



Health Education South London

Evaluation of the 'Rotational Post - End of Life Care, Cancer Care and Care of the Elderly' Project

**A Report by the Department of Adult Nursing and Paramedic Science,
Faculty of Education and Health at the University of Greenwich**



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January 2018



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Contents

Executive Summary	4
1. Background, aim and objectives of evaluation	6
1.1 Background	6
1.2 Aim & objectives of the present evaluation	7
2. Materials and Methods	8
2.1 Evaluation Methods	8
2.2.1 Focus groups with nurses who participated in the placements	8
2.2.2 Interviews with key stakeholders in the project	8
2.2.3 Data Analysis	9
3. Results	10
3.1 Participants and organisations taking part	10
3.1.1 Characteristics of the placement nurses who participated	10
3.1.2 Characteristics of the stakeholders who participated in the evaluation	10
3.1.3 Organisational issues emerging over the course of the project	11
3.2 Perceived aims and expectations of the programme	11
3.2.1 Rotational nurses' expectations of, and reasons for, taking part in the project	12
3.2.2 Stakeholders' understanding and expectations of the project	14
3.3 Perceived impact of the programme on nurses' professional development	15
3.3.1 Rotational nurses' accounts of the impact of the project on their professional development	16
3.3.2 Stakeholders' accounts of the impact of the project on nursing participants' professional development	17
3.4 Perceived impact of the project on participating nurses' confidence in managing ageing, dying and end of life care	18
3.4.1 Rotational nurses' accounts of the impact of the project on their confidence in managing ageing, dying and end of life care	18
3.4.2 Stakeholders' accounts of the impact of the project on nursing participants' confidence in managing ageing, dying and end of life care	20

3.5 Perceived impact of the project on participating nurses' communication skills with families and patients and ability to work in the multidisciplinary team.....	21
3.5.1 Rotational nurses' accounts of the impact of the project on their ability to work in the multidisciplinary team and communication skills.....	21
3.6 Perceived challenges and potential areas of improvement within the project	25
3.6.1 Perceived challenges in, and potential solutions for, the perceived clash of organisational cultures.....	25
3.6.2 Perceived challenges with, and potential solutions for, the structured learning element of the project.....	26
3.6.3 Perceived challenges with, and potential solutions for, the order, number and length of placements	27
4. Discussion of the aims, in relation to, the findings of the study.....	29
4.1 Overview	29
4.1.1 Meeting Aim 1: Promoting the development of a well trained workforce	29
4.1.2 Meeting Aim 2: Contributing to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome.....	29
4.1.3 Meeting Aim 3: Providing opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and the impact on wider workforce	30
4.1.4 Meeting Aim 4: Improving staff morale by increasing their knowledge and skills in end of life care	30
4.1.5 Meeting Aim 5: Providing opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway.....	30
4.2. Limitations of the study	31
4.3. Recommendations from the study	31
5. Conclusion.....	35
Appendix 1	36
Appendix 2	40

Executive Summary

In 2017, South London Hospices Education Collaborative approached the University of Greenwich to conduct an evaluation of the first year of the 'Rotational Post - End of Life Care, Cancer and Care of the Elderly' Project. The original project had offered newly-qualified and developing band 5 nurses (within 3 years of qualifying) the opportunity to work in three care settings over the course of a year (4 month blocks) with support from palliative care professionals, managers and the project lead. The nurses also undertook a postgraduate module in palliative care or a relevant topic. The identified care settings were - specialist inpatient palliative care in hospices, oncology wards, and care of the frail elderly in intermediate care settings or similar community provision.

The evaluation began in September 2017 and its aim was to evaluate the perceived and felt impact of the project as assessed by the nurses who took part and the key staff (stakeholders) in the host organisations. Qualitative focus groups (with participating nursing staff) and interviews (with stakeholders) were conducted and analysed to assess the perceived impact the project had on stakeholders' and participating nurses' perceptions and experiences of the rotation project, and whether the project had, according to participants' accounts, attained its original aims.

The data presented in this report are the outcome of gathering and analysing data from two focus groups (N = 7 & 5 participants) with nurses who rotated during the project, and seven interviews with stakeholder participants who rotated their own, and hosted other organisations', staff.

The evaluation found that the project has met its intended aims in the following ways:

Aim 1: Promoting the development of a well trained workforce;

Evidence of attainment: Participating nurses and stakeholders reported an enhancement of participating nurses' practice, interprofessional and clinical skills as a result of increased exposure to, and understanding of the practices of, different care sectors during the rotation.

Aim 2: Contributing to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome;

Evidence of attainment: Participating nurses and stakeholders reported participants had developed a firm understanding that a 'good death' was possible in all sectors of care – acute, community and hospice – and that this had informed a greater understanding of the different routes on the patient pathway.

Aim 3: Providing opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and the impact on the wider workforce;

Evidence of attainment: Participating nurses and stakeholders reported improvements in the participating nurses' professional development, this in and of itself offered a clear level of experience, knowledge and skill that developed the individuals' readiness for career progression. Also, two of the participating nurses were promoted during the project.

Aim 4: Improving staff morale by increasing their knowledge and skills in end of life care;

Evidence of attainment: Participating nurses and stakeholders reported improved confidence in communication skills around death and dying, greater understanding of the patient pathway, as well as greater understanding of the role of other health sectors and multidisciplinary working in the nurses who took part.

Aim 5: Providing opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway;

Evidence of attainment: Participating nurses and stakeholders reported cross-pollination of knowledge and skills being engendered by exposure to different care sectors.

Recommendations and areas for improvement emerged largely from the participants themselves. It is recommended that consideration be given to adjusting the length and number of placements in the project so that there are fewer periods of adaption for participants in the whole rotation; also that consideration be given to more structured support – both more advice and more study days – be given to participants so they can engage fully in the education module available during the rotations; and it is strongly recommended that the induction, guidelines and named support given to participants be improved in some acute sector placements.

1. Background, aim and objectives of evaluation

1.1 Background

London is particularly challenged around recruitment and retention of healthcare professionals. Recruitment problems necessitate innovative approaches to attract staff to work with people with life limiting illnesses and those facing the end of life. Equally, the quality of care for people who are dying in hospital as well as in the community is particularly important. For example, the National Cancer Patient Experience Survey Programme undertaken by Quality Health on behalf of NHS England, highlighted the progress that has been made with treatment of cancer, but also raised concern about a lack of progress on improving the patient experience, particularly for Londoners.¹ The National Survey of Bereaved Relatives² reported that patients' relatives rated hospital doctors and nurses less well than those working in other settings at ensuring that their loved ones were treated with dignity and respect but in the same survey, hospice staff ranked the highest (Office for National Statistics, 2014). Concurrent to this context, the Nursing and Midwifery Council updated the Code of Conduct for nurses and midwives to highlight the importance of delivering fundamental care to dying people so that they can expect to receive the high standard of care afforded to any other person needing nursing care.

In light of the above, the 'Rotational Post - End of Life Care/Cancer Care and Care of the Elderly' project offered developing band 5 nurses (within 3 years of qualifying) the opportunity to work in three care settings over the course of a year (in 4 month blocks) with support from palliative care professionals, managers and the project lead. The nurses also undertook a postgraduate module in palliative care or a relevant topic. The three care settings were - specialist inpatient palliative care in hospices, oncology wards and in care of the frail elderly in intermediate care settings or similar community provision. Throughout the course of the programme the participants were exposed to experiences designed to enable them to gain a better understanding and develop end of life and palliative skills focused on multidisciplinary team working, communication, working with patients and families, leadership and symptom control.

The primary aims of the Rotational Post - End of Life Care/Cancer and Care of the Elderly' Project were to:

- Promote the development of a well trained workforce;
- Contribute to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome;
- Provide opportunities for staff to develop their careers with clear opportunities for impact on the wider workforce and progression into more senior roles;

¹ Quality Health (2013) National Cancer Patient Experience Survey Available at: <https://www.quality-health.co.uk/surveys/national-cancer-patient-experience-survey> (accessed 19/01/2017).

² Office of National Statistics (2016) Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/previousReleases> (accessed 19/01/2017).

Evaluation of the 'Rotational Post - End of Life Care, Cancer Care and Care of the Elderly' Project

- Improve staff morale by increasing their knowledge and skills in end of life care;
- Provide opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway.

The project sought to give participating nurses experiences of end of life, cancer care and elderly care. Equally these would take place in both acute, hospice and community settings in the following organisations: Greenwich & Bexley Community Hospice; St Christopher's Hospice, Royal Trinity Hospice; Greenwich and Lewisham NHS Trust (Cancer care), Oxleas NHS Foundation Trust (community care); Kings College Hospital NHS Trust (elderly care and oncology), and St George's Hospital NHS Trust (elderly care and oncology).

1.2 Aim & objectives of the present evaluation

The aim of the present study was to evaluate the perceived impact of the project on the participants who took part in the project, and to gauge whether the project has, according to participants' accounts, attained its original aims.

The objectives in support of this aim sought to:

- 1) Assess the impact of the project on the participating nurses' perceptions and experiences of working in End of Life Care, Cancer Care and Care of the Elderly;
- 2) Gauge the impact of the intervention on the participating nurses' perceptions of their career development;
- 3) Explore the stakeholders' (participating palliative care professionals', managers' and the project leads') perceptions of how the project has impacted at an organisational level - including any outcomes they experienced;
- 4) Explore any benefits and challenges participants perceived with the project;
- 5) Provide a report of the findings of the evaluation including recommendations.

2. Materials and Methods

2.1 Evaluation Methods

This was a qualitative study adapting a research case study approach³ to evaluate the project, semi-structured interviews and focus groups to collect data. In order to meet objectives 1-4 above, the researchers conducted qualitative interviews (with stakeholder participants) and focus groups (with nursing participants who rotated placements). The study adopted a realist theoretical position, meaning we believed the participants' accounts are an accurate reflection of their subjective experiences and perceptions.

2.2.1 Focus groups with nurses who participated in the placements

Nursing participants who participated in the placements (N=10 in total) were invited to take part in focus groups held at naturally occurring meetings for this group, e.g. training days. Participants were recruited by the researchers on the day of the training, following an introductory email with an attached information sheet a week earlier. On the training day the researcher then verified participants had received the information, and invited them to attend the focus groups.

The topic guide (see Appendix One) included questions on:

- Nurses' reasons for taking part in the rotational placement project (and whether they were later met);
- Nurses' confidence in delivering elderly and end of life care;
- Impact of the project on nurses' experiences of working in multidisciplinary teams and their communication skills;
- Perceived benefits and challenges experienced by these participants.

The topic guides (see Appendix One) for the focus groups were designed to have 'read across' questions from the first to the second focus groups. Correspondingly, the interview schedule questions (see Appendix Two) for stakeholder participants were designed to 'read across' to the rotational nurse participants' focus groups to allow for direct comparison, and hence reflected the topics in the focus groups.

2.2.2 Interviews with key stakeholders in the project

Stakeholder participants - key persons listed as facilitating the project within each of the organisations taking part, e.g. senior managers in host organisations and mentors on the placements - were invited to take part in semi-structured interviews. A list of all people who took part in a stakeholder capacity was drawn up by organisation, role and sector by the project's steering group. A convenience sampling approach was used, i.e. those willing to take part were interviewed until all the above criteria were represented. Potential participants were invited by the researcher to take

³ Yin RK. Case study research, design and method. 4. London: Sage Publications Ltd.; 2009.

part in the study. They were given an information sheet and were informed that a researcher would like to contact them about taking part in the evaluation. It was made clear at contact that a refusal did not affect their working rights, that participation was voluntary and confidentiality would be maintained. Interviews were conducted either by telephone or in-person depending on the interviewees' preferences.

2.2.3 Data Analysis

Qualitative data from interviews and focus groups were analysed thematically using the Framework Analysis method. This is a method of analysis developed by the National Centre for Social Research, which is frequently used in health service-related research. One advantage of this method is that it provides systematic and visible stages to the data analysis process⁴. The approach involves five key stages: familiarisation, identification of a provisional thematic framework, indexing, charting, then mapping and interpretation. In short, data were read through and common themes in the responses developed and identified. The codes and thematic framework were then applied to all responses. Multiple coders were employed to enhance the rigour of the analysis.

⁴ Ritchie, J., and Lewis, J., (2006). *Qualitative research practice: a guide for social science students and researchers*. London: Sage.

3. Results

3.1 Participants and organisations taking part

3.1.1 Characteristics of the placement nurses who participated

Two focus groups took place – one close to the beginning of the project with seven participants (70% of all potential participants), and another at the end of the project with five participants – a total of five (55%) of the participants (still in the project) participated in *both* focus groups. Table 1 below shows which organisation the participant originated from (first placement) and their second and third placements:

	Greenwich & Bexley Community Hospice	Lewisham & Greenwich NHS Trust	Oxleas NHS Trust	St Christopher's Hospice	King's College Hospital Senior Care	King's College Hospital Oncology	Royal Trinity Hospice	St Georges: Oncology	St Georges: Senior Care
Nurse 1 - Greenwich & Bexley Community Hospice - Hospice	1st & 3rd		2nd						
Nurse 2 - Oxleas - Community	2nd -	x	x						
Nurse 3 - St Christopher's Hospice - Hospice				1st & 3rd	2nd	x			
Nurse 4 - Kings College Hospital - Senior Care				x	1st	x			
Nurse 5 - Kings College Hospital - Senior Care				2nd	1st & 3rd	x			
Nurse 5 - Royal Trinity Hospice - Hospice									
Nurse 7 - St George's - Oncology							3rd	1st & 2nd	x
Nurse 8 - St George's - Oncology							2nd	1st & 3rd	x
Nurse 9 - Royal Trinity Hospice - Hospice							1st	3rd	2nd
Nurse 10 - Royal Trinity Hospice - Hospice							1st & 3rd	2nd	x

Table 1: Participants by employer with order in which, and organisation where, placement took place

3.1.2 Characteristics of the stakeholders who participated in the evaluation

In total seven stakeholder participants took part representing all sectors targeted by the project (see table 2 below).

<u>Role</u> \ <u>Sector</u>	Community (C)	Acute (A)	Hospice (H)
Mentor (M)	x Due to long term illness	✓ St George's Hospital	✓ Greenwich & Bexley St Christopher's
Senior Manager (SM)	✓ Oxleas NHS Trust	✓ King's College Hospital	✓✓✓ Royal Trinity Greenwich & Bexley

Table 2: Roles of stakeholders interviewed by sector and organisation

3.1.3 Organisational issues emerging over the course of the project

The programme start date was delayed due to recruitment issues and those enrolled were nurses already employed by participating organisations. The participating nurses started the programme in their own department, and then moved for their second placement. The organisations had hoped to recruit new nurses - Royal Trinity had employed two newly qualified nurses on the understanding that they would enrol on the programme when it commenced - both only accepted the positions because of the programme. Both Royal Trinity Hospice and St Christopher's Hospice had indicated from the start of the programme that they had reservations about community placements and opted for both cancer care and senior care placements in the acute sector with potential for nurses to have community experience with Community Palliative Care teams during the hospice in-patient placement.

Royal Trinity and St George's Oncology are currently setting up a six month rotation programme following their experience on this project.

3.2 Perceived aims and expectations of the programme

As noted in section 1.1, a key aim of the project was to “provide opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway”. Nurse participants were asked why they had decided to enrol on the project and, later whether their expectations were met. Similarly, stakeholder participants were asked to describe their understanding of the aims of the project and any perceived impact of the project. The understanding and expectations of both are discussed, in turn, below.

3.2.1 Rotational nurses' expectations of, and reasons for, taking part in the project

In their first focus group, all nurse participants stated when asked, that they enrolled on the course to improve their skills – these skills included:

- Enhancing their practice skills:

"I worked in palliative care. I was really interested in enhancing my practice skills, that's why I decided to join the programme."

- Improving their skills in different sectors of healthcare provision - as is the case with these participants originally working in hospices:

"I saw this programme as not experience to get end of life care particularly but to get acute skills more than anything. That's why I did it."

"I wanted to improve my skills and knowledge in oncology."

- Gaining exposure to different working environments:

"I hadn't worked in a hospice before and I hadn't worked in haematology or oncology - so I really wanted to have that exposure. I really enjoyed this placement because of that."

In the second focus group, participants all agreed that their original expectations had largely been met by the project. Many described how they had learnt the skills they had expected and had got to practice new skills which did not fall within the remit in their usual working environment. In particular, nurses from acute wards reported that their scope of practice was enhanced during their placement in the hospice setting, e.g:

"[S]ome important situations like patients with bowel obstruction or you have constipation, at [the] Hospice, we actually can do PRs [per rectum - digital rectal examinations] and stuff like that, it's a pretty simple thing to do. Whereas, in my ward we are not allowed to do it. I think, because especially it's not really treated and addressed properly when you are at ward, so I had more freedom at [the] Hospice, whereas in my ward I don't have that freedom."

Participants also felt their skills were particularly enhanced through cross-pollination between sectors – where they gained experience and exposure by working in other environments and seeing and performing new practices first hand. One example is this hospice nurse's experience:

"I think, I learned quite a lot of like clinical skills which I took back, because I was in an acute environment."

Participants also reported that understanding different organisations and sectors helped them gain new insight into what happened in the wider care process (cross-sectorial continuity of care) and understanding the pathways available to the patient.

"I learnt quite a lot about acute skills and managing patients who were deteriorating and becoming unwell, and maybe not focusing on end of life so much, because it depends what kind of patients you're looking after. [...] I think I also learnt that, actually you know, we have quite good palliative care services in hospitals, I was quite impressed."

"I was lucky to do the district nurses and it's really good, because my discharging planning skills are much better now and I'm like, "Oh yeah, I know why they should do that. I know why they need that."

However, at both focus groups nurse participants noted issues that had emerged over the course of the project which impacted upon their experiences in a challenging manner. These issues related largely to organisational issues in the placement area and are discussed in full in sections 4.6.2 and 4.6.3. However one example is the case of a participant who was unable to get the full placement experience as the ward she rotated to closed down:

"I started on one ward, that closed down after two months and I then I had to move and the patient demographics changed as well [...] It was just really, really challenging."

Another key issue reported by a majority of participants was receiving less support than they expected on some acute ward placements, particularly in elderly care - due to pressure within these organisations to provide routine care:

"I went to an acute trust [originally from hospice], in an oncology ward, that was very busy and very understaffed, and it's easy to lose sight of the fact that you're on a rotation and you should be spending days with palliative care teams or learning things, but actually you're just, you have to just muddle in."

"[I was] just absorbed into the ward routine, so that's something negative."

Hence, we can see that pressures to provide routine care led to participants feeling they learnt skills required to work in wards rather than learning specialist skills and also that as nurses they felt it was their duty to 'just muddle in' in these situations.

In summary we can see that participants reported that the areas of skill enhancement that they envisaged gaining were largely met over the course of the project. Hence, the impact of the project included enhancing their practice skills as well as increased exposure to different care sectors, and developing skills in different types of care and treatment within different care sectors. Particular challenges, such as a perceived lack of support in placements by hosting organisations and incomplete placements, were experienced by some participants although these issues were not modifiable within the project as they occurred within the hosting organisations, and were outside the remit of the project's management.

3.2.2 Stakeholders' understanding and expectations of the project

Stakeholder participants were aware of the structure and wider aims of the project:

"[G]etting the 15 newly qualified band five staff nurses to recruit over three placements over the course of the year, and that in doing that, and with the hospice in-patient experience, they would get to have more confidence and competence caring for people approaching end of life. And not just those last couple of days, but actually identifying people who are dying, having conversations and getting people prepared if you liked, so that the hospice standard of care could then be incorporated into community care and also into the acute sector. And through doing the rotations, each nurse would learn about the challenges in the other areas, how they could incorporate work from one place into another and use good practice wherever it may be [...]. The hospice people could get an understanding of the challenges in the community and so forth."

Stakeholder participants equally linked their expectations for the project with to the impacts they later experienced. First, was a diversification and enhancement of the individual skills of the nurses they rotated out, and hosted within, their organisation:

"[The aim was ...] For my staff to get more experience in other areas around oncology and palliative care, and they did."

"I think from a personal perspective, their [nurses'] sort of person-centred care skills, they've found really useful to pick up on I think, the people who've come to us [hospice]."

"She's [hosted nurse] increased her skills and knowledge of the community setting, she's been able to feed that back to her team as well."

Hence, similar to the nurse participants the notion of cross-pollination of skills, and understanding the patient pathway across sectors was discussed by stakeholder participants:

"They would gain a different perspective - because I know with the [rotational] nurse in question, she is actually based at the local hospice. So, to actually see how palliative patients are cared for by district nursing teams is another step for her. It just gives her an overview of the patient's journey, because we very often, or not very often, but sometimes we have to send patients into the hospice. But it's nice for her to see that yes, we can look after palliative care patients in the community."

"Looking at best practice and how that can be shared amongst the three disciplines – brilliant! - helped to ground the nursing staff with knowledge behind the various aspects of medicine, palliative, and haematology, and how they do affect each other. And how we can help perfect how well it works."

The notion of cross-pollination was often illustrated with specific examples that had been integrated in practice at the host organisation:

"We set up a dementia unit here [hospice], or dementia home-from-home bay. It just so happens that this particular nurse arrived [in rotation] just as that was opening up. She was able to do some sort of practical ideas about even where you position things in the room, that kind of thing [...] to make things dementia friendly."

"On the oncology side of it, it's been things like care for PICC [peripherally inserted central catheter] lines and Venous Access Devices that we had. Our practice was fine, but it wasn't maybe as up to date as it could have been, and she's been able to share that, which is brilliant!"

Stakeholder participants also reported some of the organisational issues identified by nurse participants as challenging. However some stakeholders saw these as an indirect part of the learning experience. For example, when a rotated nurse returned to her original organisation dissatisfied with the lack of support on her placement and being co-opted into a busy ward, she reported the following to her manager:

"She [participating nurse] has told me that she's found the experience really useful just in terms of her own resilience and just learning how environmental factors can really make a difference for how positive you feel at work."

Another stakeholder reflected similarly on the learning aspects for the organisation she worked in:

"I suppose it was quite a useful learning curve for me to see how much support people needed even when they weren't in their home placement. So, that was that side of it."

In overview, we can see that as with the nursing participants, the stakeholder participants reported the project as having enhanced nurse participants' individual practice skills and increased their understanding of the cross-sectoral nature of the patient pathway. In addition both the nursing and stakeholder participants reported that the project increased participants' exposure to different care sectors, and developed the aforementioned skills in different types of care and treatment within different care sectors. Hence, key expectations were met – and later – manifested as tangible impacts of the project.

3.3 Perceived impact of the programme on nurses' professional development

A key aim of the project was to "promote the development of a well trained workforce" and "provide opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and impact on wider workforce". In evaluating this aspect of the project, nurse participants were asked how the project had impacted on their personal career development. This was discussed in most detail largely in the second focus group when participants had a better overview of the process and time to reflect. Stakeholder participants were also asked the perceived

impact of the project on the participating nurses' personal development (both those who went on placement and the nurses they hosted). An overview of both groups' responses are given, in turn, below.

3.3.1 Rotational nurses' accounts of the impact of the project on their professional development

As discussed in section 3.2, participating nurses' reported that their day-to-day practice and clinical skills were improved, which in and of itself is can be considered professional development – and that this occurred through exposure to different environments:

"I hadn't given IVs before, so that was something that was really important, managing that, fluids and, like because we don't really give fluids and manage that stuff at the hospice, so that was quite interesting"

Equally, nurse participants argued that they learnt interprofessional skills and were able to understand the patient pathway better.

"I think it's brought a real ... for all of us I'm sure, we understand everyone working in a hospice, you understand how people get there, and we then understand what goes on after they leave us, and then I think it just binds, well for me anyway, it binds it all a bit better, rather than... chaos." [This nurse was originally from an acute setting].

Nurse participants reported that they felt that their professional development was supported when the hosting organisation took time to induct participants and earmarked time for participants to discuss their progress over the placement.

"They knew who I was, that's something, that's like quite a good start in the hospital they expected me, they knew what I was doing, Yeah, I think maybe, hopefully if they do it more then the managers become more used to us, become more of a normal thing"

"I felt as though everyone in the building knew that I was coming and I was assigned a mentor and I was supernumerary for two weeks. I saw my mentor nearly every day and I also was given a booklet which was specifically for St Christopher's, which was separate from this rotation. Which helped me to ease my way into working at St Christopher's and because I was supernumerary I could just work on the booklet whilst shadowing. So I felt I learnt a lot."

However, as reported above, many felt they were just absorbed into wards with little support and felt this was not developing them professionally.

In terms of impact however, although all nurse participants reported gains in professional development, those participants originally from the acute sector argued that when they returned to their home trust they were unable to implement the new skills and knowledge they had learnt in

other sectors. Participants believed this was due to the different role for nurses, and processes surrounding treatment of death and dying within the acute sector.

"I feel like whatever I have learnt at [the hospice], I can't bring it completely to an acute setting, because we have been stopped by the consultants, doctors, policies or whatever reason and we can't provide what we want in terms of pain relief or constipation or any symptom control"

"I find it really difficult, and in the last couple of weeks I've struggled with patients trying to get palliative care, and you can see them, they were coming to the end and they're ... until the very last moment, they [staff] were giving proactive treatment ... and I didn't understand ... and I just didn't have the power or the voice."

Hence, we can see that nurses – where supported within placements – felt they gained clinical and interprofessional skills and experiences that impacted on their professional development. However, those who originally worked within the acute sector felt that they had difficulties implementing what they had learnt when they returned to their practice areas, due to the different role for nurses and processes surrounding treatment of death and dying in the acute sector.

3.3.2 Stakeholders' accounts of the impact of the project on nursing participants' professional development

Stakeholder participants felt that exposure to the different sectors contributed to the professional development of the nursing participants, as this hospice stakeholder stated:

"For our nurse here definitely, and for the nurse that also came to us as well. It's opened their eyes to obviously how palliative care can be and should be managed. We try our best to lead the way, we learn from other places as well, and we also question our practices and try to improve them [...] Here we showed them [visiting placement nurses] the use of other therapies, the way that we might use different ways of assessment and also involving other people, like family. Not necessarily going from a medication point of view straightaway, but thinking of other strategies that we might use."

This community stakeholder supported this notion of cross-pollination:

"I know our nurse at the end of her placement, she actually said that it's really interesting to have been able to work on 'some of my other skills' in other areas, such as wound care. You know, because that would actually benefit her work at the hospice."

One stakeholder also noted that two nursing participants were promoted and that participating in the project had contributed to this – however, this then unfortunately led to one nursing participant having to withdraw from the project:

"During the course of the first placement, going into the second placement, one of the nurses actually applied for a band six post, which she was successful in achieving, and then unfortunately had to leave the programme because a band six, so a senior role, they couldn't just lose that person for four months. So that was a positive, although a negative in that we lost a number, which then had a knock-on effect on placements, but it was a positive [...and...] Already two people who originally enlisted on the programme have been promoted"

Hence, the professional development of participating nurses was unanimously reported by the stakeholder participants as having improved.

"It's enhancing their careers, through enhancing their practice."

In overview, we can see that both nursing and stakeholder participants reported improvements in the professional development (of the participating nurses). This impacted positively on the career progression, clinical and interprofessional skills of the majority of participating nurses. However, some nurses originally from the acute sector reported that they were unable to implement some of their skills when returning to their trust due to the different processes and 'cultures' between sectors.

3.4 Perceived impact of the project on participating nurses' confidence in managing ageing, dying and end of life care

As noted earlier, key aims of the project were to "improve staff morale by increasing their knowledge and skills in end of life care", as well as to "contribute to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome". Therefore nurse participants were asked how the project had impacted on their confidence in managing ageing, death, dying and end of life care. Equally, stakeholder participants were also asked the perceived impact of the project on the participating nurses' approaches to ageing, death and dying had altered over the course of the project. An overview of both groups' responses are given, in turn, below.

3.4.1 Rotational nurses' accounts of the impact of the project on their confidence in managing ageing, dying and end of life care

Increased exposure to the roles of nurses in different sectors helped participating nurses to understand the constraints faced by different sectors, and by patients and families. For example, this hospice nurse discusses how her views of 'dying at home' and the role of the palliative care team had changed:

"I think I had a different opinion about people being able to die at home because we don't provide enough and because we don't support them enough. For example I found that people wanted to die at home but because the family couldn't cope with it

and we couldn't get the help in time, to have carers coming regularly during the day to support them. Then they have to be sent to the hospice and sometimes the reason why they had to die in a hospice, it wasn't because of symptom management. Not because of the clinical reason but because of the pure care reason, there was nobody that could provide the care at home... But to my surprise, a lot of people die at home and the family can cope with it and the palliative care team do support them."

Equally, the group agreed that their views had changed and they believed it was possible to have a good, planned death in hospital.

"We were saying earlier I always saw dying in the hospital as the ultimate worst thing that can happen to you and it's really awful and stuff, and it's not. If you're on the right ward under the right team with the right medication, exactly as it is in hospice. It can be really nice."

This kind of 'myth-busting' was also extended to the hospice, the non-hospice nurses from the acute and community sectors felt that their preconceptions of hospices were demystified.

P1: *"... my colleagues [in elderly care] were a bit sad that I was going to the hospice."*

P2: *"Exactly because they think the hospice is a sadness place."*

P1: *"Yes, so I can go back and actually try and communicate that actually it's a really positive place."*

P3: *"That's what I tried to do when I was there [in acute sector], just demystify that concept of the hospice."*

Another participant stated: *"I would show people the website of [the Hospice] ... I'd be like, honestly it's the nicest place on earth."*

Therefore, participants - in gaining experiences from various sectors' approaches to death, dying, palliative and end of life care - felt more confident in the ability of each sector to manage the patient pathway. Equally they trusted that different sectors could meet patient need, just in different ways.

"...You know more knowledge about the whole system rather than your bit..."

Correspondingly nursing participants with little end of life care experience felt they were much more confident in their communication around death and dying.

"I was confident talking about end of life care with my patients in my previous work, but now after being four months in [the] Hospice I think my communication skills have definitely been enhanced to a very good level. I'm very confident to talk to a patient, to anybody actually, about that. Not only dying patients but friends, families, doctors, everyone. I think that would definitely impact on how I provide my care to patients."

One hospice nurse also reported how they had disseminated her hospice knowledge during her ward placements.

"That was a really nice part of when I was on the ward, if we had a patient who was going to the hospice they'd send me in to have a speech and talk to them. I think it was the really nice part for them to not be guessing about what actually happens in a hospice and have someone who actually knew. So I think when you guys [other participating nurses] go back, that will be a really nice part of it."

Hence, nursing participants' self-reported increased confidence in managing ageing, dying and end of life care concerns. This was both in terms of confidence in the processes and practices of other sectors to meet patients' and families' needs – which they were then able to convey to other staff, patients and their families. Nursing participants also improved their practical skills, such as communication, around ageing, dying and end of life care.

3.4.2 Stakeholders' accounts of the impact of the project on nursing participants' confidence in managing ageing, dying and end of life care

Similar to the nursing participants, stakeholder participants observed an increased confidence in participating nurses' confidence of the processes and practices of other sectors to meet patients' and families' needs. An improvement in the participating nurses' practical skills was also observed.

"Everyone on the programme has had the opportunity to have placement on the in-patient unit at a hospice, so they've had an end of life rotation. People who've worked in acute, who are petrified of the word hospice and mentioning it to their patients, have spent time and realised just how different hospice is to the regional sort of care for the incurable dying person who's going to die soon. So it has certainly enhanced their skills in death and dying"

Equally, it was argued by a few stakeholder that those who participated had gained new communication and support skills.

"I do think there probably is, if I think of the people who have come from [NAME, acute sector, oncology] to us [community palliative care], I think there have been shifts in even the use of language. So, I think because we're particularly keen on getting people to talk about dying, rather than 'passing away', I think that's become something they've become more familiar with. I think support of each other as well, is something that they've probably got that element from us. So, actually caring for the team, looking out for each other, and the care of relatives. Somebody did mention that to me the other day, how that in an acute setting, their relatives are seen as a distraction or annoyance and you don't include them. In a palliative care setting they're very much part and parcel of the whole experience."

However, those stakeholders working in hospices argued that the up-close experience of death and dying in itself imparted a strong learning experience, which in and of itself, gave participants an exemplar of how good death and dying could be achieved.

"They [participating nurses] learnt to manage situations that can sometimes be tricky for people. The power of touch, the power of just being there. The power of music, the power of smells, it's things like that. And just having that support is calming, reassurance for patients and their loved ones."

"I just feel very sorry for those in hospitals, because it's not the nicest of places to die. I think sometimes you get so bogged down in the tasks that you have to do, and need to do, that sometimes those that are dying, not necessarily are forgotten, but just cannot have as good a death as they possibly can... It enhanced their understanding of death and dying and how we can help people through it."

Hence, the perspectives of stakeholders tallied with those of the nursing participants. However, those working in the hospice sector believed that there was a tangible experiential benefit to experiencing a patient having 'as good a death as they possibly can' which they will take to the home trusts. The quotes above by nursing participants discussing their experiences do appear to support this assertion.

3.5 Perceived impact of the project on participating nurses' communication skills with families and patients and ability to work in the multidisciplinary team

A key aim of the project was to "provide opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway". Hence, nurses and stakeholders were asked whether they perceived any improvements in the participating nurses' communication skills and experiences of working in multidisciplinary teams.

3.5.1 Rotational nurses' accounts of the impact of the project on their ability to work in the multidisciplinary team and communication skills

In terms of communication skills we can see from sections 3.3.1 and 3.4.1 that all participants felt nursing participants' communication skills with patients and their families had improved. The following participant sums up this impact succinctly;

"I was confident taking about end of life care with my patients in my previous work, but now after being four months in [the] Hospice I think my communication skills have definitely been enhanced to a very good level."

Many nursing participants perceived that this impact was primarily the result of exposure to new environments:

"Having any kind of different experience is definitely positive ... I know that I've learnt tons and tons of things that I can take back to the hospice 100%, that's a given for me. We've all learnt quite a lot of stuff, no matter where you were."

At the same time, many nursing participants who reported negative experiences in their placements – primarily in elderly care in the acute sector - highlighted that they (indirectly) learnt assertiveness and negotiation skills in order to get the most from their placement:

"Because we had to find out in a hard way, we had to ask all the questions and I had to find out everything on our own, and I think that yes, it comes with a negative impact at first but then actually when you draw a line you realise that actually I've done all this by myself. I didn't even know that I have to do all these things that are needed. So now I know when I'm going to go in the next placement, what to expect and what to ask."

Similar to the nurses' experiences of personal development, participants originally from the acute sector felt that when they returned to their home trust they were less able to use the communication skills they had learnt in other sectors due to the culture of wards and time constraints in acute environments.

"I've tried to speak to many people, but mainly with family. Yeah we tried to deal with that the last day when they died, their symptoms were not properly addressed, so yeah, sorry I just feel like whatever I've learnt, all my skills didn't matter. I can't use them on the ward"

All participants felt their experiences on the project had impacted on their ability to work in multidisciplinary teams (MDT). This participant from the acute sector describes this impact:

"[Working in the multidisciplinary team] has been really good because you find out who to ask, what questions to ask, how to ask, what referral you need, when you need their input. If it's too late, if it's too early, that kind of thing. It only has advantages from there."

However, participants described their MDT working as occurring predominantly within the hospice setting:

"From where I come from which is a haematology and oncology nurse, I didn't have the opportunity to participate on a MDT meeting, it's usually the manager or the person who attends it, so as staff nurses we don't get to say anything, we just escalate it to the manager or the senior person in charge. Whereas in [the] Hospice, we have had a MDT meeting once a week. It's nurse-led, it's rotating the week so everyone can attend, where everyone's concerns are brought to the MDT meeting. So now we are contributing."

The emphasis on nurse-led, MDT care in the hospices was contrasted with the hierarchical team model in the acute sector.

"In hospital, consultants are very different to hospices. I would like to be, I met some really great consultants in the hospital but there's no hierarchy in hospices. A consultant will come and make you cup of tea and it's not a big deal. Whereas in the hospital I found that if a consultant makes a joke, everyone politely laughs. I find it really, really strange. I had a fight with one of our consultants, a haematology consultant, and it was such a big deal on the ward and everyone was whispering the whole day. It was awful. I find going back to that hierarchy with doctors really difficult."

"I came from the hospice, so that really made me laugh, that consultant and hierarchy because I feel like I've come to an environment where actually it's nurse led, the MDTs are nurse led and I felt like it's empowering for the nurses and it flattens the hierarchy. We do have doctors making you cups of tea, which is quite different."

Nurses from the acute sector reported having their first experience of a 'nurse-led' MDT on their hospice placement as their usual participation was limited by the hierarchical structure in the acute sector. Hence, these participants felt they would be unable to implement what they had learnt due to the differing processes within the organisations:

"Whereas in [the] Hospice, we have had a MDT meeting once a week. It's nurse-led, it's rotating the week so everyone can attend, where everyone's concerns are brought to the MDT meeting. So now we are contributing [...] From where I come from which is a haematology and oncology nurse, I didn't have the opportunity to participate on a MDT meeting, it's usually the manager or the person who attends it, so as staff nurses we don't get to say anything, we just escalate it to the manager or the senior person in charge."

For example, the nurse below, originally from a hospice, describes how she consciously built up relationships with junior doctors to ensure she had leverage over some aspects of the fundamentals of care on the ward – but believed that this could only go so far against challenging the hierarchical nature perceived within the acute sector.

"I worked quite hard to build relationship with, especially like younger doctors that were on the ward in oncology. I don't know if they're like friendlier or they had a nice set of junior doctors, but I put like quite a lot of effort into it, and they put in a bit of effort too, and then I think having a better relationship with doctors, helps you to sort of [...] Because generally they [junior doc don't have as much authority over the overall, they can do simple things, put laxatives on if somebody is constipated, but they wouldn't say, 'Oh, okay, we're withdrawing this or we're not doing this or we are doing this' that would have to come from above."

As we can see, nurses felt the project had impacted upon both their communication skills and ability to work in multidisciplinary teams. In terms of communication skills this impact was felt in communication with families, colleagues and fellow healthcare professionals. The hospice and community settings were seen as the places where multidisciplinary skills were enhanced the most. However, the nurses felt that the hierarchical nature of acute settings acted as a barrier to implementing their existing multidisciplinary skills – i.e. both the nurses who rotated in and by returning nurses from this sector who were rotated to other sectors.

3.5.2 Stakeholders' accounts of the impact of the project on nursing participants' ability to work in the multidisciplinary team and communication skills

Stakeholders unanimously agreed that the nursing participants' communication skills had improved as a result of the project, as this stakeholder participant summed up:

"They aren't afraid of having challenging conversations. It was is a big ask, but this is a society thing, death is normal and that we can help affect a good death, and we can help affect a good life towards the end of somebody's life. Not only for the patient, but also for their loved ones."

The impact of the placements on communication about death to patients and families was felt to be a key area of impact:

"The nurse that came from the community to here [hospice], I think it definitely enhanced her skills. So really having those more holistic assessments and the difficult conversations. When she first came here, she really shied away from doing those kinds of things, talking about end of life. But, by the end of the placement, because it's what we do every day, she just developed her confidence in that, talking to the families and giving the support that they need."

[W]ith communication they've felt that even if they didn't get it quite right, having the opportunity to reflect with a mentor and say 'I did this but I forgot this, how could I have done it better?' They've learnt and taken that into the following placement. They're feeling more confident in raising issues about end of life care, about palliative treatment, about having those discussions as opposed to saying, somebody says 'Am I dying?' ... 'Oh I'll get the sister to answer that one'.

Stakeholders reported that nurses had internalised key principles of multidisciplinary working and that this was a key impact of the project:

"For example, sometimes with a community setting, the clinical nurse specialist will ask the district nurse to take bloods, and the district nurse will say "well why don't you do that?" But now there's a clearer understanding of roles as well, and yes okay, the CNS [community nurse specialist] might be able to take the bloods, but actually her role, that's not her role, and if the CNS is managing symptoms, emotional and psychological, then doing the physical bloods, she hasn't got the time to do that and

it isn't her role. So it is a clearer understanding of people's roles, how it all slots together [...] to make sure that the person in the centre needing care actually gets it."

Equally, in gaining this experience it was asserted that nursing participants, vis-à-vis, become aware of the patient pathway:

"I think they have gained an awareness of the ... You know, a more in-depth awareness of the patient's journey. From diagnosis through to being given a palliative diagnosis and the journey they would take, and the various professionals that would be involved. And how at the very end of life, what sorts of professionals would be involved there and how we would actually care for them."

A few stakeholders also felt that hosting placement nurses from other sectors also enhanced their own organisation's multidisciplinary working:

"I think it's been good in having people from outside of the organisation coming in with nice fresh ideas. We're fortunate as well that we do get new staff recruited, and have done recently for fresh ideas, fresh eyes. It does help from a multi-disciplinary point of view as well. It has been beneficial, because at points they've brought up things that perhaps we might not have thought of."

In overview we can see that stakeholder and nurse participants concurred that there were improvements with the nurses' communication skills with other healthcare teams as well as with patients and their families. Some nurse participants even felt that the more challenging placements had indirectly improved the self-advocacy and assertiveness aspects of their communication skills. The majority of stakeholder and nurse participants felt that in widening the context of learning across sectors during the project, the nurses who participated had expanded their understanding of the patient pathway and improved their practice and understanding of multidisciplinary working. However, nurses originally from the acute sector felt that there were barriers to deploying these newly-acquired multidisciplinary skills in the acute sector due to the hierarchical structure of the sector.

3.6 Perceived challenges and potential areas of improvement within the project

3.6.1 Perceived challenges in, and potential solutions for, the perceived clash of organisational cultures

These have been presented within the sections above (passim.) and are listed here for reference. The issues appear to relate primarily to the effect of moving into, or returning to, the organisational culture of the acute sector – described as hierarchical. This led to:

- A feeling of a lack of direction and support for nurses on placement in some acute sector environments (and being overwhelmed with ward-based day-to-day care);
- Experiencing barriers in accessing and participating in the MDT when moving into, or returning to the acute sector;
- Participants returning to their original work environments being unable to practice or implement their newly-acquired learning experiences due to hierarchical nature of some sectors.

It was noted above by nurse participants that having an induction, guidelines and named support contributed to how well they adapted to the placement. This process may minimise the likelihood of participants feeling they were being 'absorbed into ward life' in elderly care wards. Equally, the project leaders could make access to the MDT a tenet of participation for the organisations taking part. Another suggestion given below is that nurse participants finish their rotation in the home organisation and these be treated as an opportunity to practice and/or implement skills they have learnt – which the host organisation would need to agree to as a tenet of participation. Hence, many of the elements of this challenge could be addressed as a formative outcome of this evaluation.

3.6.2 Perceived challenges with, and potential solutions for, the structured learning element of the project

As part of the rotation project, the participating nurses also undertook a postgraduate module in palliative care or another relevant topic. It is worth noting that the majority of the nurses in the focus group reported that they had not completed an assessment.

In the following quote, for example

“So, then my clinical educator came with me, with a list of courses and went, “Just kind of pick one that fits around your rota” and I picked one, and I’ve since done it, that’s an absolute waste of time and I hate it [laughing]. And, that’s just because we just never really had any proper explanation about what the module that we were going to do would be [...] It was really vague, it was like, you’ll do this module in October and then it was just left to us and I just didn’t understand what was going on from the beginning and it’s led to me just picking a module that’s an absolute waste of time, so I think more...”

Participants felt that the clinical educators could have guided them more in the selection of a relevant module, and supported them in selecting one. Equally many felt that they could have benefitted from additional earmarked study days.

“I think, what we were saying earlier, that the set study days to do like your stuff, are really useful as well. In your placements, yeah that were like pre-allocated, every couple of weeks [...] like more of those.”

Conversely, some stakeholders reported that the nurses from their departments had finished and benefited from their modules suggesting some did benefit from this aspect of the project, e.g.

"She has done the module, which has benefited her. [...] She's passed that module. I think for her that was probably one of the most beneficial parts of it."

The overall message appears to be that nurses participants wanted to be guided towards a selection of relevant modules and supported in selecting a relevant one – and also given earmarked times to complete the module aspect of the project.

3.6.3 Perceived challenges with, and potential solutions for, the order, number and length of placements

In discussion of things they would change about the project, nurse participants discussed the notion of reducing the number of placements:

"P1: If I could change something for the next rotation programmes, I would just go with two placements, six months each. Your home trust, definitely, you would go to hospice - and community because I think where you learn the most it's through your time at the hospice."

"P2: I think I'd cut out care of the elderly of this programme completely and just go with oncology and haematology and hospices and just straight, like you say, six months. I think the care of the elderly aspect of it is unnecessary."

Many nurse participants felt that reducing the amount of placements would improve the project overall, whereas there were also concerns that if this entailed longer placements this may alienate potential applicants.

"P1: I think, scaling it back generally will only be beneficial for this. I think that, when it was decided how many wards were going to be involved, how many people there were going to be from each wards, it was just too big for a pilot course, and I think that having it like we've said, like two..."

"P2: Because the people that I spoke to at the hospital who were thinking of coming to the hospice were a bit nervous about doing six months, they were like, "That sounds like a really long time, I really like my job here, I don't know if I want to leave for six months". Whereas, we only really had to think about four months at a time."

Participants also debated how useful it was to have the first placement in their own department:

"P1: And, I think we can give up on our workplace as a placement. To me that doesn't really make sense. We can find, if we want to have this as a one year programme, then we should find another placement rather than considering our workplace as placement, because I don't know to you guys, but to me everything I aim for to do differently in this four months, didn't happen. I was just another, I was the same staff member that I was before, nobody looked at me, "Like okay now I'm on the programme, so I will do something else", just because yes, as you

said, we didn't have that studies days, and I just didn't done anything different. So considering your workplace as a placement, I don't think makes much sense to me...

P2: Or come back to your job [as the last placement] ...

P3: ... And, then that makes it more useful, because you come back, you've spent four months, and you re-evaluate has anything changed going back to your normal practice and that's what makes it more useful rather than changing something when you don't know what you want to change."

The notion of returning to their own department does appear to tally well with the notion of cross-pollination which has been a thread throughout the findings. The final 'home placement' would be an opportunity to explore and implement their accumulated learning.

In overview we can see that the main areas which participants found challenging related to: 1) the organisational differences between the acute, community and hospice sectors; 2) the structured learning element of the project; and 3) the length, order and number of placements. Interestingly, nurse participants found solutions to the latter two challenges. However, the issue of hierarchical structures in the acute structure was seen as less modifiable by the participants themselves but could be addressed as part of the condition of acute trusts being able to benefit from the project in the future.

4. Discussion of the aims, in relation to, the findings of the study

4.1 Overview

The aim of the present study was to evaluate the perceived impact of the project on participants who took part, and to gauge whether the project has, according to participants' accounts, attained its original aims. The objectives of the evaluation were designed to tally with the original aims of the project. Hence, this discussion allows us to outline how *participants' accounts* of the impact of the project support the *original aims* of the project.

4.1.1 Meeting Aim 1: Promoting the development of a well trained workforce

All participants reported that the areas of skill enhancement that they envisaged gaining at the beginning were met over the course of the project. The impact of the project on the participants' skills and knowledge was evidenced throughout by participant reporting, and in summary included:

- Enhancement of participating nurses' practice and clinical skills;
- Increased exposure to, and understanding of the practices of, different care sectors;
- The development of different types care and clinical skills within different care sectors;
- Improvements in the understanding and practice of interprofessional skills and multidisciplinary team working.

Stakeholder and nurse participants concurred that the impact was manifest in improvements with the nurses' communication skills with other healthcare teams as well as with communication and support for patients and their families. However, particular challenges such as a perceived lack of support in placements by some hosting organisations and incomplete placements were experienced by some participants. These issues were not modifiable within the project as they occurred within the hosting organisations, and were outside the remit of the project's management. In spite of this, potential solutions to these issues were given by participants and are discussed in the recommendations in section 4.3 (overleaf). Hence, the project has successfully achieved the aim of promoting the development of a well trained workforce.

4.1.2 Meeting Aim 2: Contributing to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome

Based on the placement experiences, participants all agreed that a 'good death' was possible in all sectors of care – acute, community and hospice – and that they had gained a greater understanding of the patient pathway and the choices facing patients and their families on different pathways. As such, the project has contributed to the development of a culture (amongst the participating nurses) in which death will not be regarded as a failure and a good (expected) death will be seen as a successful care outcome.

4.1.3 Meeting Aim 3: Providing opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and the impact on wider workforce

Throughout the findings we can see that both nursing and stakeholder participants reported improvements in the professional development of the participating nurses, this in and of itself offers a clear level of experience, knowledge and skill that develops the individuals' readiness for career progression. The impact was seen to have impacted on the career progression, clinical and interprofessional skills of the majority of participating nurses, with two nurses having been promoted over the course of the project. This suggests that the aim of providing opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and impact on the wider workforce has been achieved.

4.1.4 Meeting Aim 4: Improving staff morale by increasing their knowledge and skills in end of life care

Nurse and stakeholder participants reported improved confidence in communication skills around death and dying, greater understanding of patient pathway and of the role of other health sectors' and improved multidisciplinary working in the nurses who took part. For example, nursing participants' self-reported increased confidence in managing ageing, dying and end of life care concerns through:

- 1) Understanding the processes and practices of other sectors to meet patients' and families' needs; and
- 2) Being able to convey this to other staff, patients and their families.

Equally, as noted above in section 4.1.2, the discovery by participants that a 'good death' was possible regardless of the sector is intrinsically linked with their newly-acquired knowledge. As such the project has met the aim of improving staff morale by increasing their knowledge and skills in end of life care.

4.1.5 Meeting Aim 5: Providing opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway

A theme discussed by all participants throughout was the impact of cross-pollination of knowledge and the skills engendered by exposure to different care sectors. This was described as a two-way process where nurse participants;

- Imparted existing skills and knowledge to others during their placements; and

- Acquired new skills and knowledge during their placements and implemented and/or disseminated these on their return to their home organisation.

Stakeholder and nurse participants concurred that there were improvements with the nurses' understanding of the role of other healthcare teams, as well as with working with patients and their families. Hence, the majority of stakeholder and nurse participants felt that in widening the context of learning across sectors during the project the nurses who participated had expanded their understanding of the patient pathway and improved their practice and understanding of interprofessional practices. As such the aim of providing opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway has been met.

4.2. Limitations of the study

A full discussion of all the limitations of the qualitative approach is beyond the scope of this report. Rather, the main limitations of the approach that may have impacted on this study are discussed. First, the participants recruited to the present study – having either done the rotations or offered staff to the rotations - may have a vested interest in portraying the impact of the project in a good light (or even a bad light). This is a potential bias in their reporting. Equally, the focus group format adopted for the nurse participants may have further contributed to introducing this bias, as participants could be led by each other to a certain conclusion. This type of bias is common in all types of qualitative studies, and not unique to this one. Hence, it is how this bias was dealt with within a study which determines the limitations of the data. Therefore, it is worth noting that the evaluation was conducted independently by researchers from the University of Greenwich who ensured anonymity and/or confidentiality for participants – meaning they felt free to convey their actual experiences. Also, looking at the data presented we can see that participants were not afraid to constructively criticise aspects of the project or each other. This suggests that the measures put in place (independent researchers assuring anonymity and/or confidentiality) were sufficient to minimise this potential bias. Secondly, it is also worth noting that like most qualitative studies the findings will not be directly generalisable to other rotational placement projects in other settings or geographical areas. Rather the strength of this study is in capturing the direct experiences of those who took part in this particular project, and how they perceived and assessed the outcomes and impact of the project.

4.3. Recommendations from the study

The majority of recommendations presented here emerged from the study itself and were largely suggested by the participants themselves. The recommendations relate, on the whole, to changes in the structure of the project (rather than the actual content) and on ways to improve continuity between sectors:

- Adjusting the length and number of placements in the project so that there are fewer periods of adaption for participants in the whole rotation, as well as considering the order of the placements, i.e. considering having the 'home placement' at the end so participants have a period of time to practice, cross-pollinate and implement what they have learnt;
- Providing more structured support – both more advice and more study days – to ensure that participants engage fully in the education module available during the rotations;
- It was noted by nurse participants that having an induction, guidelines and named support contributed to how well they adapted to the placement. This may minimise the likelihood of participants feeling they were being 'absorbed into ward life' in elderly care wards. Equally, the project leaders could make access to the MDT a key tenet of participation for the organisations taking part - in order to ensure that participants have the opportunity to learn multidisciplinary skills in all sectors.

In terms of potential areas for future evaluation, one recommendation would be to formatively monitor and evaluate how any changes made (in light of the above recommendations) impact on participants' perceptions and experiences in the next rotation. In terms of recommendations for research, one area that would be particularly interesting to explore is the factors that act as barriers and facilitators to rotational placement participants' ability to implement their skills and knowledge in practice when they return to their home organisation.

An overview of how the project can be seen to have achieved its aims in relation to the findings of the study is given in Table 3 overleaf – note that the table also shows how the original aims and evidence from the findings often overlap between aims.

Evaluation of the 'Rotational Post - End of Life Care, Cancer Care and Care of the Elderly' Project

<p><i>Aspect of findings</i></p> <p><i>Project aims</i></p>	<p>Perceived aims and expectations of the programme</p>	<p>Perceived impact of the programme on nurses' professional development</p>	<p>Perceived impact of the project on participating nurses' confidence in managing ageing, dying and end of life care</p>	<p>Perceived impact of the project on participating nurses' communication skills with families and patients and ability to work in the multidisciplinary team</p>	<p>Perceived challenges and potential areas of improvement within the project</p>
<p>Promote the development of a well trained workforce</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported their expectations of the project were: to enhance nurse participants' individual practice skills, increase understanding of the cross-sectoral nature of the patient pathway; and increase exposure to practices different care sectors.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved communication, clinical and multidisciplinary team-working skills.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved understanding of the management of ageing, dying and end of life care amongst nurse participants.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved communication skills with other healthcare professionals, patients and their families. Equally, participants reported greater use and understanding of the value of multidisciplinary working.</p>	<p>Issues with taught element of project reported. Recommendations for future action given.</p>
<p>Contribute to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Reported understanding of 'good death' as having been established in participating nurses and that nurses had gained insights into how 'a good death' was possible across all sectors.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working in participants.</p>	<p><i>Aim supported as attained by this aspect of findings:</i> Nurses & stakeholders reported improved communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working.</p>	<p>No reported challenges or issues for improvement</p>

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<p>Provide opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and the impact on wider workforce</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported nurses' intentions to improve their skills and knowledge were expected and were achieved.</p>	<p>Aim supported as attained by this aspect of findings: 2 nurses were promoted during the project.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported increased cross-pollination of ideas and practice - at the individual team and organisational level.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved communication skills with other healthcare professionals, patients and their families. Equally, participants reported greater use and understanding of the value of multidisciplinary working – improving candidate, team and organisation.</p>	<p>Issues reported with acute sector workers having issues with applying newly acquired their skills and knowledge when returning to their home placement.</p>
<p>Improve staff morale by increasing their knowledge and skills in end of life care</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improvement of knowledge and skills in end of life care as an expected and achieved aim.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved confidence in communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working in participants.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved confidence in communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working in participants.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved confidence in communication skills around death and dying, greater understanding of patient pathway and of role of other health sectors and multidisciplinary working in participants.</p>	<p>Issues reported with acute sector workers having issues with applying newly acquired their skills and knowledge when returning to their home placement</p>
<p>Provide opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported increased cross-pollination of ideas and practice - at the individual team and organisational level.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved communication, clinical and multidisciplinary team-working skills. Greater exposure to different sectors practices improved understanding of patient pathway.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported increased cross-pollination of ideas and practice - at the individual team and organisational level.</p>	<p>Aim supported as attained by this aspect of findings: Nurses & stakeholders reported improved communication, clinical and multidisciplinary team-working skills. Greater exposure to different sectors practices improved understanding of patient pathway.</p>	<p>No reported challenges or issues for improvement</p>

Table 3: Project aims in relation to the findings of the study

5. Conclusion

To summarise, it can be said that the project has been planned and managed well – particular praise was given to project lead Brigid Williams within the data collected. Most importantly, despite issues emerging over the course of the project, it has clearly met its aims in the following ways:

Aim 1: Promoting the development of a well trained workforce;

Evidence of attainment: Participating nurses and stakeholders reported an enhancement of participating nurses' practice, interprofessional and clinical skills as a result of increased exposure to, and understanding of the practices of, different care sectors during the rotation.

Aim 2: Contributing to the development of a culture in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome;

Evidence of attainment: Participating nurses and stakeholders reported participants had developed a firm understanding that a 'good death' was possible in all sectors of care – acute, community and hospice – and that this had informed a greater understanding of the different routes on the patient pathway.

Aim 3: Providing opportunities for staff to develop their careers with clear opportunities for progression into more senior roles and the impact on wider workforce;

Evidence of attainment: Participating nurses and stakeholders reported improvements in the professional development (of the participating nurses), this in and of itself offers a clear level of experience, knowledge and skill that develops the individuals' readiness for career progression. Also, two nurses participating in the project were promoted during the project.

Aim 4: Improving staff morale by increasing their knowledge and skills in end of life care;

Evidence of attainment: Participating nurses and stakeholders reported improved confidence in communication skills around death and dying, greater understanding of patient pathway as well as of the role of other health sectors and MDT working in those who took part.

Aim 5: Providing opportunities for staff to understand the wider context of health care delivery in a range of different care settings, promoting greater partnership working and integration of care along the care pathway;

Evidence of attainment: Participating nurses and stakeholders reported the impact of cross-pollination of knowledge and skills being engendered by exposure to different care sectors.

The project also has a set of recommendations to work on moving forward, and given the benefits reported for the project the evaluation concludes that the project is ripe for continuation given the benefits outlined above.

Appendix 1

Topic Guide for Participating Nurses (Focus Group 1)	
Title of Study: Evaluation of 'Rotational Post - End of Life Care/ Cancer and Care of the Elderly' Project	
<p>Researcher introduces themselves formally and describes their role. Make it clear that there are no 'right or wrong' answers and the University of Greenwich are independent researchers. The researcher is interested in the participant's personal views and experiences. Reiterate confidentiality and anonymity arrangements.</p>	
1.	<p>Explain research and cover the key points on the information sheet and reiterate the aims of the research</p>
<p>Aim: The aim of the proposed study is to evaluate the perceived and felt impact of the project on participants', and whether the project has, according to participants' accounts, attained its original aims.</p> <p>The objectives in support of this aim will:</p> <ol style="list-style-type: none"> 1. Assess the impact of the project on the newly-qualified nurses' perceptions and experiences of working in End of Life Care, Cancer and Care of the Elderly; 2. Gauge the impact of the intervention on the newly-qualified nurses' perceptions of their career development; 3. Explore the stakeholders' (palliative care professionals', managers' & the project lead's) perceptions of how the project has impacted at an organizational level - including any outcomes they experienced; 4. Explore whether all participants perceived any advantages and/or disadvantages with the project. 	
2.	<p>Participants' Introductions</p> <p>Do you have any questions before we begin?</p>
3.	<p>About the participant</p>
a	<p>Participant/s introduce themselves.</p> <p><i>Prompts: Last placement and previous ones.</i></p>
4.	<p>Participants' Experiences: Impact on perceptions and future career development</p>
a	<p>What made you decide to enrol on the programme?</p> <p><i>Prompts: Were your expectations met?</i></p>
b	<p>How have you found the placements so far?</p>

	<i>Prompts: 1st in our area, 2nd in alternative place of practice (which might have been own organisation or other organisation)</i>
c	Have you found the placement useful to your professional/personal development? <i>Prompts: If yes how –if no, why?</i>
d	Has your confidence in delivering end of life care altered since being on the programme? <i>Prompts: If yes how –if no, why?</i>
e	Has your opinion regarding death and dying altered since enrolling on the programme? <i>Prompts: If yes how –if no, why?</i>
f	Have you learnt anything about working in multidisciplinary teams? <i>Prompts: If yes how –if no, why?</i>
g	What do you hope to gain at the end of the programme?
h	How has the programme impacted on your communication skills with colleagues, patients and families?
Participants' Experiences: Advantages and/or disadvantages with the project	
i	The programme has 4 training days, a workbook and a commitment to enrol on a relevant 15 credit module - how have you managed to deal with this time commitment while also working full time?
j	What support was available to and/or used by you?
k	What do you think would improve the programme for you?
5. Outlier Topics and Clarifications	
	<ul style="list-style-type: none"> • Anything else you would like to add to what you have said? • You said earlier Could you just run through that to make sure I understand what you meant? • Finally, is there anything that you think we should have covered, which you would like to talk about?
Thank you for your participation	

Topic Guide for Participating Nurses (Focus Group 2)	
Title of Study: Evaluation of 'Rotational Post - End of Life Care/ Cancer and Care of the Elderly' Project	
<p>Researcher introduces themselves formally and describes their role. Make it clear that there are no 'right or wrong' answers and the University of Greenwich are independent researchers. The researcher is interested in the participant's personal views and experiences. Reiterate confidentiality and anonymity arrangements.</p>	
1.	<p>Explain research and cover the key points on the information sheet and reiterate the aims of the research</p>
<p>Aim: The aim of the proposed study is to evaluate the perceived and felt impact of the project on participants', and whether the project has, according to participants' accounts, attained its original aims.</p> <p>The objectives in support of this aim will:</p> <ol style="list-style-type: none"> 5. Assess the impact of the project on the newly-qualified nurses' perceptions and experiences of working in End of Life Care, Cancer and Care of the Elderly; 6. Gauge the impact of the intervention on the newly-qualified nurses' perceptions of their career development; 7. Explore the stakeholders' (palliative care professionals', managers' & the project lead's) perceptions of how the project has impacted at an organizational level - including any outcomes they experienced; 8. Explore whether all participants perceived any advantages and/or disadvantages with the project. 	
2.	<p>Participants' Introductions</p> <p>Do you have any questions before we begin?</p>
3.	<p>About the participant</p>
a	<p>Participant/s introduce themselves.</p> <p><i>Prompts: Last placement and previous ones.</i></p>
4.	<p>Participants' Experiences: Impact on perceptions and future career development</p>
a	<p>How have you found the placements valuable?</p> <p><i>Prompts: 1st in our area, 2nd in alternative place of practice (which might have been own organisation or other organisation)</i></p>

b	<p>What were the <u>most</u> useful aspects of the placements?</p> <p>What were the <u>least</u> useful aspects of the placements?</p>
c	<p>What tangible aspects of your placement have you found useful to your professional/personal development?</p> <p>So, have your aspirations changed since taking part? <i>Prompts: If yes how –if no, why?</i></p>
d	<p>Has your confidence in delivering end of life care altered since being on the programme?</p> <p><i>Prompts: If yes how –if no, why?</i></p>
e	<p>Has your opinion regarding ageing altered since enrolling on the programme?</p> <p><i>Prompts: If yes how –if no, why?</i></p>
f	<p>Have you learnt anything about working in multidisciplinary teams?</p> <p><i>Prompts: If yes how –if no, why?</i></p>
g	<p>What do you hope to gain at the end of the programme?</p>
h	<p>How has the programme impacted on your communication skills with colleagues, patients and families?</p>
Participants' Experiences: Advantages and/or disadvantages with the project	
i	<p>The programme has 4 training days, a workbook and a commitment to enrol on a relevant 15 credit module - how have you managed to deal with this time commitment while also working full time?</p>
j	<p>What support was available to and/or used by you?</p>
k	<p>If you were to have another placement, where would you want it?</p>
l	<p>What do you think would improve the programme for you?</p>
5. Outlier Topics and Clarifications	
	<ul style="list-style-type: none"> • Anything else you would like to add to what you have said? You said earlier Could you just run through that to make sure I understand what you meant? • Finally, is there anything that you think we should have covered, which you would like to talk about?
<p>Thank you for your participation</p>	

Appendix 2

Interview Schedule for Stakeholders	
Title of Study: Evaluation of 'Rotational Post - End of Life Care/ Cancer and Care of the Elderly' Project	
<p>Researcher introduces themselves formally and describes their role. Make it clear that there are no 'right or wrong' answers and the University of Greenwich are independent researchers. The researcher is interested in the participant's personal views and experiences. Reiterate confidentiality and anonymity arrangements.</p>	
1.	<p>Explain research and cover the key points on the information sheet and reiterate the aims of the research</p>
<p>Aim: The aim of the proposed study is to evaluate the perceived and felt impact of the project on participants', and whether the project has, according to participants' accounts, attained its original aims.</p> <p>The objectives in support of this aim will:</p> <ol style="list-style-type: none"> 9. Assess the impact of the project on the newly-qualified nurses' perceptions and experiences of working in End of Life Care, Cancer and Care of the Elderly; 10. Gauge the impact of the intervention on the newly-qualified nurses' perceptions of their career development; 11. Explore the stakeholders' (palliative care professionals', managers' & the project lead's) perceptions of how the project has impacted at an organizational level - including any outcomes they experienced; 12. Explore whether all participants perceived any advantages and/or disadvantages with the project. 	
2.	<p>Participants' Introductions</p>
<p>Do you have any questions before we begin?</p>	
3.	<p>About the participant</p>
a	<p>Participant/s introduce themselves.</p> <p><i>Prompts: Please describe your role in the 'Rotational Post - End of Life Care/ Cancer and Care of the Elderly' Project.</i></p>
4.	<p>Participants' Experiences: Impact on perceptions and future career development</p>
a	<p>What, for you, were the main aims of the programme?</p>

	<i>Prompts: Were your expectations met?</i>
b	What has been the impact of the placements so far in your organisation?
c	Have you found that the placement useful to the nurses' professional/personal development? <i>Prompts: If yes how –if no, why?</i>
d	Have you found that the placement contributed to the nurses' ability to deliver end of life care as a result of the programme? <i>Prompts: If yes how –if no, why?</i>
e	Do you think nurses' opinions regarding ageing, death and dying have altered since enrolling on the programme? <i>Prompts: If yes how –if no, why?</i>
f	Have you noticed the project having any impact on working in multidisciplinary teams? <i>Prompts: If yes how –if no, why?</i>
g	What do you hope nurses will have gained at the end of the programme?
h	How has the programme impacted on nurses' communication skills with colleagues, patients and families?
5.	Outlier Topics and Clarifications
	<ul style="list-style-type: none"> • Anything else you would like to add to what you have said? • You said earlier Could you just run through that to make sure I understand what you meant? • Finally, is there anything that you think we should have covered, which you would like to talk about?
	Thank you for your participation