the capacity to perform all elements of their role.

3.39 While not consistently observed by respondents, the most frequent types of positive impact on the team are highlighted in Figure 18.

Figure 18. Main examples of reported impacts on teams, settings and Boards

<table>
<thead>
<tr>
<th>Examples of reported secondary outcomes</th>
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<tbody>
<tr>
<td>• Better and clearer lines of communication within teams and units</td>
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<tr>
<td>• Better supported teams</td>
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<tr>
<td>• Greater cohesiveness and team working</td>
</tr>
<tr>
<td>• Greater peer networking and collaboration among SCNs, SCMs and TLs</td>
</tr>
<tr>
<td>• Enhanced capacity of managers of SCNs, SCMs and TLs to undertake their role</td>
</tr>
</tbody>
</table>

“Team felt under less pressure. Service delivery was more streamlined and morale in the ward was heightened”. (SCN)

“Smoother team working and increased awareness of patient-centred care and research-based practice”. (Nurse Manager)

3.40 Very few consultees felt that LBC had an observable impact on their organisations more generally. It is possible that this is a more difficult type of impact to identify, however, it also reflects the fact the local structures were not in place to provide the opportunity for SCNs, SCMs and TLs to influence directorate or Board-level decision-making or that post-holders worked with a limited capacity, prioritised the other three dimensions of their role.

3.41 While providing a mixed response, a substantial number of managers of SCNs, SCMs and TLs also felt that LBC had a positive effect in terms of their own ability and capacity to undertake their role. Some related this to the improved ability of the SCNs, SCMs and TLs whom they managed enabling them as managers to undertake additional duties or work more effectively with their staff. Others commented on the value of the role framework and/or CQIs in providing a useful structure and mechanism for reviewing their teams’ quality and performance.
“I feel the competence level of SCNs has increased greatly thus enabling me to carry out my role with greater capacity for managing extra pieces of work”. (Nurse Manager)

“It has meant that I am having to intervene less with the difficult issues as these staff are now enabled and empowered”. (Nurse Manager)

**Impact on tertiary outcomes**

**3.42** The third level of outcomes of LBC-related activity focus on patients, families and service users. These were the most difficult outcomes to attribute and evidence but the final case study highlights the tertiary outcomes for patients being cared for in this particular unit.

### Tertiary outcomes case study – NHS Lanarkshire example

**Board LBC Context**
The Board had early involvement in the development phase of LBC and had set foundations for LBC prior to its full roll out. The Board adopted the national job description for SCNs and developed performance objectives for SCNs, SCMs and TLs prior to the launch of LBC, which were then mapped to the education and development framework and KSF. The intention was to provide a framework which would evidence their good practice and identify role development needs. The Board took a distinctive approach from the outset not to have a formal LBC education programme, as it was felt there were sufficient developments already existing that incorporated LBC alongside other national programmes e.g. RTC. Instead they have delivered a model of 1:1 or small group coaching support for SCNs, SCMs and TLs, facilitated through their practice development centre. The focus is on providing in situ knowledge and skills development and linking in with other national initiatives and agendas. The LBC support is governed by a programme board that oversees all aspects of LBC finance and activities within the Board.

The current approach to LBC is a partnership with University of the West of Scotland which is focused on a defined programme of work linked to the four key domains of the LBC role framework. There is a research and evaluation strategy to underpin programme activities and build evidence.

**Case study context for improvement work**
SCNs, SCMs and TLs were tasked to undertake an improvement project. SCNs within the renal dialysis unit worked closely together, and with medical colleagues, their nursing team and patients to identify, plan and deliver improvement projects using the PDSA methodology. Two examples of improvement projects that were developed to address specific issues identified within the unit are set out below.

**Details of improvement work implemented**
1. **Reducing line-related infections in renal dialysis patients.** The renal dialysis unit SCN, together with colleagues, identified that haemodialysis patients frequently
developed hospital acquired infections related to AVF cannulation and buttonhole technique. Her improvement project focused on planning and testing a process change model that aimed to reduce the frequency of line-related infections in the adult renal unit through improved cleaning and drying processes.

2. Enhancing quality of care and experience through creative prescribing. Working together on a joint improvement project SCNs in the dialysis unit used the PDSA model to introduce a series of arts and crafts activities in the unit to tackle isolation and loneliness for patients and allow staff to have valuable contact time with patients. They also planned and introduced a friends and family day to raise awareness of staff roles in the unit and establish relationships with patients’ visitors.

**Measurable outcomes**

**Secondary outcomes**

SCNs observed that in reducing stress and anxiety levels for patients and families, the creative prescribing project had had an indirect impact on staff morale and stress levels.

**Tertiary outcomes**

Early data from the infection-reduction project indicated a positive effect on reducing the frequency of infection and longer-term targets were set. The SCNs recorded data and anecdotal evidence suggesting that dialysis patients found the creative prescribing project to be valuable, and noted positive effects in relation to peer support, personal satisfaction and social interaction.

3.43 In this case study example the Board’s approach to using an improvement project to take action in individuals’ settings was a key element to reinforcing expectations and behaviours of SCNs, SCMs and TLs.

“We tried to do something a little more novel and tried to work with people and understand the problems they were having to help them through them while at the same time giving them a framework to evidence their good practice.” (LBC facilitator)

3.44 On the whole, impact on the experiences of patients and families is the area least commonly observed as a result of LBC. This is mainly due to its reliance on SCNs, SCMs, TLs and their teams making effective changes to practice which, as already discussed was hampered by a number of factors.

“It’s frustrating as we now have tools to enhance patient experience but struggle to implement them”. (SCN)

3.45 Some respondents felt that LBC had not had an impact on patients and families’ experience because they and their team were already performing highly and had high levels of patient satisfaction and quality. Others noted the difficulty in separating out LBC
from the effects of other programmes e.g. RTC, SPSP and local quality improvement programmes.

3.46 There were some positive examples where respondents identified LBC support and working in the revised role as directly contributing to improved patient experience and service quality. For those who had changed their practice, e.g. introducing care rounding or adjusting work rotas, so that they were more accessible to patients and their families, then there was more involvement in overseeing patient care and ensuring needs were met. There were other examples of greater use of feedback mechanisms and confidence to act on issues and address complaints, explaining that LBC gave them the skills and insight to do this more effectively.

“Within my particular service I have seen a reduction in complaints that I feel can be attributed to the SCNs having this framework to support them in their roles”. (Nurse Manager)

**Figure 19: Main examples of reported impacts on patients and their families**

<table>
<thead>
<tr>
<th>Examples of reported tertiary outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved patient experience</td>
</tr>
<tr>
<td>• Increased awareness of the care team</td>
</tr>
<tr>
<td>• Increased contact time with patients and families</td>
</tr>
<tr>
<td>• Improved levels of patient satisfaction</td>
</tr>
</tbody>
</table>

“It has raised my confidence to seek feedback and address any issues”. (SCN)

“We get more feedback and the staff now feel empowered to participate in making changes to enhance the delivery of care, regardless of how small”. (SCM)

“Staff are spending more time with the patient, they have more time to speak to the relatives”. (SCN)

**Factors closely associated with impact**

3.47 Across all the interviews and surveys a number of common themes emerged as factors that were critical to the impact of LBC. These are summarised in Figure 20.
3.48 These, often inter-connected factors, were important facilitators or barriers to the impact of LBC. A combination of them influenced the way in which LBC was introduced, implemented and reinforced in the individual Boards and ultimately the impact it had in those local settings.

**Support from the Executive management within the Board**

3.49 Many of the consultees indicated that LBC had ‘dropped off the radar’ in their Board and been replaced by newer or alternative priorities. Some felt that LBC had never been fully embraced at a strategic level and that their efforts to work within the role were hampered by that lack of overt support or real belief in LBC.

“I do not think there has been the level of commitment required from the management to allow real changes to happen”. (SCN)
In contrast, others indicated that having the strong buy in of senior managers and the commitment from the Board enabled them to deliver in their role.

“It helps to have the whole Health Board behind LBC. It is a way of life now”. (SCN)

“The organisation has supported and provided me with the opportunities to put the learning into practice”. (SCN)

**Buy-in and support from line managers**

Some SCNs, SCMs and TLs felt, although there was a strategic commitment to LBC, they did not have the support they needed from their line manager to implement improvements and work within the revised role framework. They commented on a lack of support from line managers who were unaware of or uninterested in supporting them to work effectively within their role.

“It feels like LBC is a tick box exercise for managers”. (TL)

In contrast having strong support from their managers was felt by many SCNs, SCMs and TLs to be instrumental to being able to move forward and work within the four role domains.

“I have recently moved from another NHS Board, previously I was thrown the ‘pink book’ and told to get on with it!!! I am about to complete my three months’ probation in my new role and NHS Board and look forward to implementing LBC, with the fantastic support of my clinical and site manager”. (SCN)

**Content and delivery of the LBC support**

Again, as highlighted in chapter 2, when the content and delivery of the LBC support had been appropriate and relevant, SCNs, SCMs and TLs understood and could relate to the role domains and their applicability to their post and in their setting. When actionable knowledge was gained and new skills were developed and successfully applied in the workplace then there was a greater appreciation of the role expectations and changes that might need to be introduced. When these content elements were absent and the delivery mechanism had limited peer networking and learning in situ then SCNs, SCMs and TLs often viewed LBC as not relevant to their role.

**Capacity to work within the role**

A large majority of consultees who indicated that their expectations had not been met, identified the main reason as a lack of capacity to introduce changes in order to work within the role. This was normally due to the following factors:
• An active patient caseload requiring dedicated time to a number of patients within the setting

“I am caseload holding on 80% of my shifts and this means that I cannot give sufficient attention to developing the team and managing performance – it feels as though I am always chasing my tail and being reactive rather than proactive”. (SCN)

• Staff shortages requiring the SCN, SCM or TL to fill in for other members of staff

• Administrative and HR tasks, like finding cover for staff absences, completing HR paperwork etc that were time consuming and pulled the SCN, SCM, or TL away from playing a more visible role in the setting

“Due to increased workload in clinical area and increasing amounts of admin I feel I am in a worse position than ever. I am expected to be in the numbers except on one shift per week and I often don’t even have this”. (SCN)

• Involvement in wider hospital duties like management of the sites over weekend periods

**Supervisory status/non-caseload holding**

3.55 In contrast to those having to manage a full patient caseload, SCNs, SCMs and TLs who had been given protected time to fulfil their role and who were working with a reduced or no patient caseload noted that this was a major factor in being able to work effectively within the revised role:

“My position as a ‘supervisory’ charge nurse.. has allowed me greater scope in organising my working day and priority setting within that timetable”. (SCN)

3.56 Whilst this status gave them the time and resource to deliver on their role responsibilities, it was also viewed as signifying the strategic support and belief in the role and marked a change in the expectations and role behaviour of the post-holders and the staff that worked with SCNs, SCMs and TLs.

**Reinforcement of LBC and continued development opportunities**

3.57 As discussed earlier in the chapter, consultees valued the opportunities to reinforce LBC principles and practice and in Boards which provided refresher sessions, continued 1:1 support to individuals or maintained a forum for peers to meet regularly and share experiences, it was recognised as an important element of continued development within the role.

“This [the forum] has led to a greater understanding of the pressures on the hospital as a whole and to sharing of ideas that can work. Local initiatives can now be shared in a
variety of ways across the Board, allowing others with similar interests or problems to ‘cherry pick’ tried solutions that may be adaptable in their own area’. (SCN)

**National profile of LBC**

3.58 Many consultees identified a change in the profile of LBC and a move away from specific LBC targeted activities. The expansion into the community setting, some felt, had diluted the focus and rationale for LBC and the loss of two CQIs to the SPSP some felt had contributed to a lower prioritisation within their Board. For those Boards where LBC had maintained its prominence, there was a sense that they were holding an increasingly isolated position in still championing the pivotal role of the SCN, SCM and TL. The need for a reinvigorated commitment to LBC was identified by many of the consultees.
4. **Sustainability of LBC principles and practice**

4.1 In addition to exploring impact the second round of fieldwork also considered the future development and sustainability of LBC principles and practice. Specifically it looked to:

- elicit more junior nurses’ perceptions of the attractiveness of the revised SCN, SCM and TL role and gauge to what extent succession planning is developing;
- identify local and national factors affecting sustainability; and
- identify key lessons for further development of the initiative.

**Attractiveness of the revised role**

4.2 One of the aspirations of the effect of LBC was to improve the attractiveness of the SCN, SCM, and TL role and support succession planning. It is evident from some consultees that by clarifying the SCN, SCM and TL role and supporting them to lead and develop their teams effectively this has led, for some, to greater job satisfaction.

4.3 Many consultees considered the educational investment in SCNs, SCMs and TLs had heightened the profile and professionalism of this staff group and the role framework provided clear parameters for the functions and responsibilities of staff aspiring to those positions. Consultees recognised that the opportunities for Band 6 staff to be supported through LBC and understand the role requirements has helped develop Band 6 staff leadership skills, provided a better perspective of their career progression as well as helping them to support the SCN, SCM or the TL that they work with. Whilst it was acknowledged that this did have a positive effect on those involved, it was felt that there were very few opportunities for Band 6 staff to either move into a Band 7 role or to put the learning into practice. This support to the Band 6 staff should assist with future succession planning.

4.4 The discussions with staff nurses and the perceptions of the SCN, SCM and TL role showed a very mixed view and level of understanding of the functions and responsibilities of these posts. Where there was an appreciation of the roles and what they entailed, it had helped those staff nurses with career aspirations to decide whether the role of SCN, SCM or TL was desirable. For many staff nurses, however, these roles did not present an attractive career prospect. A number of other consultees agreed that LBC had clarified the responsibilities and functions of the posts, however, in the absence of support from managers and appropriate systems and processes, junior staff viewed it as a difficult role to fulfil.
Local factors affecting sustainability

4.5 As discussed in Chapter 3, there are sharp differences in the profile and presence of LBC across the Boards and this has a direct impact on the extent to which LBC principles and practice are being sustained.

4.6 Some Boards view LBC as a driver for increased efficiency and productivity, in others it has been a vehicle for ensuring quality of care. There are Boards where the Senior Executives are still enthusiastic about LBC, where it is still being championed and where the SCN, SCM and TLs are supported to work in the role. This support is reinforced by line managers, by processes and systems and by continued investment to embed the functions and responsibilities expected of the postholders. In these Boards they use SCN, SCM or TL dashboards or performance objectives, diagnostic tools, improvement data and patient satisfaction levels to evidence the impact of LBC.

4.7 In contrast, in other Boards, LBC has lost its profile and has been superseded by new initiatives or programmes with heavier reporting or accountability requirements. In some of these Boards there has been little or no recent LBC support activity for new or existing SCNs, SCMs and TLs compared to other Boards that continue to provide 1:1 support to their staff, refresher sessions or still deliver an LBC programme.

4.8 This variation in activity to sustain LBC principles and practice continued in the monitoring and management of LBC. In some Boards the Education and Development Framework and, in particular, the Impact Resource tool are key resources for managing the development and performance of SCNs, SCMs and TLs. In others the use of both resources was limited and, in the absence of any monitoring, the operational activity of these staff has drifted away from the national role framework.

4.9 Some Boards have committed and continue to seek ways to alleviate the patient caseload and have piloted the supervisory role in hospital settings or reduced the number of days that staff manage an active patient caseload to better support SCNs, SCMs and TLs to work within the four role domains.

4.10 The sustainability of LBC principles and practice in a Board is heavily linked to the implementation, short term reinforcement, management and commitment to LBC at a local level and, ultimately, the impact of LBC in that Board.

4.11 Table 2 summarises the different approaches and factors in those Boards that continue to engage and support (green) or inhibit (red) their SCNs, SCMs and TLs to work within the role and deliver LBC principles and practice. By identifying approaches and characteristics in this way, it should provide key indicators for individual Boards and the NES team as they manage LBC in Phase 3.
### Table 2: Key factors for implementing and sustaining LBC principles and practice

<table>
<thead>
<tr>
<th>Governance &amp; management</th>
<th>Implementation</th>
<th>Short-term reinforcement</th>
<th>Sustained Board activity</th>
<th>Evidencing the work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local steering group with diverse &amp; senior representation</td>
<td>• Clear articulation of role development and changes in expectations of post-holders functions and responsibilities, using the Education and Development Framework</td>
<td>• Strong leadership with visible support from END or AND</td>
<td>• Senior commitment continues along with system/process changes that reinforce support to SCNs, SCMs and TLs</td>
<td>• Board level evaluations of LBC</td>
</tr>
<tr>
<td>• Liaison and consultation with Senior Nursing &amp; Midwifery Group/Forum</td>
<td>• New knowledge is actionable and learning applied in situ through action learning, work based project etc.</td>
<td>• Board commit additional funding</td>
<td>• Nurse Managers use four domains to develop &amp; manage post-holders and assess performance</td>
<td>• External evaluation support, e.g. with universities</td>
</tr>
<tr>
<td>• Retained dedicated LBC facilitator/s</td>
<td>• Awareness raising sessions for Nurse Managers to support staff in revised role</td>
<td>• Explored/tried to implement supervisory status</td>
<td>• SCNs, SCMs and TLs are working fully / partially in a supervisory capacity</td>
<td>• Use of balance scorecards, dashboards, diagnostic tools with key measurement and improvement data</td>
</tr>
<tr>
<td></td>
<td>• Approach able to be tailored to address individual needs or setting to ensure relevance</td>
<td>• Forums/networks developed to provide peer support &amp; learning opportunities</td>
<td>• LBC continues to be delivered to new &amp; existing staff</td>
<td>• Use of the Impact Resource tool</td>
</tr>
<tr>
<td></td>
<td>• Inclusive approach with staff groups to share learning and develop peer networks</td>
<td>• Follow up support and/or refreshers</td>
<td>• LBC is embedded and aligned with other Board priorities &amp; programmes</td>
<td>• Regular reporting to Board Committees on LBC activity and outcomes</td>
</tr>
<tr>
<td></td>
<td>• LBC used as a platform or ‘glue’ to pull together other national policies</td>
<td>• LBC celebration events</td>
<td>• LBC funding targeted effectively to support SCNs, SCMs and TLs in working within their revised roles</td>
<td></td>
</tr>
<tr>
<td>Governance &amp; management</td>
<td>Implementation</td>
<td>Short-term reinforcement</td>
<td>Sustained Board activity</td>
<td>Evidencing the work</td>
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<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>Local steering group</td>
<td>Possibly slower to engage and take LBC forward</td>
<td>Senior support but not as visible</td>
<td>No or limited use of the role framework as a development and management tool for SCNs, SCMs and TLs</td>
<td>Issues evidencing progress, e.g. irregular submission of reports &amp; data</td>
</tr>
<tr>
<td>Standing agenda item on clinical governance meetings</td>
<td>Content of support focused on particular elements e.g. CQIs and therefore not always clear about the role development</td>
<td>Reduced caseload and some protected time but still elements of ‘office days’</td>
<td>Limited profile of LBC within the Board</td>
<td>Limited additional local evaluation activity</td>
</tr>
<tr>
<td>Meetings with nurse managers</td>
<td>Delivery of support sometimes a ‘sheep dip approach’ with information sharing rather than opportunities to apply learning</td>
<td>Limited or no follow up after LBC support</td>
<td>Few opportunities / encouragement for new and existing staff to engage with LBC (networks or training)</td>
<td>Some settings using additional measurement and improvement data</td>
</tr>
<tr>
<td>LBC facilitator time scaled back</td>
<td>LBC support extended to staff groups but some areas of community not yet engaged</td>
<td>CQI approach more audit like than improvement focus driven</td>
<td>Staff ‘in the numbers’ &amp; expected to undertake duties outside the role framework</td>
<td>Limited use of Impact Resource Tool</td>
</tr>
<tr>
<td></td>
<td>Some joining up of other policies &amp; practice but elements fragmented</td>
<td>LBC commonly seen as one-off training</td>
<td>Not always clear as to how LBC funding is being used to support SCNs, SCMs and TLs to work within the revised role</td>
<td>Irregular reporting to Board committees of Senior Executives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National job description introduced in some areas and settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance &amp; management</td>
<td>Implementation</td>
<td>Short-term reinforcement</td>
<td>Sustained Board activity</td>
<td>Evidencing the work</td>
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</tr>
<tr>
<td>Local steering group short-lived or inactive</td>
<td>Slower to engage and take LBC forward</td>
<td>Senior support but not as visible</td>
<td>No or limited use of the role framework as a development and performance tool for SCNs, SCMs and TLs</td>
<td>Issues evidencing progress, e.g. irregular submission of reports and data</td>
</tr>
<tr>
<td>Irregular meetings about governance</td>
<td>Content of support focused on particular elements e.g. CQIs and Education and Development Framework not used as a core part of the support</td>
<td>SCNs, SCMs and TLs continue working in the same way as they did before LBC</td>
<td>Limited or no profile of LBC within the Board</td>
<td>No additional local evaluation</td>
</tr>
<tr>
<td>LBC facilitator time limited or no facilitator in post</td>
<td>Delivery of support sometimes a 'sheep dip approach' with information sharing rather than opportunities to apply learning</td>
<td>No follow up after LBC support</td>
<td>No opportunities for new post–holders to engage with LBC</td>
<td>No use of Impact Resource Tool</td>
</tr>
<tr>
<td></td>
<td>LBC support extended to staff groups but some areas of community not yet engaged</td>
<td>CQI data not consistently gathered or used</td>
<td>Staff expected to undertake duties outside the role framework</td>
<td>Limited reporting of LBC at all levels within the Board</td>
</tr>
<tr>
<td></td>
<td>Limited joining up of other policies and practice</td>
<td>LBC commonly seen as one–off training</td>
<td>Use of LBC funding does not appear to support SCNs, SCMs and TLs to work within the revised roles</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>National job description not introduced</td>
<td></td>
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</table>
National factors that affect sustainability

The Education and Development Framework and the Impact Resource Tool

4.12 These resources were used almost universally in some Boards and hardly at all in others. However, interviewees strongly believed that the Education and Development Framework was still valid and relevant but many felt that it could be more interactive and, together with the Impact Resource tool, could link better with e-portfolio and eKSF.

4.13 The majority of interviewees recognised the potential of the framework in developing, supporting and managing current and future SCNs, SCMs and TLs and wanted to see changes, for example modules that needed to be worked through, that would better ensure that it was used consistently and that there was widespread understanding about the role functions and responsibilities.

4.14 Several interviewees highlighted the system of validation for nurses and midwives and its renewal and introduction in 2015. In those Boards where the Impact Resource Tool was widely used it was popular with staff and their managers, and individuals felt that they were in a strong and unique position of using the tool to provide evidence for revalidation. They believed that this fact alone should be driving up the use of both resources by staff and senior managers.

The national focus of LBC

4.15 There was frequent mention of the uncertainty around LBC and a sense of drift which had resulted in some Boards shifting their focus on to other priorities or, in those still championing LBC, to create a feeling of isolation from the national position. However, there were very positive comments about the revived focus that NES could now have and an appetite to see some concrete changes and actions as a result of its management of LBC.

4.16 Regardless of their Board’s commitment to LBC, the interviewees regularly commented on the need for LBC to be reinvigorated and refocused, and made suggestions as to how this could be done. These included:

- revitalising LBC and emphasising the national commitment to the standardised role and that every SCN, SCM and TL should be working within the four role domains;
- the importance of securing collective commitment from all ENDs that the investment in the SCN, SCM and TL roles was still crucial and that LBC principles and practice were critical for ensuring high quality care;
- increasing Board accountability to deliver the LBC national programme, evidence the use of LBC funding to support SCNs, SCMs and TLs to work in the role and the outcomes on the service and care being provided.
4.17 There were concerns raised about the difficulties in fulfilling the revised role when carrying an active patient caseload and most interviewees highlighted the importance of moving towards the goal of the supervisory status of SCNs, SCMs and TLs, whilst recognising the financial implications of such a move. They looked to LBC management or the CNO to articulate the importance and desire to move to this goal.

4.18 The interviews with national stakeholders acknowledged mission drift of LBC and repeated the need for a coherent vision and purpose which had better alignment to existing clinical leadership programmes and career development that was appropriate for nursing and midwifery in the 21st Century. They also identified the need for greater accountability and, with an improved focus, more clarity on the key LBC priorities that Boards needed to address and evidence.
5. **Conclusions and recommendations**

5.1 As with any national programme that is implemented at a local level there has been huge variation in the approach, content, commitment and resourcing of the LBC support to introduce, implement and reinforce the revised role amongst SCNs, SCMs and TLs.

5.2 This two year service evaluation has identified that, even with the wide variety in approaches and a series of barriers to the impact of LBC, the investment in the education and professionalism of the key roles of SCN, SCM and TL has raised the profile and resulted in positive outcomes for this critical staff group.

5.3 In the Boards where the LBC support clarified the change in role functions and expectations, where the content of the support was relevant to post-holders and where the opportunities to develop actionable knowledge and apply learning in situ, the SCNs, SCMs and TLs exhibit clinical leadership and role modelling within their setting.

5.4 Where LBC is still championed and there are systems, structures and a culture that continues to encourage and develop the SCNs, SCMs and TLs they flourish in their revised roles and confidently lead and manage their clinical areas and deliver safe and effective practice.

5.5 Nevertheless, the vision of LBC was to enable SCNs, SCMs and TLs to deliver better care in a consistent, measurable and evidence based way. There is still a lack of consistency, a lack of measurement and a lack of evidence in the way care is being delivered across NHSScotland. The SCN review identified aspects of clinical coordination that the SCN should not be involved in – a direct clinical caseload, participating in the management of hospital sites, having significant administrative duties. However an active caseload and time consuming administration are still part of the role for many SCNs, SCMs and TLs.

5.6 Although there were Boards where there was little evidence of the sustainability of LBC, amongst most local and national stakeholders, there was still a strong belief that LBC principles and the four role domains were appropriate and relevant to delivering high quality patient care. They did however recognise the need to refocus and reinvigorate LBC and crucially to secure Executive level commitment in Boards where this had waned.

5.7 Since LBC was introduced there have been many new policies and initiatives – the Quality Strategy\(^{13}\), 20:20 workforce vision\(^{14}\), SPSP and an increased use of improvement techniques and tools like Plan, Do, Study, Act (PDSA) LEAN, workload and workforce

\(^{13}\) The Healthcare Quality Strategy for NHS Scotland

\(^{14}\) Everyone Matters: 2020 Workforce Vision
planning tool. The SCN, SCM and TL post holders play a pivotal role in adapting to new policies and translating them into practice and leading changes and improvements in their setting. To do this, they need the skills, confidence and capacity to fulfil all elements of their role.

5.8 The Board discussions, survey responses and national stakeholder contributions showed how important it is to continue to articulate the supervisory role of the SCN, SCM and TL and explore ways in which this can happen in as many sites and teams as possible so that the repositioning of the role as the “guardians of clinical standards and quality of care for patients and families” can be better realised.

Lessons learnt from the evaluation of the national LBC programme

5.9 There are a number of lessons that can be learnt from this two–year evaluation of LBC and these are captured below.

Local implementation of a national programme

5.10 Whilst there are sensitivities about the expectations on local boards to make local decisions about national programmes, LBC is an example of a national programme that offered too much flexibility at a local level. This has led to wide variations and inconsistencies about how the standardised role has been enacted in individual Boards.

5.11 Future national programmes need to consider including core or foundation elements that still allow for local flexibility but ensure a level of consistency in the delivery of activities and a focus on common outcomes identified at the outset.

Management of a national programme

5.12 The most appropriate resource and infrastructure to operationally manage a sizeable programme is important so that knowledge is developed and shared over the lifecycle of the work and roles and responsibilities are spread across a team.

5.13 Funding priorities and identified outcomes should direct activity and delivery should be monitored and outcomes evidenced. Funding allocations should be communicated and released in a timely manner to allow sufficient planning and resourcing of appropriate activities.

5.14 Wherever possible the evaluation of any programme should be planned into its design and occur during the most appropriate period so that identified learning can be maximised and inform ongoing and future activity.

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15 Nursing and Midwifery Workload and Workforce Planning: learning toolkit
Delivering local education and leadership programmes

5.15 There needs to be appropriate awareness raising in advance of any programme or initiative in order to improve understanding and engagement of participants and those supporting them.

5.16 The most effective programmes have high quality facilitators with the skills and enthusiasm for the subject who can engage participants.

5.17 The programme should contain relevant and actionable knowledge, opportunities to apply learning in situ and share learning with peers so that changes are more easily embedded.

5.18 The content and delivery of any education or leadership programme is important for the learner but in the absence of the strategic support, processes and systems to implement the learning, the impact will be minimal.

Recommendations for the future sustainability of LBC

5.19 There are a number of recommendations that should be considered in taking forward Phase 3 that will improve the consistency of approach, the accountability and governance of LBC and the focus of support.

Recommendation 1: Refocus and reinvigorate LBC by identifying and rationalising priority areas that LBC support should target.

Recommendation 2: Identify outcomes that LBC funding should deliver that demonstrably support SCNs, SCMs and TLs to work within their roles and deliver person-centred, safe and effective patient care.

Recommendation 3: Develop appropriate and proportionate reporting systems to evidence outcomes and achievements of LBC support.

Recommendation 4: Review the governance and monitoring mechanisms to increase national and Board level accountability.

Recommendation 5: Consider the relevance of LBC support for those staff not in the SCN, SCM or TL post and identify alternative development opportunities to support career progression.

Recommendation 6: Identify ways to encourage and consolidate the gains made by boards that have embraced LBC, e.g. through piloting new approaches to evidencing achievements.
**Recommendation 7**: Explore ways to support those Boards where SCNs, SCMs and TLs are not fulfilling functions and responsibilities within the standardised role.

**Recommendation 8**: Review the existing LBC materials to sense check relevance to different settings and the changing policy environment.

**Recommendation 9**: LBC is not a gateway and there should be offerings throughout duration of the SCN, SCM, TL career.

**Recommendation 10**: Articulate and strengthen the links between career development, clinical leadership programmes, improvement programmes and LBC.

**Recommendation 11**: Champion the supervisory status of the SCN, SCM and TL roles and collect evidence of the impact.
APPENDIX 1 – EVALUATION STEERING GROUP MEMBERS

Carole McKenna (Chair)  Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)
Stuart Cable  NHS Education Scotland NES  (joined September 2014)
Kate Cocozza  NHS Greater Glasgow & Clyde
Karen Hills  NHS Dumfries
David Logie  NHS Forth Valley
Hugh Masters  Chief Nursing Officer Directorate
Colin Macduff  Robert Gordon University
Donna Maclean  NHS Education Scotland NES  (joined September 2014)
Clare McGuire  NHS Lanarkshire
Mike Sabin  NHS Education Scotland
Vicky Thompson  National LBC Lead  (left March 2014)
Lesley Whyte  NHS Education Scotland NES
Rosemary Wilson  NHS Forth Valley
## APPENDIX 2 – INTERVIEW AND SURVEY RESPONDENTS

Health Board staff interviews conducted over both evaluation phases

Selection of staff and arrangements for interviews and focus groups were made in discussions with Health Board LBC facilitators. The evaluation team were unable to establish contact with the LBC facilitator in NHS Ayrshire and Arran in order conduct Phase 2 fieldwork in that Board, so the views from NHS Ayrshire and Arran are limited to those obtained during the initial fieldwork only.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>No. interviews Phase 1</th>
<th>No. focus groups Phase 1</th>
<th>No. interviews Phase 2</th>
<th>No. focus groups Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>4</td>
<td>1 (1 x SCN Acute &amp; 1 x MH Line Manager)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>7</td>
<td>1 (1 x SCN Acute and 1 x SCN Community Hospital)</td>
<td>6</td>
<td>(1 x LBC facilitator, 1 x Deputy Nurse Director, 1 x Nurse Manager, 2 x SCNs, 1 x Band 5)</td>
</tr>
<tr>
<td>Fife</td>
<td>5</td>
<td>2 (6 x SCN Acute &amp; 8 x TLs)</td>
<td>12</td>
<td>(1 x LBC facilitator, 1 x Acting Director of Nursing, 3 x Nurse Manager, 4 x SCNs, 3 x Band 5)</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>5</td>
<td>2 (10 x SCN Acute &amp; 7 x TLs)</td>
<td>9</td>
<td>(1 x LBC facilitator, 1 x AND, 1 x Nurse Manager, 2 x SCN, 4 x Band 6)</td>
</tr>
<tr>
<td>Grampian</td>
<td>8</td>
<td>1 (2 x TLs)</td>
<td>7</td>
<td>(2 x LBC facilitator, 1 x AND, 1 x Nurse Manager, 1 x SCN, 1 x Senior Staff Nurse, 1 x Staff Nurse)</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>3</td>
<td>5 (3 x LBC facilitator, 2 x Nurse Directors for acute &amp; MH, 9 x SCN/Ms Acute, 8 x Band 6s/TLs Community, 4 x SCNs/TLs MH)</td>
<td>2</td>
<td>(1 x LBC facilitator, 1 x SCN)</td>
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<tr>
<td>Highland</td>
<td>5</td>
<td>2 (17 x SCN/SCM/TL, 4 x Line Manager/Lead Nurse &amp; 1 x Associate Clinical Director)</td>
<td>8</td>
<td>(1 x LBC facilitator, 1 x Nurse Director, 1 x Assistant Nurse Manager, 3 x SCN, 1 x Band 6, 1 x Band 5)</td>
</tr>
</tbody>
</table>

62
<table>
<thead>
<tr>
<th>NHS Board</th>
<th>No. interviews Phase 1</th>
<th>No. focus groups Phase 1</th>
<th>No. interviews Phase 2</th>
<th>No. focus groups Phase 2</th>
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<tr>
<td>Lanarkshire</td>
<td>4 (1x LBC facilitator, 1x LBC Programme Manager, 1x END, 1x TL)</td>
<td>2 (2x SCN Mental Health, 6x SCN Acute)</td>
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<tr>
<td>Lothian</td>
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<td>3 (6x SCN/M, 3x SCN/Mental Health, 4x TLs/SCNs)</td>
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<td>2 (3x Line Manager, 12x SCN/TLs)</td>
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<td>1 (3x participants from community and acute settings)</td>
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<td>4 (3x LBC facilitator, 1x AND)</td>
<td>2 (4x TLs &amp; 4x SCNs acute)</td>
<td>13 (1x LBC facilitator, 1x Head of Nursing, 1x END, 3x Nurse Manager, 4x SCN, 3x Band 6)</td>
<td>2 (1x Volunteer, 4x Junior Nurses)</td>
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<tr>
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<td>5 (1x LBC facilitator, 1x Nurse Director, 1x Head of Clinical Governance &amp; Professional Practice, 1x Lead Nurse for Acute Services, 1x Lead Nurse for Community)</td>
<td>2 (6x SCNs acute, 4x SCN/TLs community)</td>
<td>10 (1x LBC facilitator, 1x Chief Operating Officer, 2x SCN, 2x Band 6, 2x Band 5, 2x Patient Representatives)</td>
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<td>1 (3x SCNs &amp; 2 x lead nurses)</td>
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Interviews with national stakeholders over both evaluation phases

Selection of national stakeholders to interview was made based on the recommendations of the evaluation steering group. The stakeholder consultee list differed in size and composition between the two phases. For the second phase of the evaluation stakeholders were identified who were best placed to comment on the impact of LBC and questions around sustainability of LBC principles and practice.

<table>
<thead>
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<th>Phase 1 Interviews</th>
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<tr>
<td><strong>Paul Martin</strong></td>
<td><strong>Ros Moore</strong></td>
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<tr>
<td>Depute Principal, University of the West of Scotland and former</td>
<td>Chief Nursing Officer for Scotland</td>
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<tr>
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<tr>
<td><strong>Eileen McKenna</strong></td>
<td><strong>Hugh Masters</strong></td>
</tr>
<tr>
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<td>Associate Chief Nursing Officer</td>
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<td>Programme Manager</td>
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<tr>
<td><strong>Karen Wilson</strong></td>
<td><strong>Angela Wallace</strong></td>
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<tr>
<td>Director for Scottish Ambulance previously deputy CNO with a remit for LBC</td>
<td>Executive Nurse Director for NHS Forth Valley and former Programme Chair</td>
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<tr>
<td><strong>Dorothy Armstrong</strong></td>
<td><strong>Vicky Thompson</strong></td>
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<tr>
<td>Previously worked at NES and key LBC partner</td>
<td>Professional Advisor Leadership &amp; Quality, Effective Healthcare, Education and</td>
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<td>Workforce Team, CNO Directorate. Former national LBC Lead</td>
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<tr>
<td><strong>Ros Moore</strong></td>
<td><strong>Hazel Mackenzie</strong></td>
</tr>
<tr>
<td>CNO for Scotland</td>
<td>Head of the National Leadership Unit, NHS Education Scotland</td>
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<tr>
<td><strong>Ann Murray</strong></td>
<td><strong>Lesley Anne Smith</strong></td>
</tr>
<tr>
<td>National Falls Programme Manager</td>
<td>Quality Improvement Programme Director, NHS Education Scotland</td>
</tr>
<tr>
<td><strong>Clare Mayo</strong></td>
<td><strong>Kathryn Paterson</strong></td>
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<tr>
<td>Policy Officer Royal College of Nursing</td>
<td>Associate Improvement Advisor SPSP</td>
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<td><strong>Elinor Smith</strong></td>
<td><strong>Stuart Cable</strong></td>
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<td>Executive Nurse Director, NHS Grampian</td>
<td>Programme Director (Health and Social Care Integration / Leading Better Care)</td>
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<td><strong>Fiona Mackenzie</strong></td>
<td><strong>Mike Sabin</strong></td>
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<td>Professional advisor Nursing Midwifery Workforce Workload Planning (NMWWP)</td>
<td>Associate Director Nursing and Midwifery, NHS Education Scotland</td>
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<td><strong>Hazel Borland</strong></td>
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<td><strong>Jane Harris</strong></td>
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<td>National programme manager for community nursing CNOPPPD</td>
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<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Margot Russell</td>
<td>LBC facilitator NHS Lanarkshire</td>
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<tr>
<td>Shona Chaib</td>
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<td>Rhoda Walker</td>
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<td>Angela Wallace</td>
<td>Executive Nurse Director NHS Forth Valley and Programme Chair</td>
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<td>Vicky Thompson</td>
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### Responses to 2013 survey of staff in Boards supported by LBC

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</table>
There were 704 responses in total with responses from all territorial Health Board areas and all of the special Boards involved in LBC, except NHS 24. The 2013 survey was distributed by LBC facilitators to all staff within the Board who had been supported by LBC. Most respondents were band 7 (64%, 454) and around a third were band 6 (34%, 236). In addition there were a small number of responses from band 5 (1%, 8) and band 8a (1%, 6).

Responses to 2014 survey to SCNs, SCMs, TLs or equivalent roles

There were 137 responses in total. There were no responses from NHS Ayrshire and Arran, NHS Highland, NHS Orkney, NHS Western Isles or the State Hospital.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Total</th>
<th>Acute hospital</th>
<th>Community hospital</th>
<th>Acute &amp; community hospital</th>
<th>Community</th>
<th>Prison Healthcare</th>
<th>Other</th>
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<td>9</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

There were 704 responses in total with responses from all territorial Health Board areas and all of the special Boards involved in LBC, except NHS 24. The 2013 survey was distributed by LBC facilitators to all staff within the Board who had been supported by LBC. Most respondents were band 7 (64%, 454) and around a third were band 6 (34%, 236). In addition there were a small number of responses from band 5 (1%, 8) and band 8a (1%, 6).

Responses to 2014 survey to SCNs, SCMs, TLs or equivalent roles

There were 137 responses in total. There were no responses from NHS Ayrshire and Arran, NHS Highland, NHS Orkney, NHS Western Isles or the State Hospital.
Responses to 2014 survey to managers of SCNs, SCMs, TLs or equivalent roles

There were 59 responses in total. There were no responses from NHS Ayrshire and Arran, NHS Highland, NHS Orkney, NHS Western Isles, NHS 24 and the State Hospital.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Total</th>
<th>Manager of one or more services within the Board</th>
<th>Direct manager of nursing and / or midwifery staff</th>
<th>Professional lead with responsibilities to support the role development of SCN / SCM / TL</th>
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</table>

NHS Greater Glasgow and Clyde: 33 responses; 13 managers of one or more services within the Board, 2 direct managers of nursing and/or midwifery staff, 14 professional leads with responsibilities to support the role development of SCN / SCM / TL, 4 other.

NHS Lanarkshire: 8 responses; 4 managers of one or more services within the Board, 1 direct manager of nursing and/or midwifery staff, 3 professional leads with responsibilities to support the role development of SCN / SCM / TL, -.

NHS Lothian: 43 responses; 14 managers of one or more services within the Board, 8 direct managers of nursing and/or midwifery staff, 16 professional leads with responsibilities to support the role development of SCN / SCM / TL, 1 other.

NHS Shetland: 3 responses; 1 manager of one or more services within the Board, - direct manager of nursing and/or midwifery staff, 2 professional leads with responsibilities to support the role development of SCN / SCM / TL, 2 other.

NHS Tayside: 2 responses; - managers of one or more services within the Board, - direct manager of nursing and/or midwifery staff, 2 professional leads with responsibilities to support the role development of SCN / SCM / TL, -.

NHS National Services Scotland (SNBTS): 2 responses; - managers of one or more services within the Board, - direct manager of nursing and/or midwifery staff, 1 professional lead with responsibilities to support the role development of SCN / SCM / TL, 1 other.

Golden Jubilee: 1 response; 1 manager of one or more services within the Board, - direct manager of nursing and/or midwifery staff, - professional lead with responsibilities to support the role development of SCN / SCM / TL, - other.
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</table>
APPENDIX 3 – INTERVIEW TOPIC GUIDES

2013 BOARD VISITS

Topic guide for interviews with LBC facilitators

Governance and management of LBC in your Board

1. What has your role as an LBC facilitator involved?
2. How much time do you spend facilitating LBC?
3. What informed the approach to introducing LBC?
4. What is your Board’s governance process and structures for LBC? How helpful has this been?
5. How was LBC managed on a day to day basis?
6. How is it managed now?

Support for implementing LBC

7. What support and guidance have you received at a national and local level to undertake your role? How helpful has this been?
8. To what extent have you participated in the national facilitators meeting? How has this supported you in your role?
9. What other national resources/supports have you used to implement LBC? How helpful have these been?
10. In what ways have you been involved in the decision making about use of LBC funding?

Local implementation of LBC

11. Describe your approach locally to supporting staff to re-focus their role.
12. What was the rationale for this approach? Which staff group/departments were supported in Phase 1 and Phase 2? Who was excluded and why?
13. What were the challenges in introducing LBC at Board level? How were these overcome?
14. How is/was LBC integrated with other local and national programmes or priorities?
Transition to the revised role

15. Can you give some examples of the key differences between the current roles and the pre-LBC role?

16. How are SCNs/SCMs/TLs working differently to:
   - ensure safe and effective clinical practice
   - enhance the patient experience
   - manage and develop the performance of the team; and
   - ensure effective contribution to the delivery of the organisation’s objectives?

17. How are teams working differently compared to pre-LBC?

18. The aim was to have all SCNs/SCMs/TLs working within the revised role by March 2013 – when did/will your Board achieve this? What facilitated/hindered this?

19. What changes in operational policies or procedure supported the implementation of LBC?
   (e.g. standardised job descriptions and t&cs, changes to uniform, use of the pink book)

20. Once staff were supported to re-focus their role, how was the revised role rolled out?
   (e.g. what infrastructure/process changes reinforced the implementation of the revised role?)

21. How did you adapt/develop the support to include staff in the community settings? Have you included Band 6s? What worked well about this? What were the challenges?

Information & evidence

22. How were CQIs introduced to SCNs/SCMs?

23. How have CQIs been used in your Board? What has worked well about implementing them? What has been challenging?

24. How valuable have the CQIs been to clinical practice and improving patient outcomes?

25. The aim was to have CQIs in place in the majority of inpatient areas by end of 2010 – to what extent did your Board achieve this? What facilitated/hindered this?
Education & development

26. Has the Education and Development Framework (‘the Pink Book’) been used to support individuals? How has it been used? Why hasn’t it been used?

27. How is it used alongside other educational, development and learning resources?

28. Which elements of the pink book were most useful? What was least useful? Why is that?

29. How has it been used by staff in the different settings?

30. How does your Board evidence the transition and enactment of the revised role?
Topic guide for interviews with Executive Nurse Directors

Governance and management of LBC

1. What is your strategic role in LBC across your Board?
2. What did you hope LBC would achieve in your Board?
3. What informed the approach?
4. What are the local governance arrangements and how have these worked?
5. How was/were the LBC facilitator/s selected for their role?

Local implementation of LBC & national support

6. How have you used the funding to support LBC implementation in Phase 1 & 2?
7. What were the challenges in introducing LBC across the different sites and settings in your Board? How were these overcome?
8. How is/was LBC integrated with other local and national programmes or priorities?
9. How effective have the project management and support arrangements been at a national programme level?

Enactment of LBC

10. How have SCN/SCM/TLs been used to deliver organisational objectives and does this differ to the pre-LBC role?
11. How is the revised role taken into account in workforce planning and development?
12. How is the revised role taken into account in planning education and development needs?

Evidencing LBC

13. The aim was to have all SCNs/SCMs/TLs working within the revised role by March 2013 – when did/will your Board achieve this? What facilitated/hindered this?
14. How does your Board evidence the transition and enactment of the revised role?
Topic guide for Focus Groups

Introduction to LBC and support to move into the revised role

1. How was LBC introduced to you?

2. What help or support did you receive to re-focus your role? (organisational, education & development, supervision)

3. What worked well about this support that you received?

4. What worked less well?

5. How has LBC linked to other local and national programmes and priorities?

Working in the revised role

6. As a result of LBC, what are the key differences between your current role and your role pre-LBC?

7. Giving examples, as a result of your revised role, how are you or your team are now working differently to:
   - ensure safe and effective clinical practice
   - enhance the patient experience
   - manage and develop the performance of the team and
   - ensure effective contribution to the delivery of the organisation’s objectives?

8. What, if anything, was challenging about transitioning to the revised SCN/SCM/TL role?

   What has helped overcome these challenges? (e.g. standardised job descriptions and t&cs, changes to uniform, use of the education & development framework, also known as the pink book)

9. What continued support have you received to work within the revised role? How has it helped?

10. Have you used the Education and Development Framework ('the Pink Book') If not, why not?

11. How have you used it to support you or your team? Are you still using it?

12. Which elements were most useful and why?

13. Which elements were least useful and why?
Topic guide for interviews with Strategic Stakeholders

Governance and management of LBC in your Board

1. What has been your role in supporting the planning and implementation of LBC?
2. What is your Board’s governance process and structures for LBC? How helpful has this been?
3. How was LBC managed on a day to day basis?
4. How is LBC managed now?
5. What informed the approach to introducing LBC?
6. How was/were the LBC facilitator/s selected for their role?

Local implementation of LBC

7. Describe your approach locally to supporting staff to re-focus their role.
8. Which staff group/departments were supported in Phase 1 & Phase 2? Who was excluded and why?
9. What were the challenges in introducing LBC at Board level? How were these overcome?
10. How did you use the funding to facilitate implementation?
11. What other national resources/supports have you used to implement LBC? How helpful have these been?
12. How is was LBC integrated with other local and national programmes or priorities?

Transition to the revised role

13. Can you give some examples of the key differences between the current roles and the pre–LBC role?
14. How are SCNs/SCMs/TLs working differently to:
   - ensure safe and effective clinical practice
   - enhance the patient experience
   - manage and develop the performance of the team; and
   ensure effective contribution to the delivery of the organisation’s objectives?
15. How are teams working differently compared to pre–LBC?
16. The aim was to have all SCNs/SCMs/TLs working within the revised role by March 2013 – when did/will your Board achieve this? What facilitated/ hindered this?

17. What changes in operational policies or procedure supported the implementation of LBC? (e.g. standardised job descriptions and t&cs, changes to uniform, use of the pink book)

18. Once staff were supported to re-focus their role, how was the revised role rolled out? (e.g. what infrastructure/process changes reinforced the implementation of the revised role?)

19. How did you adapt/develop the support to include staff in the community settings? Have you included Band 6s? What worked well about this? What were the challenges?

Information & evidence

20. How were CQIs introduced to SCNs/SCMs?

21. How have CQIs been used in your Board? What has worked well about implementing them? What has been challenging?

22. How valuable have the CQIs been to clinical practice and improving patient outcomes?

23. The aim was to have CQIs in place in the majority of inpatient areas by end of 2010 – to what extent did your Board achieve this? What facilitated/hindered this?

Education & development

24. How has the Education and Development Framework (‘the Pink Book’) been used to support individuals?

25. How is it used alongside other educational, development and learning resources?

26. Which elements of the pink book were most useful? What was least useful? How well has it been used? Why/why not?

27. How has it been used by staff in the different settings?

28. How does your Board evidence the transition and enactment of the revised role?
Topic guide for interviews with National Stakeholders

1. What was your role on the programme board/what has your involvement in the development or implementation of LBC?
2. Why did you become involved?
3. What did you hope LBC would achieve?

Approach to introducing LBC & supporting the Boards

4. How was the programme of work identified?
5. What were the challenges in introducing the national LBC programme at Board level? How were these overcome?
6. How was the national action plan developed? How was it used?
7. How effective have the governance arrangements been at the national level?
8. How effective have the project management arrangements at a national level been?
9. How did you expect funding to support implementation at Board level?
10. How is/was the LBC initiative integrated with other national programmes or priorities?

Implementation of LBC

11. How did you expect LBC to roll out across NHS Scotland and to what extent has that been realised?
12. What are the challenges with introducing a national requirement for a standardised role across all Boards in Scotland?

Enactment of LBC

13. Have you experienced or witnessed any changes in the role of SCN/SCM/TL since LBC commenced?
2014 Board visits – Interview topic guides

Topic guide for interviews with LBC facilitators

Perceptions on the impact of LBC

1. How aware are staff teams about the changes to the SCN/SCM/TL role?

2. In what ways are SCNs/SCMs/TLs accessible and visible to their teams, their colleagues and their patients or service users?

3. In what ways, if any, is the working environment in units/settings different, e.g. ethos, culture, morale, organisation, since LBC?

4. As a result of LBC, how has the service to the patient or service user changed?

5. (If able to comment) As a result of LBC what positive changes did you expect to see for:
   a. staff teams
   b. units/settings
   c. patients or service users

6. To what extent have these changes been realised?

7. What other changes have occurred as a result of LBC?

8. How will the impact of LBC (on patients or service users, on teams, on service provision) continue to be evidenced in your Board?

Key lessons for further development of LBC particularly educational & practice issues

9. What aspects of the revised role still need to be addressed/enhanced?

10. How will this be achieved?

11. How are new staff supported to fulfil the role of SCN/SCM/TL?

12. The Education Development Framework supports LBC, how can this resource be even more effective in supporting SCN/SCM/TL and reinforcing the way in which they fulfil their role?

13. How will existing SCNs/SCMs/TLs continue to be supported to deliver all elements of their role?

14. How is this activity being resourced?

15. How are LBC practice and principles being embedded?

16. What national resources/support or priorities could assist in the reinforcement of LBC principles and practice?
Topic guide for interviews with END or AND

Perceptions on the impact of LBC

1. As a result of LBC what positive changes did you expect to see for:
   a. staff teams
   b. units/Settings
   c. patients or service users

2. To what extent have these changes been realised?

3. As a group, how are SCNs/SCMs/TLs working collectively? If able to comment, how has LBC supported this?

4. How has a more standardised role impacted on the Board?

5. In what ways are SCNs/SCMs/TLs involved in driving strategic priorities? Is this what you expect/want it to be?

6. What other changes have occurred as a result of LBC?

7. How will the impact of LBC (on patients or service users, on teams, on service provision) continue to be evidenced in your Board?

Key lessons for further development of LBC particularly educational & practice issues

8. What aspects of the revised role still need to be addressed/enhanced?

9. How will this be achieved?

10. How are new staff supported to fulfil the role of SCN/SCM/TL?

11. The Education Development Framework supports LBC, how can this resource be even more effective in supporting SCN/SCM/TL and in reinforcing the way in which they fulfil their role?

12. How will existing SCNs/SCMs/TLs continue to be supported to deliver all elements of their role?

13. How is this activity being resourced?

14. How are LBC practice and principles being embedded?

15. What national resources/support or priorities could assist in the reinforcement of LBC principles and practice?
Interview topic guide for focus groups (or telephone interviews) with staff nurses

1. Did you know the role of SCN changed in 2008 (for SCMs & TLs 2010)?
   a. If yes, in what way?

2. What is your general view of the SCN/SCM/TL role in the way they:
   a. provide clinical expertise?
   b. manage the ward or setting?
   c. create a positive patient experience?
   d. create a positive learning & working environment?
   e. lead the team?
   f. influence or contribute to wider service developments?

3. How has this changed since pre-LBC (where able to comment)?

4. How, if at all has this changed your view of the SCN/SCM/TL role?

5. How is your SCN/SCM/TL accessible to you and your team? e.g., appropriately located?

6. What role does the SCN/SCM/TL play in directing clinical practice?

7. How are learning and development organised/supported in your unit?

8. How has this changed (if around pre-LBC)?

9. What role does the SCN/SCM/TL play in Learning & Development?

10. What specific support have you received from SCN/SCM/TL in facilitating your learning and development?

11. What other support have you received to facilitate your learning and development, e.g. through practice development, organisational development, etc?

12. How do you see/hope your career will progress? Is the SCN/SCM/TL role an attractive prospect?

13. What training and development opportunities can you access that will support your career development?
Case study examples of the impact of LBC – SCN/SCM/TL & their Band 6/5

The discussions should gather detailed case study examples of the positive impact LBC has made in terms of improving the patient or service user experience; the management of the setting/unit; the operation of the team; and/or the way the SCN/SCM/TL contributes to strategic policy and practice.

The discussions will include questions that describe the change and explore:

- the rationale for the change and what it was inspired by
- what this involved
- who provided support to make these changes
- how others were convinced of the need for the change

The focus will then be on the impact and consider:

- What has this change/these changes resulted in for:
  - you?
  - your team?
  - your unit or setting?
  - your patients/service users?
- What evidence do you have of these results?
- How, if at all, did the Education Development Framework (Pink Book) support you to achieve this change?
- How could this resource be even more effective in supporting you or future SCN/SCM/TLs to fulfil the role?
**Topic guide for interviews with Nurse Managers**

**Perceptions on the impact of LBC**

1. How aware are staff teams about the changes to the SCN/SCM/TL role (since 2008 SCN and 2010 SCM/TL)?

2. In what ways are SCNs/SCMs/TLs accessible to their teams, their colleagues and their patients or service users?

3. What is the SCNs/SCMs/TLs role in supporting learning & development in their units/settings? If able to comment, what was their role pre-LBC?

4. What is the SCNs role in directing clinical practice in their units/settings? If able to comment, what was their role pre-LBC?

5. In what ways, if any, is the working environment in units/settings different, e.g. ethos, culture, morale, organisation, since LBC?

6. In what ways are SCNs/SCMs/TLs visible to their teams, their colleagues and their patients or service user? If able to comment, how has this changed since pre-LBC?

7. As a result of LBC, how has the service to the patient or service user changed?

8. How have the service changes affected the patient or service user and their family's experience?

9. As a group, how are SCNs/SCMs/TLs working collectively? If able to comment, how has this changed since pre-LBC?

10. How has a more standardised role impacted on the Board?

11. How, if at all, has the standardised role impacted on the attractiveness of these posts?

12. In what ways are SCNs/SCMs/TLs involved in driving strategic priorities? Is this what you expect/want it to be?

13. (if able to comment) As a result of LBC what positive changes did you expect to see for:
   a. staff teams
   b. units/settings
   c. patients or service users

14. To what extent have these changes been realised?

15. What other changes have occurred as a result of LBC?

16. How will the impact of LBC (on patients or service users, on teams, on service provision) continue to be evidenced in your Board?
Key lessons for further development of LBC particularly educational & practice issues

17. What aspects of the revised role still need to be addressed/enhanced?

18. How will this be achieved?

19. How are new staff supported to fulfil the role of SCN/SCM/TL?

20. The Education Development Framework (Pink Book) supports LBC, how can this resource be even more effective in supporting SCN/SCM/TL and reinforcing the way in which they fulfil their role?

21. How will existing SCNs/SCMs/TLs continue to be supported to deliver all elements of their role?

22. How is this activity being resourced?

23. How are LBC practice and principles being embedded?

24. What national resources/support or priorities could assist in the reinforcement of LBC principles and practice?
Topic guide for interviews with National Stakeholders

1. What has been your involvement in the implementation or monitoring of LBC?

2. Overall to what extent do you think that LBC is achieving its aims?

3. When considering LBC we have identified a range of different potential outcomes:
   - primary ones which are outcomes for the staff supported by LBC,
   - secondary outcomes which are the impacts on NHS Boards and teams and units, and
   - tertiary outcomes which are the outcomes in care experienced by patients / carers.

   Amongst these, do you think any particular outcomes have been achieved more than others?

4. What positive changes did you personally expect to see from LBC? To what extent have they been realised?

5. Are there factors that you think have particularly influenced (contributed to or hampered) the extent to which LBC has had an impact? Are these local or national influences?

6. Where/how should national resources / support be prioritised to assist in the reinforcement and sustainability of LBC principles and practice?

7. What further local resources / support or priorities could assist in delivering LBC?

8. With hindsight, what could have been done differently that would have increased the impact of LBC and ensured the introduction of the standardised role across Scotland?

9. In the current climate, what policy drivers will reinforce LBC principles and practice?

10. What do you think should be the priority for further development / sustainability of LBC?
APPENDIX 4 – SURVEY QUESTIONS

Survey Questions – 2013 survey of staff in Boards supported by LBC

About you

1. From the list below please select which Health Board you are based in (drop down)
2. In which setting do you work?
3. In which area/s do you work? (tick all that apply)?
4. What is your Agenda for Change band?
5. How long have you been in your current role for?
   - Less than 5 years
   - More than 5 years
6. Are you currently non-caseload holding on every shift you work, except emergencies?
7. Has this changed as a result of LBC?
8. If you work in community, do you have a reduced caseload?
9. Has this changed as a result of LBC?
10. Do you manage staff?
11. [if yes] How many staff? [tick box]

Support from Leading Better Care from your NHS Board

LBC introduces four key role dimensions – ensuring safe and effective clinical practice; enhancing patients’ experiences; managing and developing team performance; and contributing to the delivery of the organisation’s objectives.

12. What support did you receive to focus your role on these four dimensions? (tick all that apply)
   - LBC course/training programme
   - 1:1 support from a facilitator (e.g. LBC, Practice Development, Organisational Development)
   - 1:1 support from your line manager
   - Action Learning sets
   - Peer support meetings
   - LBC workshops
   - Coaching
   - Other (please specify)
13. [If course/training/workshops] Over how many days in total did your course/training/workshops run?
14. Please indicate how relevant you felt the support was that you received through LBC.
[scale very relevant, quite relevant, not very relevant, not relevant at all]

15. Please feel free to comment on your answer

16. Please indicate how you feel about the quality of the support you received.
   [scale very high quality, fairly high quality, fairly low quality, very low quality]

17. Please feel free to comment on your answer

Changes as a result of LBC

18. Has LBC made a difference to the way you are working?

19. [If no] please expand on your answer

20. [If yes] what has changed for you as a result of LBC? (tick all that apply)
   - Reduced case load
   - Increased caseload
   - Increased HR administration
   - Increased clinical supervision of staff
   - Increased auditing / improvement activities
   - More visible presence on the ward/unit/team
   - Provided me with greater clarity about the role
   - More accessible to patients and their families and carers
   - Increased sharing and learning with other wards/units/teams
   - No case load
   - Decreased HR administration
   - Increased general administration
   - Decreased general administration
   - Increased management of the workforce
   - Increased input into organisational issues
   - Greater job satisfaction
   - Less job satisfaction
   - Greater clarity about my role for other members of staff
   - Increased use of improvement techniques to address quality
   - Other (please specify)

21. What has been most challenging about working towards the four role dimensions of:
   - Ensuring safe and effective clinical practice
   - Enhancing the patient experience
   - Managing and developing the performance of the team
   - Ensuring effective contribution to the delivery of the organisation’s objectives

22. Out of the four role dimensions, which, if any, do you feel you do not have enough time or capacity to undertake? (tick all that apply)
   - Ensuring safe and effective clinical practice
   - Enhancing the patient experience
   - Managing and developing the performance of the team
   - Ensuring effective contribution to the delivery of the organisation’s objectives
23. Have any of the following supported /reinforced your work? (tick all that apply)
   - Revised job description
   - New uniform
   - Education and Development Framework (‘the Pink Book’)
   - Reduced caseload
   - Awareness raising with senior/strategic staff
   - Clinical Quality Indicators
   - Workload and workforce planning
   - Other improvement work – i.e. SRI / MHICPs / SPSP/HAI/RTC
   - Other (Please specify)

Continued support

24. What continued support have you received to reinforce your role? (tick all that apply)
   - Peer support
   - 1:1 support from line manager (as part of PDP/KSF)
   - 1:1 support from a facilitator (e.g. LBC, Practice Development, Organisational Development)
   - Follow-up events/refreshers
   - Coaching
   - LBC Impact Resource
   - Other (please specify)

Clinical Quality Indicators

25. Do any of the CQIs (Falls, Pressure, Area Care & Food, Fluid & Nutrition) apply in your area of work?
26. [If yes] How are the CQIs used?
27. [If yes] How valuable are the CQIs in enhancing the patient experience?
   [scale – very valuable, quite valuable, not particularly valuable, not at all valuable]
28. If yes] How valuable are the CQIs in enhancing clinical practice?
   [scale – very valuable, quite valuable, not particularly valuable, not at all valuable]

Education and Development Framework

29. Have you used the Education and Development Framework (also referred to as ‘the Pink Book’)?
30. [If no or you don’t know] what is this due to? (tick all that apply)
   - I haven’t seen it /I’m not familiar with it
   - I haven’t had time
   - I don’t have a hard copy
   - I don’t think it’s that useful
   - I don’t know how to use it
• I’ve been put off by the length of the document
• Other (please specify)

31. [If yes] How have you used it? (tick all that apply)
   • I’ve completed sections as part of the LBC course/training
   • As an education and development resource to develop my role
   • To help support my staff
   • To help me with promotion/applying for jobs
   • To personally reflect on my learning and development
   • To form the basis of my supervision with my line manager
   • Alongside the LBC impact resource
   • Other (please state)

32. How helpful has the Education and Development Framework been in clarifying the role of the Senior Charge Nurse/Senior Charge Midwife/Team Leader. [Scale very helpful, quite helpful, not particularly helpful, not at all helpful]

33. How could it have been more helpful? [open response]

Other comments

34. Do you have any other comments you’d like to make about your experience of LBC and your role? [open response]
Survey questions 2014 – Impact of Leading Better Care for Managers of Senior Charge Nurses, Senior Charge Midwives, Team Leaders or equivalent

About you

1. Please select which Health Board you are based in (drop down)

2. Which of the following best describes your management responsibilities? (Please all that apply)
   - Manager of one or more services within the Board
   - Direct manager of nursing and / or midwifery staff
   - Professional lead with responsibilities to support the role development of SCN / SCM / TL
   - Other (please specify)

Your introduction to Leading Better Care

3. How was Leading Better Care introduced to you? (Please tick all that apply)
   - I attended training, workshops or information sessions specifically aimed at managers of staff supported by LBC
   - I attended training, workshops or information sessions for staff supported by LBC
   - I had an informal introduction to LBC from a LBC facilitator or other staff
   - I was introduced to LBC through existing local meetings or professional forums
   - I had no introduction to LBC
   - Unsure / I don’t remember
   - Other (please specify)

4. How useful was this introduction?
   [Scale very useful, somewhat useful, not at all useful, unsure/don’t know]

5. On the basis of your knowledge about Leading Better Care what outcomes did you expect to see in relation to:
   - staff working within the role framework? Please explain [open response]
   - the way teams are led, managed and supported? Please explain [open response]
   - the experiences of patients and families? Please explain [open response]

The implementation of Leading Better Care

6. To what extent do you think the role framework is embedded within the team of staff you manage?
   [Scale very embedded, somewhat embedded, not at all embedded, unsure]

7. How consistent do you think this is across your Board?
   [Scale very consistent, somewhat consistent, not consistent at all, unsure]
8. What tools and resources do you currently use to support your staff to work within the role? Please tick all that apply

- The Education and Development Framework (‘the Pink Book’)
- The Impact Resource Tool
- The Clinical Quality Indicators (CQIs)
- Performance management tools
- Improvement tools
- Training, learning and development resources
- None
- Other (please describe)

9. Please specify the training, learning and development resources you use to support your staff to work within the role [open response]

10. What do you use these tools or resources for? (Please tick all that apply)

- Identifying learning and development needs of SCN / SCM / TLs
- Supporting the learning and development of SCN / SCM / TLs
- Managing the performance of SCN / SCM / TLs in relation to the dimensions within the role framework
- Monitoring and improving quality of care
- Workforce planning
- Other (please specify)

Your views on the impact of Leading Better Care

11. Referring to the outcomes you expected to see resulting from Leading Better Care (your answer to Q5 above), have these outcomes been realised? Please explain [open response]

12. How, if at all, has the range of support for Leading Better Care affected your Board’s investment in the leadership and development of staff at other levels? Please explain [open response]

13. What impact, if any, has the delivery of Leading Better Care had on your own role or professional development? Please explain [open response]

Sustainability of Leading Better Care principles and practice

14. In managing your team, in what ways have you been able to build on Leading Better Care principles and practice? Please explain [open response]

15. What local or national factors do you feel have helped to embed the standardised role framework for SCNs, SCMs and TLs in your Board? Please explain [open response]
16. What local or national factors do you feel have not helped to embed the standardised role framework for SCNs, SCMs and TLs in your Board? Please explain [open response]

17. Are there any changes to Leading Better Care you would like to see with regard to:
   - the content or functionality of the Education and Development Framework? Please give details [open response]
   - the support provided for LBC within your Board? Please give details [open response]
   - national resources or priorities to reinforce LBC? Please give details [open response]
   - promotion of LBC and the role framework? Please give details [open response]
   - monitoring, reporting or performance measurement of LBC from a national and/or local perspective? Please give details [open response]
   - anything else not covered in the above options? Please give details [open response]

Other comments

Do you have any other comments you'd like to make about Leading Better Care? [open response]
Survey questions 2014 – Impact of Leading Better Care for Senior Charge Nurses, Senior Charge Midwives, Team Leaders or equivalent

About you

1. Please select which Health Board you are based in (drop down)

2. In which setting do you work? (Please tick one)
   - Acute hospital
   - Community hospital
   - Acute and community hospital
   - Community
   - Prison Healthcare
   - Other (please specify below)

3. What is your role? (Please tick one)
   - Senior Charge Nurse
   - Senior Charge Midwife
   - Team Leader
   - Other (please specify below)

How you use Leading Better Care

4. What tools and resources do you and your manager currently use to work within the LBC role framework? Please choose from the answer options below for each one

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<th>My manager uses it</th>
<th>We both use it</th>
<th>We don't use it</th>
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5. If you use any training, learning and development resources, please specify which you and/or your manager use to work within the role [open response]

6. What do you use these tools or resources for? (Please tick all that apply)
   - To identify my learning and development needs
   - To support the learning and development of more junior staff in my team
   - To review my performance in relation to the dimensions within the role framework
   - To monitor and improve quality of care
   - Workforce planning
   - Other (please specify)

7. Out of the four role dimensions which, if any, do you feel you do not have enough time or capacity to undertake? (Please tick all that apply)
   - Ensuring safe and effective clinical practice
   - Enhancing the patient experience
   - Managing and developing the performance of the team
   - Ensuring effective contribution to the delivery of the organisation's objectives
   - None – I have time and capacity for all of the above

7a. Please explain your response [open response]

Your views on the impact of Leading Better Care

8. What outcomes did you expect to see resulting from LBC in relation to:
   - your development? (for example, your confidence, knowledge, skills etc) Please explain [open response]
   - your role? (for example, changes to your day-to-day job, greater clarity, authority, visibility, accessibility etc) Please explain [open response]
   - your team? (for example, the way it operates, communicates, delivers care etc) Please explain [open response]
   - the experiences of patients and families? Please explain [open response]

9. Have the outcomes you expected to see from LBC been realised? (Please tick one)
   - Yes
   - No

9a. Please explain your response [open response]

10. To what extent has LBC made a difference to the way you are working?
    [Scale a major difference, some difference, no difference]

10a. Please explain your response [open response]
Sustainability of Leading Better Care principles and practice

11. What local or national factors do you feel have helped to embed the four role dimensions in your setting or Board? Please explain [open response]

12. What local or national factors do you feel have not helped to embed the four role dimensions in your setting or Board? Please explain [open response]

13. Are there any changes to LBC you would like to see with regard to:
   - the content or functionality of the Education and Development Framework? Please give details [open response]
   - the support provided for LBC within your Board? Please give details [open response]
   - national resources or priorities to reinforce LBC? Please give details [open response]
   - promotion of LBC and the role framework? Please give details [open response]
   - monitoring, reporting or performance measurement of LBC from a national and / or local perspective? Please give details [open response]
   - anything else not covered in the above options? Please give details [open response]

Other comments

14. Do you have any other comments you would like to make about Leading Better Care? [open response]