

**AN EVALUATION OF NHS ENGLAND'S
CARE MAKER PROGRAMME**

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FINAL REPORT
Prepared for NHS England

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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LIST OF ACRONYMS USED IN THIS REPORT

6Cs	Those values and behaviours identified as being at the heart of providing high service provision within the National Health Service: <i>Care, Compassion, Competence, Communication, Courage and Commitment.</i>
AGM	Annual General Meeting
CM	Care Maker
CMC	Care Maker Co-ordinator
CSAI	Case Study 'A' Interview
CSBI	Case Study 'B' Interview
EBSCO	Elton B. Stevens Co (journal articles database)
DH	Department of Health
EHU	Edge Hill University
CINHAL	Cumulative Index of Nursing and Allied Health Literature (journal articles database)
CIP	Compassion in Practice
CMRC	Care Maker Regional Co-ordinator
EPRC	Evidence-based Practice Research Centre
HEI	Higher Education Institution
I	Interviewee

NHS	National Health Service
NIHR	National Institute for Health Research
NVQ	National Vocational Qualification
PGMI	Postgraduate Medical Institute
PhD	Doctorate of Philosophy
PubMed	Public/Publisher MEDLINE (journal articles database)
Q	Questionnaire
RCQ	Regional Co-ordinator Questionnaire
TCAB	Transforming Care at the Bedside
UK	United Kingdom
USA	United States of America

EXECUTIVE SUMMARY

I INTRODUCTION

In 2013, the Care Maker programme was launched to support the implementation and spread of the nursing, midwifery and care staff strategy, 'Compassion in Practice' (Cummings and Bennett, 2012). Initially NHS Employers were commissioned by NHS England to deliver the Care Maker programme. However, on the 1st April 2015 the operational delivery of the Care Maker programme transferred to NHS England. Edge Hill University was commissioned to undertake the evaluation of the Care Maker programme in January 2015.

In April 2015, during the evaluation's data collection period, there were 692 health and social care staff who were Care Makers across the NHS in England. They represent both student and qualified staff and clinical and non-clinical staff. Roles included care assistants, student nurses, midwives, physiotherapists, medical staff and board members. Their remit is to act as ambassadors for the 6Cs, to help communicate these values and to inspire and encourage others to provide their best practice (Garratt, 2014).

The evaluation focused on four distinct empirical data collection phases: a Care Maker questionnaire (258/692 responses, 37.3%); Care Maker Regional Co-ordinator questionnaire (7/11 responses (63.7%); five Care Maker Intern semi-structured interviews; and two case studies based on two separate NHS Trust sites.

II MAIN FINDINGS

There was a consensus within all four data collection phases that the Care Maker programme has had a positive impact on health care. The values and behaviours that underpin the role were reported to be already inherent in individuals' clinical practice; however the Care Maker appointment was seen to validate their work. Findings demonstrate that the Care Maker programme has supported and helped to underpin the nursing, midwifery and care staff strategy 'Compassion in Practice' (Cummings and Bennett, 2012). The programme has provided opportunities for Care Makers in two distinct ways: to enhance quality of care in their own workplaces; and develop their own professional practice. Support structures and networking were vital influences on the perceived success of the Care Maker programme. In some cases however these support structures and networking opportunities were reported to be variable.

The Care Maker questionnaire revealed that 93% of respondents (n=241) were proud to be a Care Maker, upholding the key principles of the programme (NHS Employers, 2015). Seventy-eight per cent (n=203) felt that being a Care Maker had made them think differently about the way that they work, with 84% (n=218) indicating that the role had enabled them to be enthusiastic about delivering high quality care. The role of Care Maker had enhanced their awareness of how to deal with difficult situations (64%, n=164). They also felt that it had given them the opportunity to voice concerns about lapses in compassionate care (69%, n=178) and to challenge staff who do not provide positive care (71%, n=183).

Respondent Care Makers felt strongly that they were able to act as an ambassador for the 6Cs and compassionate care in practice (77%, n=199). Although 55% (n=141) felt they had the personal ability to have influence on changes in practice, they were less positive about their influence on decision making at local level (48%, n=125) and national level (25%, n=65). This may be linked to Care Maker respondents reporting that they were unable to attend either national (56%, n=145) or local (56%, n=146) Care Maker networking events. Forty-three per cent of the Care Maker respondents (n=109) felt that they had the appropriate resources to be able to fulfil their Care Maker role effectively. It is open to interpretation what is deemed as 'appropriate resources'. Just 35% (n=88) of the respondents felt they had sufficient time to fulfil their Care Maker role effectively. Managerial support for the role was also found to be variable with 127 (50%) Care Makers feeling that they had sufficient support to fulfil their role effectively.

All Care Maker Regional Co-ordinators who responded to the question indicated that they agreed that the programme had been successful in impacting on policy and practice. Additionally, it was felt that the programme had 'enabled' the 'shop floor' to be heard and created 'new leaders'.

Care Maker Interns who participated in the interviews were positive about their experiences although they indicated that more support and recognition of their work would be welcomed. Opportunities to develop skills to reflect on their clinical practice while increasing their research knowledge were particularly appreciated. Personal development and the facilitation of potential academic careers were particularly valued by participants.

III RECOMMENDATIONS

Key Recommendations

1. Given the evidence that supports the value of the Care Maker programme there would be benefits to its continued support from NHS England.
2. Ensure that the ethos of the 6Cs remain at the heart of the Care Maker programme to help contribute to improving standards of care.
3. Continue to develop a fully comprehensive national standardised Induction process for Care Makers.
4. Initiate a national media campaign to raise awareness of the Care Maker programme.
5. Embed the Care Maker initiative for those involved as part of their individual appraisal and Personal Development Planning process.
6. Investigate the feasibility to develop an allocation for protected time to carry out the Care Maker role.

7. Open dialogues between NHS England and those Trusts and Higher Education Institutions who might not have engaged as fully in the programme thus far, in order to identify potential barriers

1 INTRODUCTION

1.1 Background

The importance of providing high quality compassionate care has been well-recognised (Department of Health, 2013; NHS England, 2014). The values and behaviours at the heart of this vision have been termed the 6Cs – Care, Compassion, Competence, Communication, Courage and Commitment (Cummings and Bennett, 2012). In April 2013 the Care Maker programme was launched to provide a link between the national policy objective and front-line care. Edge Hill University was commissioned to undertake the evaluation of the Care Maker programme in January 2015.

1.2 The Care Maker programme

The Care Maker programme was launched to support the implementation and dissemination of the nursing, midwifery and care staff strategy, 'Compassion in Practice' (Cummings and Bennett, 2012). Initially NHS Employers were commissioned by NHS England to deliver the Care Maker programme. However, on the 1st April 2015 the operational delivery of the Care Maker programme transferred to NHS England. Edge Hill University was commissioned to undertake the evaluation of the Care Maker programme in January 2015.

Based on the 'spirit' of London 2012 Olympic Games, the Care Maker Programme aimed to capture the learning from the model of 'Games Makers', in an attempt to emulate the energy and enthusiasm that was created during the Games. The initial expectation for Care Maker recruitment was to recruit around 1,000 Care Makers and the primary purpose of the programme was to build a social movement which advocated and supported the spread and implementation of Compassion in Practice (Cummings and Bennett, 2012) and the 6Cs locally. It was envisioned that these attributes could be utilised to disseminate and link national policy and strategy to frontline care.

1.3 The Care Maker

Care Makers are health and social care staff, both student and qualified, clinical and non-clinical, from care assistants, student nurses, midwives, physiotherapists through to medical staff and board members who volunteer to be selected for demonstrating a passion and commitment to act as ambassadors for the 6Cs. The aim of the Care Maker role is to help communicate these values and to inspire and encourage others to provide their best practice (Garratt, 2014).

The initial principles for the National Care Maker Network were:

- To represent the whole of the NHS, from all parts of England and all care settings.
- To inspire people by recruiting student nurses and midwives (including those newly qualified).
- A shared purpose to transform the NHS culture in nursing, midwifery and care staff.
- Creativity – using social media and social movement expertise.
- Diversity from different ethnicities, backgrounds, range of experiences and opinions.
- To provide an opportunity for individuals through exposure to a wide variety of experiences, activities, and people across the NHS.

(Adapted from NHS Employers, 2015)

Aspirations for the role of a Care Maker were:

- Care Makers are ambassadors for the 6Cs (Care, Compassion, Competence, Communication, Courage and Commitment).
- They inspire people – students, health care assistants, qualified staff and allied health professionals of all levels and disciplines.
- They practice excellent person centred care.
- They encourage others to emulate their best practice by embodying the essence of the 6Cs in everyday life at work.
- They have a part to play in helping transform the NHS and its culture.
- They are creative – they use different channels including social media to connect the hearts and minds of our sector, engage and inspire.
- They volunteer at events - visit universities, Trusts, hospitals and others venues spreading the word about the Care Makers programme, Compassion in Practice and the 6Cs.
- They are diverse – by ensuring there are no boundaries to care within ethnicity, background, range of experiences and opinions.

(NHS Employers, 2015)

1.3.1. Number of Care Makers

Recruitment exceeded expectations with 1,462 Care Makers initially taking on the role. In December 2014 NHS Employers contacted all (1,462) Care Makers asking them to recommit to the Care Maker role. The Care Makers were asked to select one of the two responses available. These were:

- I confirm I would like to continue to be a Care Maker in 2015
- I no longer wish to be Care Maker, please remove me from your mailing list

At the time the Care Maker questionnaire was sent out there was a network of 692 Care Makers who had recommitted to their role, working across the NHS in England with a commitment to spreading the word about the 6Cs, and helping to transform the organisation and its culture. This number rose to 708 in May 2015 when Care Maker central team conducted an evaluation of Care Maker numbers and roles in each region. This was in preparation for meetings with each of the Care Maker regional leads.

At this time there were 708 active Care Makers and an additional 754 Care Makers who remained on the database transferred from NHS Employers that had not responded to the recommitment request. Table 1 and table 2 show the regional spread of Care Maker Recruitment and re-commitment, by locality and region respectively.

Table 1: Number of Care Makers per Local Region

Local Region	Number of Recruited Care Makers	Number of active Care Makers	Number of Care Makers not re-committed
North West	261	114	147
Yorkshire & Humber & North East	312	146	166
East Midlands	172	102	70
East of England	97	42	55
West Midlands	327	178	149
South East (Beds & Herts)	71	31	40
London	81	40	41
South East (excluding Beds & Herts)	87	33	54
South West	54	22	32
Total	1462	708	754

Table 2: Number of Care Makers per National Region

National Region	Number of Recruited Care Makers	Number of active Care Makers	Number of Care Makers not re-committed
Total for North	573	260	313
Total for M&E	667	353	314
Total for London	81	40	41
Total for South	141	55	86
Total	1462	708	754

1.4 The Care Maker Regional Co-ordinators (CMRCs)

The role of the Regional Co-ordinators is to act as ambassadors for the ‘6Cs’ and ‘Compassion in Practice’, inspiring and supporting other Care Makers to make a difference to both patients’ and staff’s experience of care. Their remit is to support new recruitment initiatives, disseminate the philosophy of the programme and encourage others to embed these values, represent Care Makers at various events and communicate regularly with Care Makers. They provide a link between Care Makers, the local area teams, the steering group, the strategy board and Care Maker headquarters. In addition, they are active Care Makers, providing regular feedback to all stakeholders.

1.4.1 Number of CMRCs

At the time of the evaluation there were 11 active CMRCs in the role. Table 3 shows the number of CMRCs split by local region.

Table 3: Number of CMRCs Split by Local Region

Local Region	Number of Active CMRCs
North West	2
Yorkshire & Humber & North East	2
East Midlands	2
East of England	2
West Midlands	1
South East (Beds & Herts)	0
London	2
South East (excluding Beds & Herts)	0
South West	0
Total	11

1.5 The Care Maker Interns

The Care Maker internship programme, a joint initiative between NHS England and Health Education England, was established in 2014. This provided an opportunity for Care Makers considering a clinical research career to undertake a short, structured programme designed to gain mentored learning experience working within a research environment. The intention being to help to develop candidate's ability to compete for formal research training. Participants were required, upon completion of the internship, to produce an academic report, a reflective piece and to deliver a presentation on the project. Two cohorts of interns (less than ten internships in total) have completed their programme between March 2014 and April 2015.

2 LITERATURE REVIEW

A literature review was conducted in order to help inform the development of the data collection tools within the evaluation. A literature search using the search term 'Care Makers' was undertaken on 10th March 2015. The following search engines were used: Google scholar; EBSCO 'discover more'; CINHAL; British Medical Association; Internurse; PubMed; Proquest Journals; Proquest dissertation and thesis; and Sage. As a result of this search no 'hits' were generated.

Given the dearth of literature specifically centred on the Care Maker initiative a wider literature search was conducted. Analogous schemes aiming to bring about change or improvement, both inside and outside the clinical setting, were examined. These were: the Olympic Games Makers; the use of 'champions'; and the 'transforming care at the bedside' project. The following section will discuss how each of these models have been evaluated in terms of their effectiveness to bring about cultural change. This will provide a broader context to situate an evaluation of the Care Maker Programme.

The Game Makers Programme, with its aims of encapsulating the enthusiasm and inspiration of the Olympic Games through its volunteers, has contributed to a change in attitude towards volunteering. The 2012 'Games Meta Evaluation Report' (Department for Culture, Media and Sport, 2013) recognised that the Games inspired many people to volunteer for the first time and increased enthusiasm for volunteering in general. It was found that the volunteers benefitted from the experience and gained the opportunity to develop a variety of transferable skills. In turn, the role played by the Games Makers attracted a high level of media coverage and interest from the public raising the profile of volunteering (Department for Culture, Media and Sport, 2013). This analysis provides some insight which is beneficial to an evaluation of the Care Maker programme. It shows the potential ripple effect of enthusiasm and commitment to a cause. This is alongside the benefits it provides to the individuals involved in terms of increased satisfaction and transferable skills. The value of media interest and an increase in the recognition for an initiative that can be generated locally, nationally and internationally should be recognised. It also prompts an awareness of the potential challenges going forward in maintaining levels of engagement and enthusiasm. Given the Care Maker programme was inspired from the ethos of the Games Makers awareness of these issues provides valuable background information.

Within the clinical context the value of having individuals advocate and champion high quality care has been recognised with the formation of the 'champion' role. This model of change is focussed either upon a particular disease process or raising clinical standards generally. A critical review of the 'Champions for Older People' initiative found that champions were able to use their role to implement national policy at a local level, to promote service improvements and advocate for patients (Manthorpe, 2012). A further example is that of the 'Dementia Champions'. An evaluation of the impact of the 'Dementia Champions' role across Scotland showed that it had been successful in raising the profile of dementia at a local level (and to some extent at a national level), had supported progress in improving care, and was seen as a catalyst for change (Ellison et al, 2014). These examples revealed that the Champions made personal gains in terms of the positive impact of the role in addition to the effect on clinical practice. Moreover, examining these evaluations provides some understanding of the potential barriers and enablers to such projects, alongside key elements in ensuring their sustainability. Common themes in relation to time, resources, support from a managerial and strategic level, opportunities to form networks and communication channels and how to embed the role within organisations can be identified. Furthermore, both evaluations identified some limitations in terms of response rate from the Champions which may affect

generalisability of the findings. This background provides some awareness of the potential elements relevant in informing an evaluation of the Care Maker programme. An international example of individual empowerment at local level in order to initiate change is the 'Transforming Care at the Bedside' (TCAB) initiative started within the United States of America (USA). TCAB aims to improve the quality and safety of patient care; increase teamwork; encourage patient-centered care and improve effectiveness and efficiency of the entire team; and provide transformational leadership (Robert Wood Johnson Foundation, 2011). Frontline staff are encouraged to identify and make changes needed to improve care and teamwork using tools such as intensive mind-mapping of issues and plans to translate improvements into practice (Stefancyk, 2008a and 2008b). Evaluation of this initiative revealed some improvements in patient safety (Robert Wood Johnson Foundation, 2011); improvements in communication within health care teams and with patients (Lavoie-Tremblay et al, 2014) and the importance of ensuring adequate resources, staffing and pre-planning for such programmes (Osman and Nolan, 2013). Given the complexities of implementing and co-ordinating a strategy which while on a national scale is focussed upon local, front-line empowerment the TCAB provides further context to inform the Care Maker programme and its evaluation.

A selection of grey and unpublished literature (Ball, 2014; Dowling, 2014; Smith, 2014) was supplied to the evaluation team by NHS Employers. The three reports provided were authored by Care Maker Interns as part of the 'Care Maker Research Internship Programme' (NHS England and Health Education England, 2014). Each area of research focussed upon exploring an aspect of clinical practice aligned to the ethos of 'Compassion in Practice' (Department of Health and NHS Commissioning Board, 2012). Analysis of the key themes within each project was conducted. Underpinning each of the projects was a commitment to the importance of the nurse-patient relationship, patient-centred care, communication, and inter-personal skills. Each of the projects recognised, either explicitly or implicitly, the significance of the 6Cs in clinical practice. The process of analysis enabled further understanding of the remit of the Care Maker Interns. This insight was used as a discussion point by the evaluation team and contributed to framing the data collection tools.

3 METHODS

After an initial analysis of documentary evidence (outlined above) the evaluation focused on four distinct empirical data collection phases: a Care Maker questionnaire, a Care Maker Regional Co-ordinator questionnaire; Care Maker Intern semi-structured interviews; and two case studies based on two separate NHS Trust sites.

3.1 Care Maker Questionnaire

Phase one collected data from Care Makers. The survey was designed by the Edge Hill University research team in consultation with NHS Employers and NHS England and was informed by the previously collected grey literature and background

information. The survey was piloted with seven EHU research colleagues and eight other EHU staff members who had knowledge of the Care Maker programme. Minor amendments were made to the survey informed by piloting comments.

The survey contained ten items plus a collection of demographic information. Seven questions required closed responses, where participants were required to select from a series of responses to questions asked, with an 'additional information' box included for any further information respondents wished to provide. Three questions were open ended with free text boxes allowing for more in-depth answers. Items gathered data on: the personal experience of being a Care Maker, opportunities in Care Maker role, networking as a Care Maker, leadership as a Care Maker, and support received in Care Maker role. No identifiable personal details were collected and all responses were anonymous (a copy of the survey can be found in appendix 1). Consent was implied by voluntary completion of the questionnaire. In accordance with research and ethical requirements, introductory and closing text (with contact details for the research team and an independent contact) were also included on the questionnaire.

The survey employed a total population sample approach (Patton, 2015). Having been uploaded online via Survey Monkey® software for self-completion, an invitation email containing a link to complete the survey was sent by representatives of NHS England. The survey was sent to all 692 Care Makers on 24th March 2015 with a reminder email being sent out on 1st April 2015. The survey was also advertised on social media, asking Care Makers to check their personal email accounts in order to complete the survey via the link provided. The survey was closed on 20th April 2015.

3.1.1 Care Maker Questionnaire Analysis

The quantitative data were analysed using basic descriptive statistics and graphs with summaries produced. The qualitative data were independently analysed by two member of the EHU research team (JK & KZ) thereby increasing the internal validity of the findings (Silverman, 2013). Responses to open text items were analysed using a thematic analysis approach (Polit and Beck, 2013). Themes were identified and refined through multiple readings. The two researchers then met to agree a consensus of themes. QSR Nvivo 10 was used to assist this process.

3.2 Care Maker Regional Co-ordinator (CMRC) Questionnaire

Respective organisations have supported the development of a network of Care Makers facilitated by CMRCs. Phase two explored the views and experiences of CMRCs. An online survey was designed in April 2015 by the EHU research team in consultation with NHS England and was informed by the previously collected grey literature and background information. The survey was piloted with EHU academic staff with knowledge of the Care Maker Programme. Minor amendments were made to the survey informed by piloting comments.

The survey contained 11 items in total – four required closed responses, where participants were required to select from a series of responses to questions asked, while seven were open ended with free text boxes allowing for more in-depth

answers. Items gathered data on the professional groups of CMRCs, the circumstances that led to them accepting the role of CMRC, the role of a CMRC, any benefits to being a CMRC, any support received, the sustainability of the programme, any challenges faced, examples of good practice and suggestions for improving the programme. No identifiable personal details were collected, and all responses were anonymous (see Appendix 2 for full survey). Consent was implied by voluntary completion of the questionnaire. In accordance with research and ethical requirements, introductory and closing text (with contact details for the research team and an independent contact) were also included.

A total population (11 CMRC participants) sample approach (Patton, 2015) was taken, inviting all NHS and HEI who have Care Makers to participate in the evaluation. Having been uploaded online via Survey Monkey® software for self-completion, an invitation email containing a link to complete the survey was sent by representatives of NHS England to all CMRCs on 5th May 2015. A reminder invitation was sent one week later and a second reminder was sent out at the beginning of June. The survey was closed on 12th June 2015.

3.2.1 CMRC Questionnaire Analysis

Closed questions were analysed using basic descriptive statistics e.g. frequencies and percentages. The qualitative data were independently analysed by two member of the EHU research team (AK & JB) thereby increasing the internal validity of the findings (Silverman, 2013). Responses to open text items were analysed using a thematic analysis approach (Polit & Beck, 2013). Sections of text that related to ideas or concepts relevant to the study's aims and objectives were identified, and labels and codes used to describe them. Emerging categories were then used to organise the coded sections of text.

3.3 Care Maker Intern Interviews

Phase three collected data from five Care Makers Interns. Qualitative digitally recorded telephone semi-structured interviews were conducted to explore the experiences of the Care Maker Internship. Interviews were designed to enable interns to describe their experiences and perceptions without the restrictions that a structured format would bring (Holloway & Wheeler, 2013). Each intern had a unique experience and this flexible approach was deemed the most appropriate to gain the required information.

The semi-structured interview schedule was designed by the EHU research team in consultation with NHS England and was informed by the previously collected grey literature, background information and data collected previously through the Care Maker and CMRCs questionnaires. Discussion topics covered the following areas of interest; a detailed description of their particular role as intern, their motivation to be an Intern, their expectations and their experiences so far. (A copy of the interview schedule can be found in appendix 3). All five interns volunteered to take part after an invitation sent out by email (with a participant information sheet attached) via NHS England. Verbal consent was taken at the start of the telephone interview.

3.3.1 Care Maker Intern Interviews Analysis

Data were independently analysed by two members of the EHU research team that had conducted the interviews (PS & KZ). Data were analysed using a thematic analysis approach (Polit and Beck, 2013). Themes were identified and refined through multiple readings. The two researchers agreed a consensus of themes.

3.4 Case studies

Case study sites were selected by NHS Employers in February 2015 to represent a range of different health and social care providers across the UK. Data collected through semi-structured telephone interviews with key informants who were selected formed the basis of the case studies. Key informants were identified by the gatekeeper at each case study site. The gatekeepers helped in the quick and positive identification of those well-placed to help. A semi-structured interview schedule was developed based on emerging findings from phase one (Care Maker questionnaire). The interview schedule was used to facilitate data coding to ensure consistency across study sites (a copy of the interview schedule can be found in appendix 4). Interviews were conducted with a range of professionals working in diverse roles and with engagement in the Care Maker Programme; clinical management, team leadership and non-clinical roles. Data were analysed by one member of the research team (AC) who had conducted the interviews. The transcripts were further analysed by second member of the research team (JB) thereby increasing the internal validity of the findings (Silverman, 2013). Data were analysed using a thematic analysis approach (Polit and Beck, 2013). Themes were identified and refined through multiple readings. The two researchers then agreed a consensus of themes.

3.5 Research Governance processes

To ensure relevant approvals to conduct the study were secured at the earliest possible date. In February 2015 discussions were held between the research team, representatives of NHS Employers and the R&D lead for NHS England. Discussions established that the study would be deemed as a service evaluation as per Health Research Authority guidelines (2015) and as such it would not be necessary to contact each research site for permissions in relation to phases one (Care Maker questionnaire), two (CMRC questionnaire), and three (Care Maker Intern Interviews). Administration of the electronic surveys was administered by NHS Employers and NHS England rather than members of the research team as prior permission had been given to NHS Employers to store and use contact details for activities relating to the Care Maker programme (including evaluation and review) and there would be no collection of sensitive data. These matters were outlined in a letter from NHS England (see Appendix 5) to Edge Hill University in March 2015 and this approach was subsequently deemed appropriate by the Chair of Edge Hill University's Faculty of Health and Social Care's Faculty Research Ethics Committee in the same month.

In order to comply with the requirements of the Research Governance Framework (DH 2005), permission from each of the research sites associated with phase four (case studies) of the study was required before data collection commenced. Both NHS Trusts classified the case studies as service evaluation and granted the project permission to proceed (Case Study A on 13th April 2015; Case Study B on 17th April 2015).

Processes of recruitment, consent, confidentiality, and storage of data observed Edge Hill University's framework for research ethics (Edge Hill University, 2014).

4 FINDINGS

4.1 Care Maker Questionnaire Quantitative Findings

The questionnaire was sent out by NHS England to 692 Care Makers. Responses were received from 258 Care Makers giving a response rate of 37.3%.

4.1.1 Demographic of Respondents

Tables containing detailed demographic information of questionnaire respondents can be found in appendix 7.

The largest group of questionnaire respondents were aged between 31 and 50 years old (31-40, n=68) and 41-50 (n=63). Respondents were mainly female (n=186, 72.1%). This gender split is a reflection of the total population of Care Makers (88%, 609 Care Makers nationally are female). 139 respondents identified their professional status as registered, 40 pre-registered and 39 unregistered.

Respondents to the questionnaire were from two professional groups, Nurses (n=161, 62.4%) and Allied Healthcare Professionals (n=30, 11.6%). More than half of the questionnaire respondents were educated to degree level or higher (n=148, 57.4%). The respondents to the questionnaire were mostly identified themselves as being 'white background' ethnic group (74.1%, n=192). There were respondents from each region in England (See figure 1).

Figure 1: Region of England where Care Makers Respondents are located (total respondents n=258)

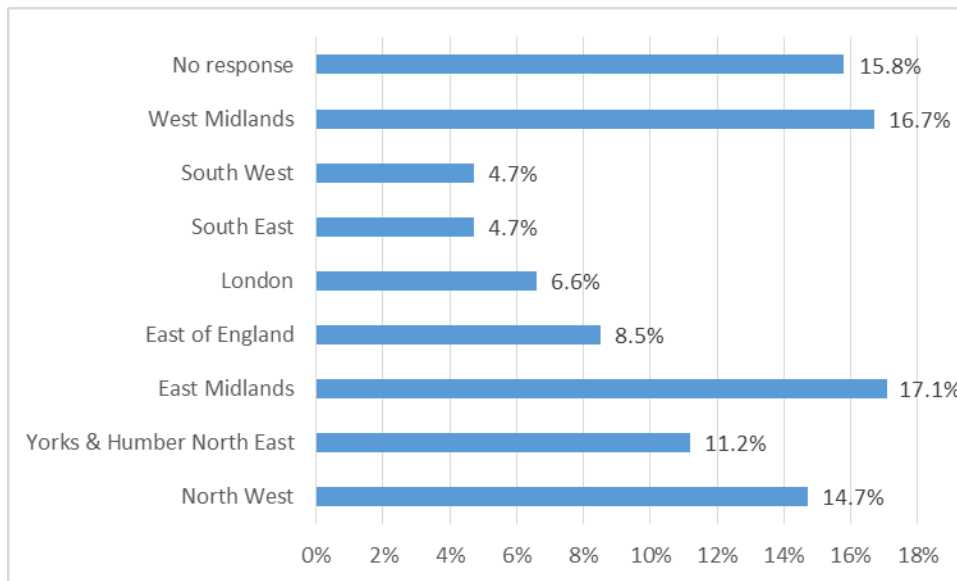


Figure 1 shows the regional location of Care Maker respondents to the online questionnaire.

Figure 2: Regional Location of Care Makers (Total Population n=692)

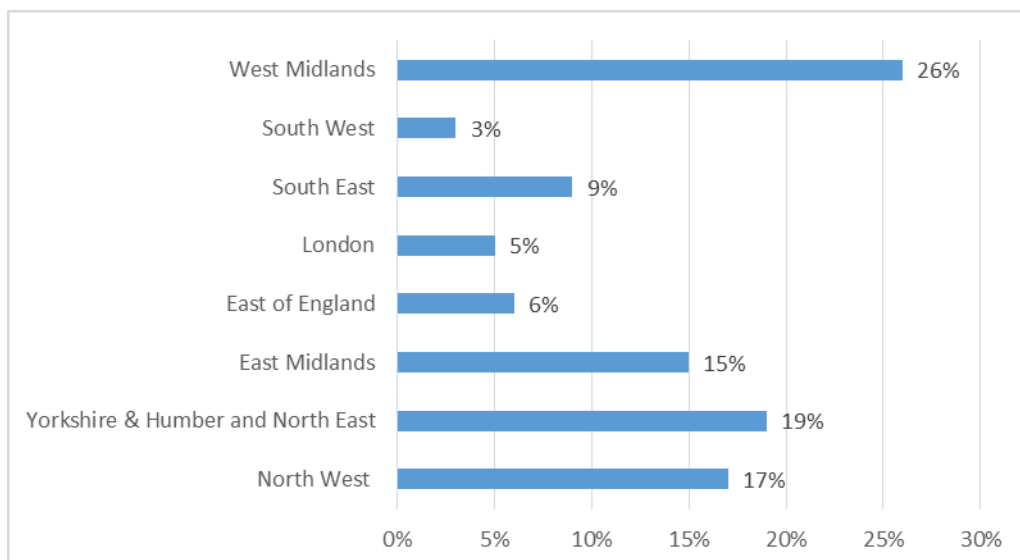


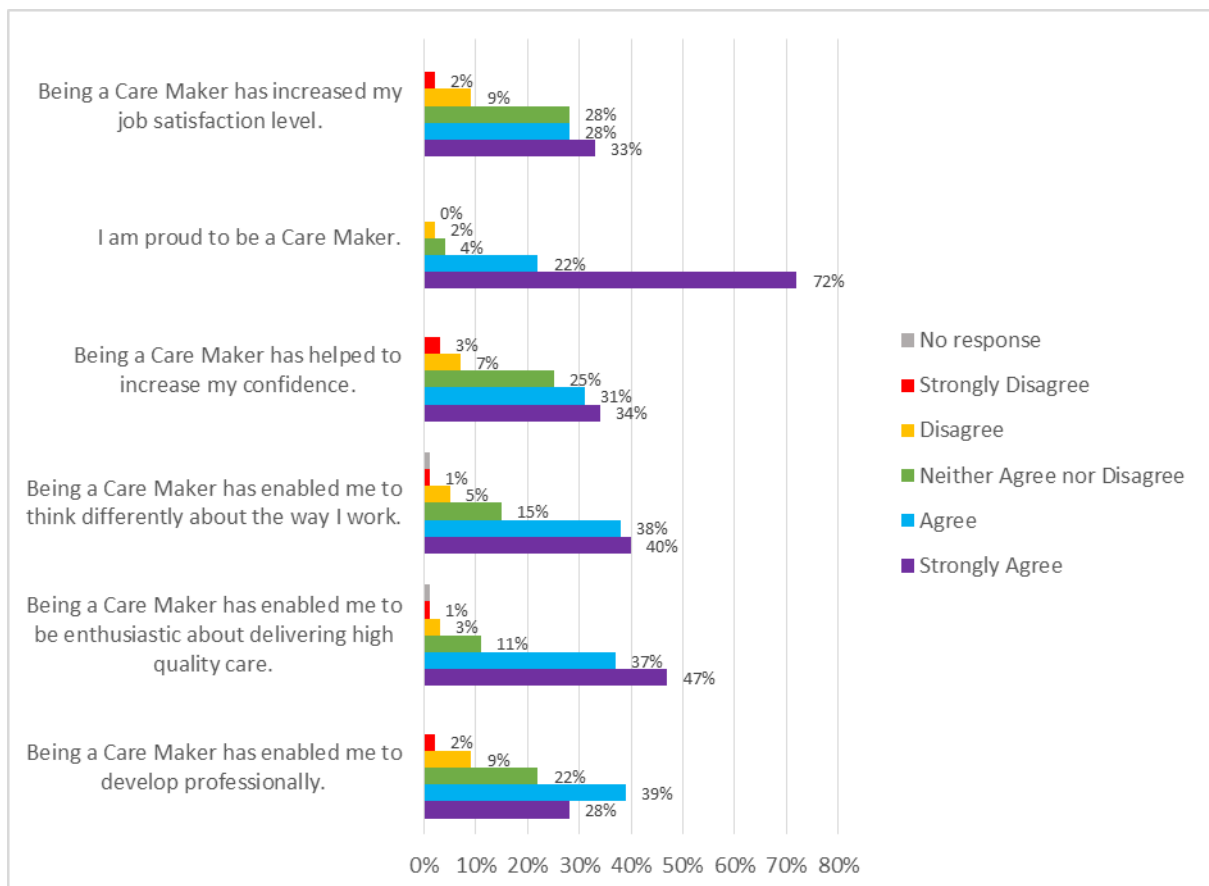
Figure 2 shows the total regional spread of Care Makers in England

4.1.2 Being a Care Maker

Care Makers were asked to state their agreement level with six statements regarding their feelings about being a Care Maker using a five point Likert rating scale; (Strongly Agree (1), Agree (2), Neither agree or disagree (3), Disagree (4) and Strongly Disagree (5)). See figure 3 below. Care Maker respondents were overwhelmingly in agreement with the positive statements about being a Care Maker. Numbers stated are the combination of strongly agree and agree responses.

Sixty-one per cent (n=156) felt that the Care Maker role had increased their job satisfaction (average rating 2.19). Care Makers were proud to be a Care Maker (93%, n=241, average rating 1.37) and felt that the Care Maker role had increased their confidence level (65%, n=167, average rating 2.13). Seventy-eight per cent of Care Maker respondents (n=203) felt that being a Care Maker had made them think differently about the way that they work (average rating 1.87) and that the Care Maker role had enabled them to be enthusiastic about delivering high quality care (84%, n=218, average rating 1.73). They also felt that the Care Maker role had enabled them to develop professionally (67%, n=173, average rating 2.17).

Figure 3: Respondents agreement levels with statements about being a Care Maker (total respondents n=258)



Care Maker respondents were again asked to indicate their agreement level to statements regarding opportunities provided to them through their Care Maker role on a five point Likert (Strongly Agree (1), Agree (2), Neither agree or disagree (3), Disagree (4) and Strongly Disagree (5)). Please see figure 4 below. Numbers stated are the combination of strongly agree and agree responses.

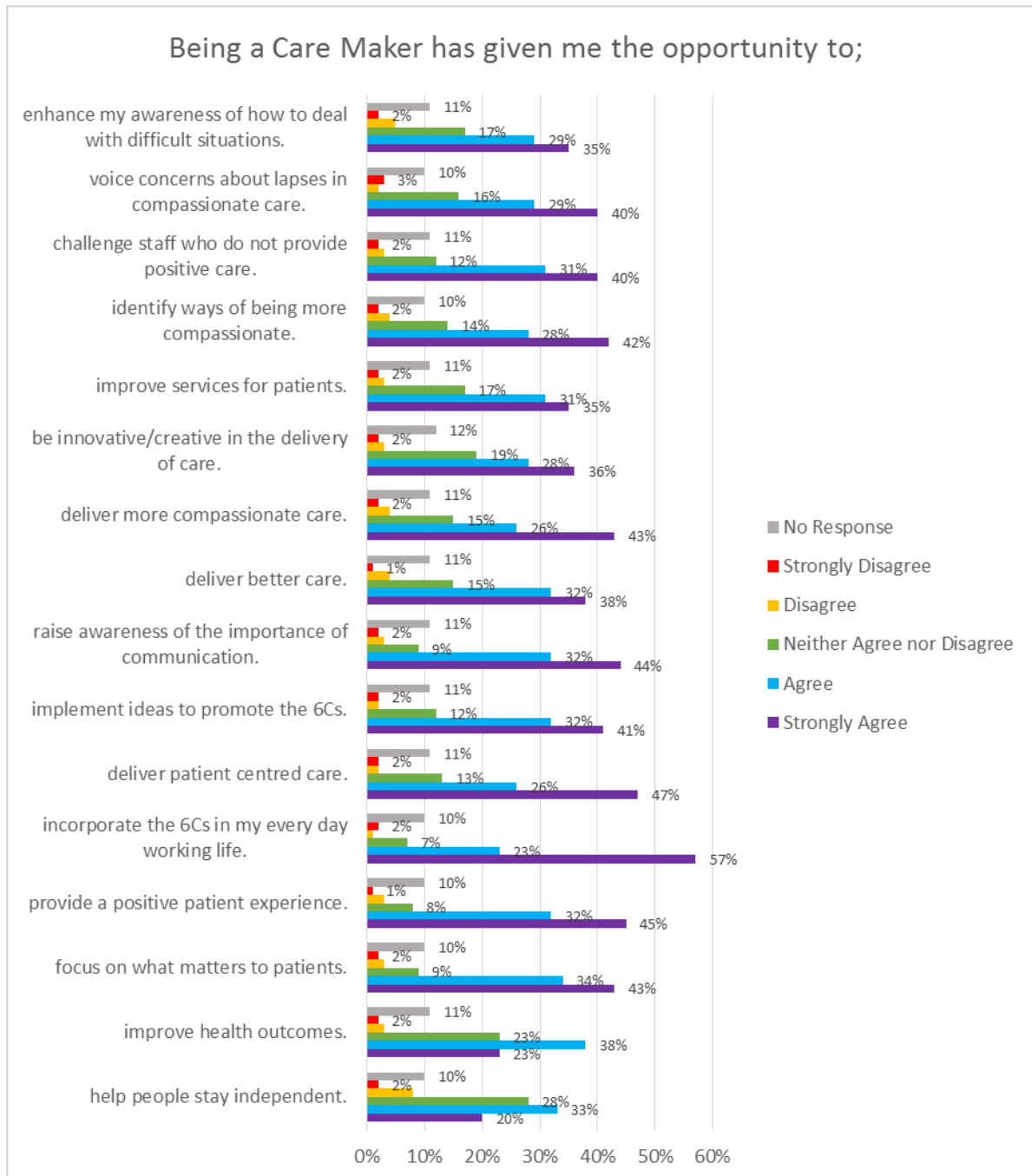
Respondents felt that the role of Care Maker had enhanced their awareness of how to deal with difficult situations (64%, n=164, average rating 2.00). They also felt that it had given them the opportunity to voice concerns about lapses in compassionate care (69%, n=178, average rating 1.88). Respondents felt that they had also been given the opportunity to challenge staff who do not provide positive care (71%, n=183, average rating 1.85).

Care maker respondents also felt that the role had enabled them to identify ways to be more compassionate (70%, n=182, average rating 1.82) and that it had enabled them to improve services for patients (66%, n=172, average rating 1.94). Care Makers agreed that the role had enabled them to be innovative/creative in the delivery of care (64%, n=166, average rating 1.95). They also agreed that the role had given them the opportunity to deliver more compassionate care (69%, n=177, average rating 1.83) and indeed that meant that they had the opportunity to deliver better care (70%, n=179, average rating 1.87).

Respondents additionally felt that the role gave them the chance to raise awareness about the importance of good communication (76%, n=196, average rating 1.73). They felt they had opportunity to implement ideas to promote the 6Cs (73%, n=190, average rating 1.77) and to promote patient centred care (73%, n=186, average rating 1.73).

Care Makers felt that the role had enabled them to incorporate the 6Cs into their everyday working lives (80%, n=207, average rating 1.53) and to provide a positive patient experience (77%, n=200, average rating 1.70), focusing on what matters to patients (77%, n=198, average rating 1.74). They felt that the role had given them the opportunity to improve health outcomes (61%, n=158, average rating 2.13) and help people stay independent (53%, n=136, average rating 2.31).

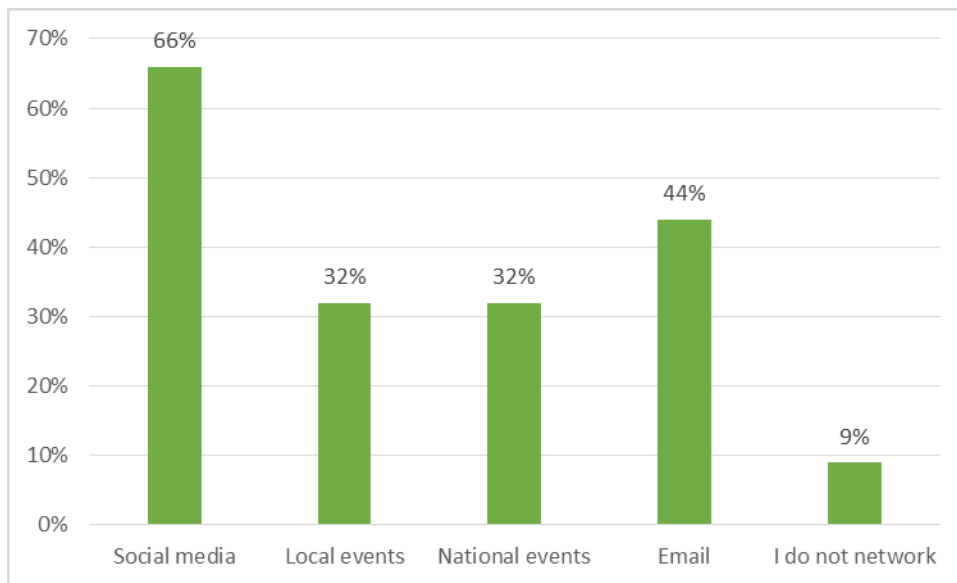
Figure 4: Respondents agreement levels with statements about opportunities available to them in their role as Care Maker (total respondents n=258)



4.1.3 Networking with other Care Makers

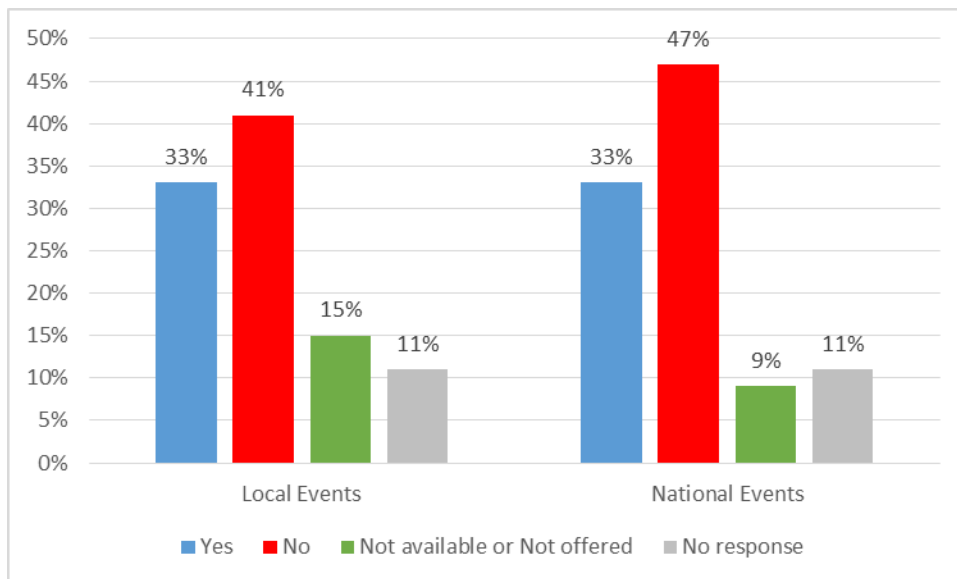
Care Makers used various different methods to get in contact with other Care Makers and other colleagues. Social media (66%, n=149) and email (44%, n=100) were both popular sources of networking. Local events (32%, n=73) and national events (32%, n=71) were also used to network. Please see figure 5 below.

Figure 5: Methods of Networking used by Care Makers (total respondents n=258)



More than half of Care Maker respondents have been unable to attend either national (56%, n=145) or local (56%, 146) Care Maker networking events. Please see figure 6 below. The reasons stated for not attending were insufficient time to attend events, and not having sufficient notice period to request a change in off duty to attend.

Figure 6: Care Makers attendance at Care Maker networking events (total respondents n=258)

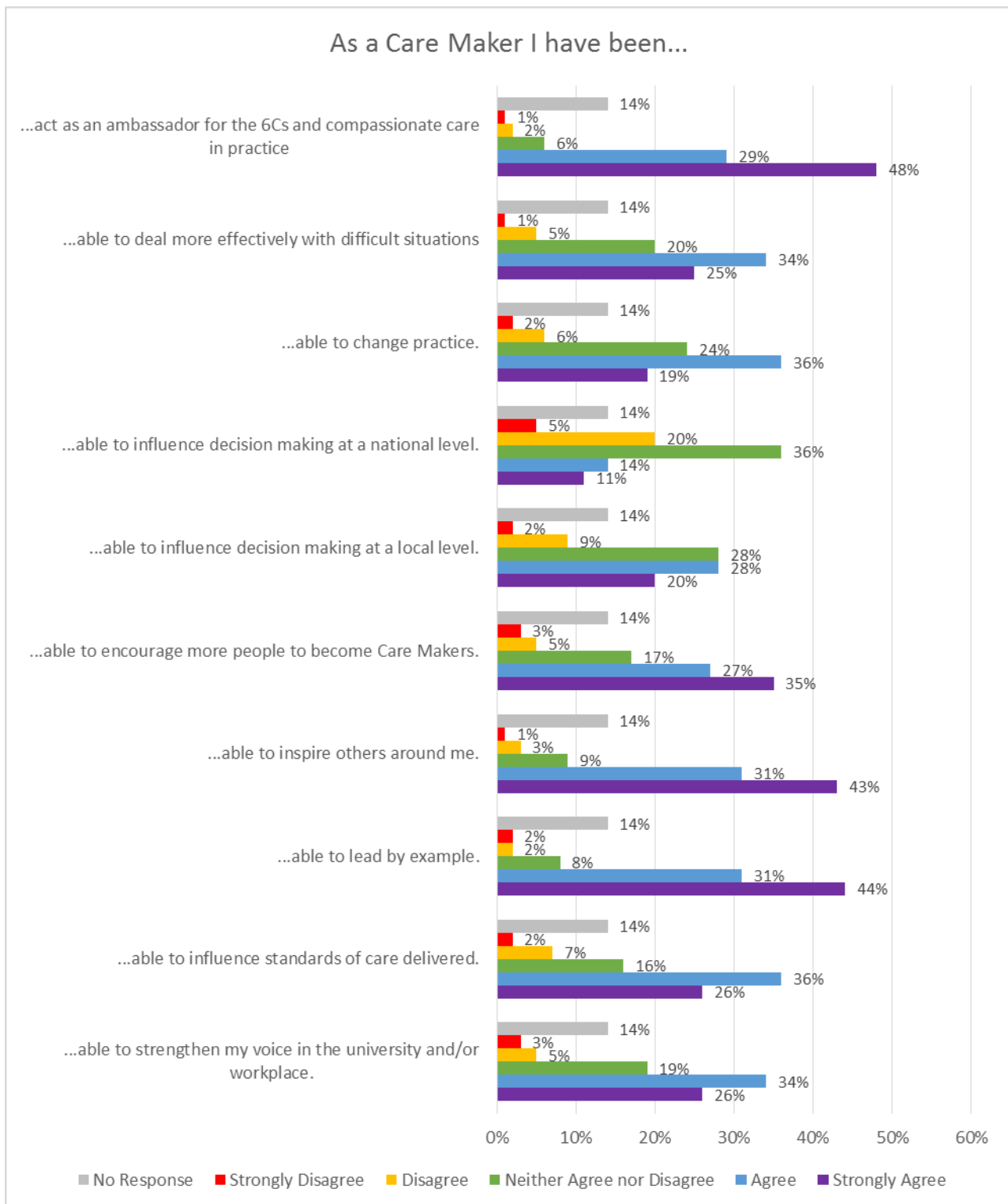


4.1.4 Opportunities for Care Makers

As outlined in figure 7 on the next page (page 21), Care Makers felt strongly that they were able to act as an ambassador for the 6Cs and compassionate care in practice (77%, n=199, average rating 1.60) and that they were able to deal with difficult situations more effectively (59%, n=153, average rating 2.11). However, respondents were slightly less positive about their personal ability to have influence on changes in practice (55%, n=141, average rating 2.25) and to influence decision making at local level (48%, n=125, average rating 2.35) and at a national level (25%, n=65, average rating 2.93).

Care Makers were positive regarding their influence in their immediate practice surroundings. They felt able to encourage more people to become Care Makers (62%, n=160, average rating 2.00), that they were able to inspire others around them (74%, n=189, average rating 1.73) and to lead by example (75%, n=193, average rating 1.69). Furthermore, Care Makers felt able to influence the standards of care delivered 62%, n=160, average rating 2.09) and felt that they were able to strengthen their voice in their university/workplace (60%, n=155, average rating 2.12).

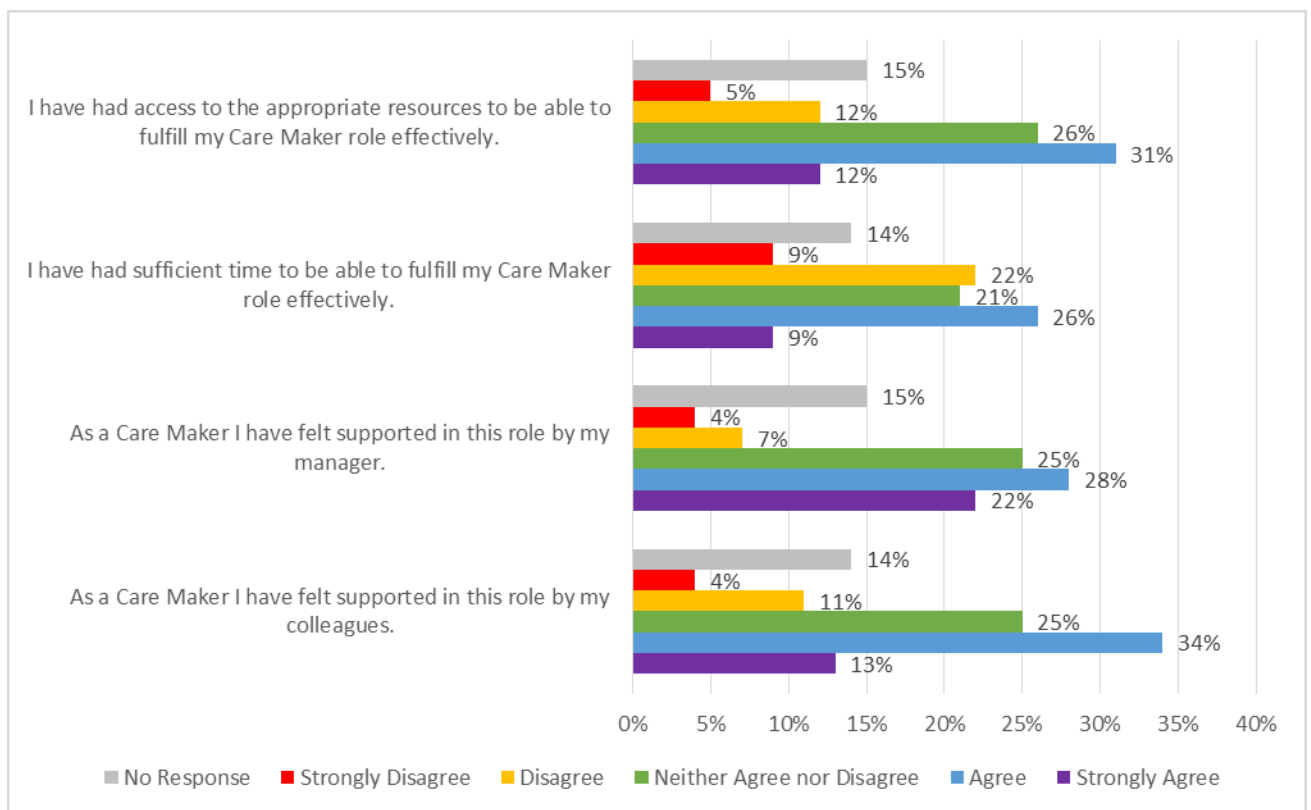
Figure 7: Personal opportunities in practice in the Care Maker role (total respondents n=258)



4.1.5 Support for Care Makers

Less than half of the Care Maker respondents (43%, n=109, average rating 2.62) felt that they had the appropriate resources to be able to fulfil their Care Maker role effectively (as shown below in figure 8). Just 35% (n=88, average rating 2.93) of the respondents felt they had sufficient time to fulfil their Care Maker role effectively. Managerial support for the role was also found to be variable with 127 (50%) Care Makers feeling that they had sufficient support to fulfil their role effectively (average rating 2.35). One hundred and twenty Care Makers (47%) felt supported by their colleagues sufficiently to fulfil their role (average rating 2.54).

Figure 8: Respondents responses to support received for Care Maker role (total respondents n=258)



4.1.6 Regional Variations in Care Maker's responses to Statement questions

Table 4 on page 24 shows the average rating scale scores for each of the five point Likert scale questions asked to Care Makers on the questionnaire. (1= Strongly Agree, 2= Agree, 3= Neither Agree nor Disagree, 4=Disagree and 5= Strongly Disagree). The main body of the table shows average scores split by the region of England that the Care Makers identified themselves as working in. The total average rating scale score for each Likert scale question from the total population of questionnaire respondents is highlighted in yellow for comparison purposes. Individual regions that scored an average score that was below the total population

of respondent's average score is highlighted in blue. N.B. In this table a below average response (in blue) is more positive as the lower number represents a stronger agreement level on the Likert scale (1= Strongly Agree to 5= Strongly Disagree).

It is important to note that regional differences were not explicitly investigated as part of the remit of this evaluation. The results shown in this table use numbers to express general agreement levels to statements provided, results must be interpreted with this in mind

Table 4: Average Rating Scale Scores for Questions Asked to Care Makers on the Questionnaire

Being a Care Maker has enabled me...		North West	Yorks & Humber	East midlands	East of England	London	South East	South West	West Midlands	Average score from all regions
...to be enthusiastic about delivering high quality care.	change practise	1.5	1.69	1.7	1.68	1.47	1.58	1.64	1.77	1.65
... to think differently about the way I work.		1.63	2.14	1.73	1.86	1.59	1.58	1.91	1.93	1.81
...to deliver better care.		1.87	2.04	1.95	1.73	1.63	1.67	1.83	1.77	1.84
...to deliver more compassionate care.		1.87	2.04	1.91	1.5	1.47	1.75	1.83	1.74	1.79
...to be innovative/creative in the delivery of care.		1.82	2.22	2	1.55	1.59	2.08	2.08	1.85	1.9
...to improve services for patients.		1.76	2.11	1.98	1.73	1.82	1.75	2.17	1.88	1.9
...to change practice.		2.13	2.46	2.32	2	1.81	2.25	2.55	2.28	2.23
...to help people stay independent.	improve patient care	2.24	2.41	2.39	2.14	1.94	2.42	2.17	2.35	2.28
...to improve health outcomes.		1.89	2.3	2.16	1.82	1.76	2.17	2.25	2.28	2.09
... to focus on what matters to patients.		1.47	1.82	1.73	1.64	1.71	1.67	1.75	1.86	1.71
...to provide a positive patient experience.		1.42	1.79	1.8	1.55	1.41	1.92	1.67	1.74	1.66
...to incorporate the 6Cs in my every day working life.		1.29	1.61	1.66	1.23	1.41	1.58	1.67	1.53	1.5
...to deliver patient centred care.		1.53	1.81	1.82	1.5	1.5	1.83	1.58	1.77	1.69
...to implement ideas to promote the 6Cs.		1.61	1.89	1.7	1.67	1.63	1.92	1.83	1.84	1.75
...to influence standards of care delivered.	Influence others	1.97	2.21	2.11	2.09	2	2.25	1.92	2.07	2.08
...to lead by example.		1.66	1.86	1.52	1.68	1.56	1.5	1.83	1.77	1.68
...to inspire others around me.		1.68	1.76	1.61	1.59	1.56	2	1.92	1.77	1.71
...to encourage more people to become Care Makers.		1.87	2.07	1.84	2.05	1.88	2.25	2	2.07	1.98
...to influence decision making at a		2.34	2.54	2.3	2.32	2	2.5	2.42	2.33	2.34

local level.											
...to influence decision making at a national level.		2.92	3.11	2.98	2.68	2.63	3.08	3.17	2.91	2.93	
...to act as an ambassador for the 6Cs and compassionate care in practice.		1.5	1.72	1.43	1.55	1.5	1.67	2	1.65	1.59	
...to develop professionally.	personal development and opportunities	1.87	2.14	2.07	2.18	1.59	2.08	2.75	2.09	2.06	
... to increase my confidence.		1.89	2.31	1.98	2.05	1.76	2.17	2.73	2.05	2.06	
...to identify ways of being more compassionate.		1.74	1.96	1.82	1.73	1.65	1.75	2.08	1.71	1.79	
...to challenge staff who do not provide positive care.		1.84	1.82	1.8	1.5	1.65	2	2	1.9	1.81	
...to voice concerns about lapses in compassionate care.		1.84	1.82	1.82	1.59	1.76	1.92	1.92	1.98	1.84	
...to enhance my awareness of how to deal with difficult situations.		1.87	2.19	1.93	1.86	1.71	2.17	2.25	1.95	1.96	
...to strengthen my voice in the university and/or workplace.		1.95	2.18	2.05	1.95	1.88	2.42	2.33	2.26	2.1	
...to deal more effectively with difficult situations.		2.05	2.31	2	1.95	1.69	2.08	2.45	2.14	2.08	
...to increase my job satisfaction level.		personal satisfaction	1.97	2.28	2.02	2.27	1.65	2.25	2.25	2.22	2.11
...to raise awareness of the importance of communication.			1.79	1.74	1.61	1.59	1.69	1.67	1.75	1.72	1.7
I am proud to be a Care Maker.	1.26		1.48	1.47	1.32	1.24	1.42	1.5	1.26	1.36	
As a Care Maker I have felt supported in this role by my colleagues.	support	2.53	2.41	2.66	2.23	2.12	2.83	2.67	2.58	2.51	
As a Care Maker I have felt supported in this role by my manager.		2.65	2.41	2.27	2	2	2.5	2.33	2.4	2.35	
I have had sufficient time.		2.76	2.72	3.02	3	2.76	3.33	3.33	3.05	2.95	
I have had access to the appropriate resources.		2.47	2.55	2.68	2.5	2.24	3	3	2.76	2.63	

4.2 Care Maker Questionnaire Qualitative Findings

Data analysis of the qualitative responses to questions within the Care Makers questionnaire identified four distinct aspects of the role which could be represented as broad themes. These were:

- The impact on patient care,
- Personal value,
- Opportunities the role provided,
- Support available.

The themes reported are representative of the consensus of opinion evident from the qualitative questionnaire data and are illustrated with verbatim quotations labelled with the respondent questionnaire number. The quotations that are included here represent the best characterisation for the identified themes. Where particularly strong quotations were found, more than one example is included.

4.2.1 The impact on patient care

One of the areas that the questionnaire sought to examine was the impact of being a Care Maker on the quality of patient care. The qualitative responses revealed that for many participants being a Care Maker provided the opportunity to further champion high quality patient care. This was seen as an important part of promoting and embodying the 6Cs:

'To me, being a Care Maker is about remembering, practicing and spreading the word about the 6Cs. I hope that leading through example as a Care Maker, I might inspire more people to also deliver care with the 6Cs'.
(Questionnaire (Q)19)

'Being a Care Maker means that I get to represent the fundamental nursing values (6Cs) to the public and my fellow nurses who may have lost their way and got caught up in all of the red tape that nursing has in the 21st century'.
(Q6)

Alongside this, participants noted that being a Care Maker enabled an increased capability to challenge examples of poor practice:

'It has given me inspiration and confidence to challenge people on the 6Cs'.
(Q9)

'I have made various concerns known to staff, then management regarding bad practice which has been resolved with management intervention'. (Q16)

Participants commented positively on their increased opportunity to shape practice and initiate new ways of working and knowledge to improve patient care:

'I have taken steps to implement change on the ward for both patients and staff in relation to better communication and increasing competence amongst newly qualified staff and health care assistants'. (Q204)

'I live the values and being a Care Maker reinforces my passion to strive for making improvements and enhancing our patients' experience of care'.
(Q233)

This aspect of influence was also described in relation to working with colleagues:

'I don't think being a Care Maker has improved the quality of care I provide - I think I was providing quality, patient centred, compassionate care already - that's why I became a Care Maker. It has however, given me the opportunity to promote this level of care and refocus thinking of others to centre on quality and compassion'. (Q105)

'I have been able to encourage staff to look at and reflect on situations differently and look at how they are delivering compassionate care'. (Q109)

Respondents also felt that Care Maker values and the 6Cs were a useful way to benchmark the care they were providing:

'When dealing with complex situations ... I am able to contribute by relying on the 6 C's almost as a default way of checking the level of care we are discussing'. (Q24)

'It means I am making a conscious effort to do the best for my clients and improve their experience of the care I provide. I benchmark the care I give against the 6Cs and evaluate whether I am achieving compassion in practice. It helps me to retain focus when work becomes stressful and challenging'.
(Q34)

Indeed, several respondents actually felt that their own personal clinical practice had improved through being a Care Maker:

'The Care Maker scheme has given me the ideas and support to enable me to provide better care and challenge poor care. It sounds cliché, but it really has made a difference!' (Q201)

'Through being a Care Maker I have understood better how my involvement in an individual's care can make a difference, and with my role and the 6Cs as a backdrop reminder, I have had the energy and drive to push forward and make that difference. It really has lit a fire under me and given me more passion and energy to succeed and make a difference'. (Q215)

In contrast, there were participants who felt that the role had not made a marked difference to their practice. This was because the 6Cs already existed as part of their clinical role. However they acknowledged the value of being a Care Maker was to support this ethos:

'Being a Care Maker hasn't changed the way I do my work but it had endorsed how I work'. (Q1)

'I feel that I was delivering a high quality, professional service prior to the Care Maker launch. What the project has done is enable me to reference my professional behaviour to the 6Cs and have challenging conversations within the framework in order to improve and clarify patient care and pathways'.
(Q106)

4.2.2 Personal Value

Participants commented on the impact of the Care Maker role, both on a personal and professional level. Respondents stated that they were proud to be a Care Maker and felt part of 'something special':

'I feel part of something special and innovative. To be at the forefront of updates and current practice changes, I feel privileged to be part of the Care Maker family'. (Q43)

This, in turn, also seemed to impact on the pride the individual had in working for the NHS and in their own professional role:

'Being a Care Maker means that I am proud to be a member of the NHS, giving care to the best of my ability and always remaining an advocate for the patient'. (Q92)

'It's inspiring to be a part of a group with similar values to myself and I am proud to be a part of this group, who endeavour to deliver high quality healthcare. As a result, I feel supported and more confident in promoting my values to others'. (Q133)

Overwhelmingly, being a Care Maker was viewed as a positive experience. One of the most valued aspects of the role was being part of a community of other Care Makers:

'I feel privileged to be part of the Care Maker family'. (Q43)

'Being a Care Maker has allowed me to connect with other professionals from across the UK that I previously wouldn't have had any contact with, through this it has allowed me to develop and share best practice by learning from others'. (Q252)

This seemed to provide a sense of connection to other like-minded professionals:

'It has helped me connect with those who share the same passion and enthusiasm as me'. (Q 38)

'Being a Care Maker makes me feel part of an amazing multi-disciplined family, I never feel alone as I know I can speak with other Care Makers and they can speak to me for all aspects of support when needed'. (Q219)

Another noteworthy feature of being a Care Maker was the importance respondents placed upon being a role model and leading by example:

'Being a Care Maker for me is a really big privilege. It has allowed me to become a role model for other staff to help them understand the 6Cs more and to look deeper into their practice to understand why we behave in the way that we do and how to develop to adapt and connect better with individuals'. (Q252)

It seemed that the role provided an opportunity for those involved to undertake some self-reflection about their own clinical practice:

'Being a Care Maker has made me really think about my own practice and reflect on how I come across to others. I see myself as an ambassador of

good care and try really hard to be a good example to others which I wouldn't have thought about before'. (Q136).

'Being a Care Maker enables me to remember why I decided to become a nurse'. (Q75).

Personal gains in relation to an increase in confidence and in job satisfaction were also noted:

'Being a Care Maker has really increased my job satisfaction and joy doing my job'. (Q18)

However, there were those who expressed disappointment in the role. This seemed to stem, in part, from a lack of general awareness of the role of the Care Maker.

'I still (1 year on) have not received my welcome pack, t-shirt and hoodie or my pin. These things may seem trivial to you and for the most part they are. However, I feel that being a Care Maker sets the applicant apart from the rest.....having a pin to place in your uniform is a recognition of this and is also a focal point for other staff and indeed patients. It also helps spark conversation'. (Q4)

In this respect, a sense of visibility in the role appeared to be important. This was valued as it provided an opportunity to start conversations with other staff, patients and visitors about the role of a Care Maker:

'I am proud to wear my badge as most people ask what it is for, I can with pride explain my role'. (Q9)

4.2.3 Opportunities the role provided

For many of the participants being a Care Maker brought a range of opportunities for professional development. This included presenting at and attending events such as conferences and training courses:

'I have been involved in conferences and events that would not happen as part of my normal working life'. (Q89)

There were also examples of Care Makers working at a more strategic level within Trusts: delivering reports and attending meetings:

'I have really enjoyed attending events as a Care Maker and feel that I have developed as a person from this. I feel confident talking to people that are high up in the NHS and other organisations.' (Q62)

Some of the Care Makers reported that meeting and working with those holding strategic positions to influence policy at a local, regional and national level was amongst the most beneficial opportunities provided:

'Networking opportunities have allowed me to develop a greater understanding of issues and the 'politics' encountered within the wider healthcare environment'. (Q119)

4.2.4 Support available

One of the areas the questionnaire aimed to investigate was the level of support Care Makers received in carrying out the role. The comments of respondents illustrated a range of experiences. For some, the level of support was good:

'My manager is supportive, we have the 6Cs as a standard agenda item for every meeting and this is an opportunity to provide good and bad examples, to raise any concerns and to look at feedback from patients'. (Q69)

'As part of being a Care Maker we have shared our knowledge and gained buy in from the executive team, they fully support the Care Maker role and are very keen to continue to develop this role in practice'. (Q252)

However, others felt that there had been a lack of support from their manager or Trust.

'Trust not engaged - paid early lip service to CM [Care Maker] role when CiP [Compassion in Practice] initially launched. All further engagement has been in own time'. (Q236)

There also seemed to be some lack of support from other members of staff and a lack of awareness of the role. One of the most notable barriers to undertaking the Care Maker role and in particular accessing the opportunities within the role was a lack of time:

'Lack of time during my clinical hours makes it hard to spread the message of 6Cs outside my work area'. (Q140)

Furthermore, some respondents commented that they felt there was a lack of support in terms of an absence of supportive resources:

'I am very passionate about being a nurse and I wanted to spread the word and enrol my colleagues into becoming Care Makers. I was expecting some resources to help me to do this. (Q20)

Some respondents also expressed dissatisfaction in relation to their induction into the role:

'I am proud to be a Care Maker but I don't think the organisation is run very efficiently, I have never received a welcome pack and all events in my area have been cancelled or moved to a place where I cannot attend. All online events have technical difficulties and the communication is very slow'. (Q202)

'I have never been sent an induction pack. I have never been informed about local meetings to meet others and learn how to really get involved'. (Q212)

Conversely it was noted that central support was helpful in establishing the role:

'The support from the Care Makers HQ is second to none. Their communication and recognition for the work we do is priceless. I have fully understood what my role is, in which I refer to my doing role'. (Q215)

4.3 Care Maker Regional Co-ordinator (CMRC) Survey findings

The electronic survey was distributed to all 11 CMRCs that were in post at the time of the survey. Responses were received from seven Care Maker Co-ordinators giving a response rate of 63.6%. Six respondents (54.5%) described their professional group as 'Nurse'; one (9.1%) described their group as a 'student nurse adult' (Respondent (R) 5); one additional respondent (9.1%) chose not to answer this question (R1). With such a small sample it is not possible to generalise from the data gathered; however a summary of results is described here.

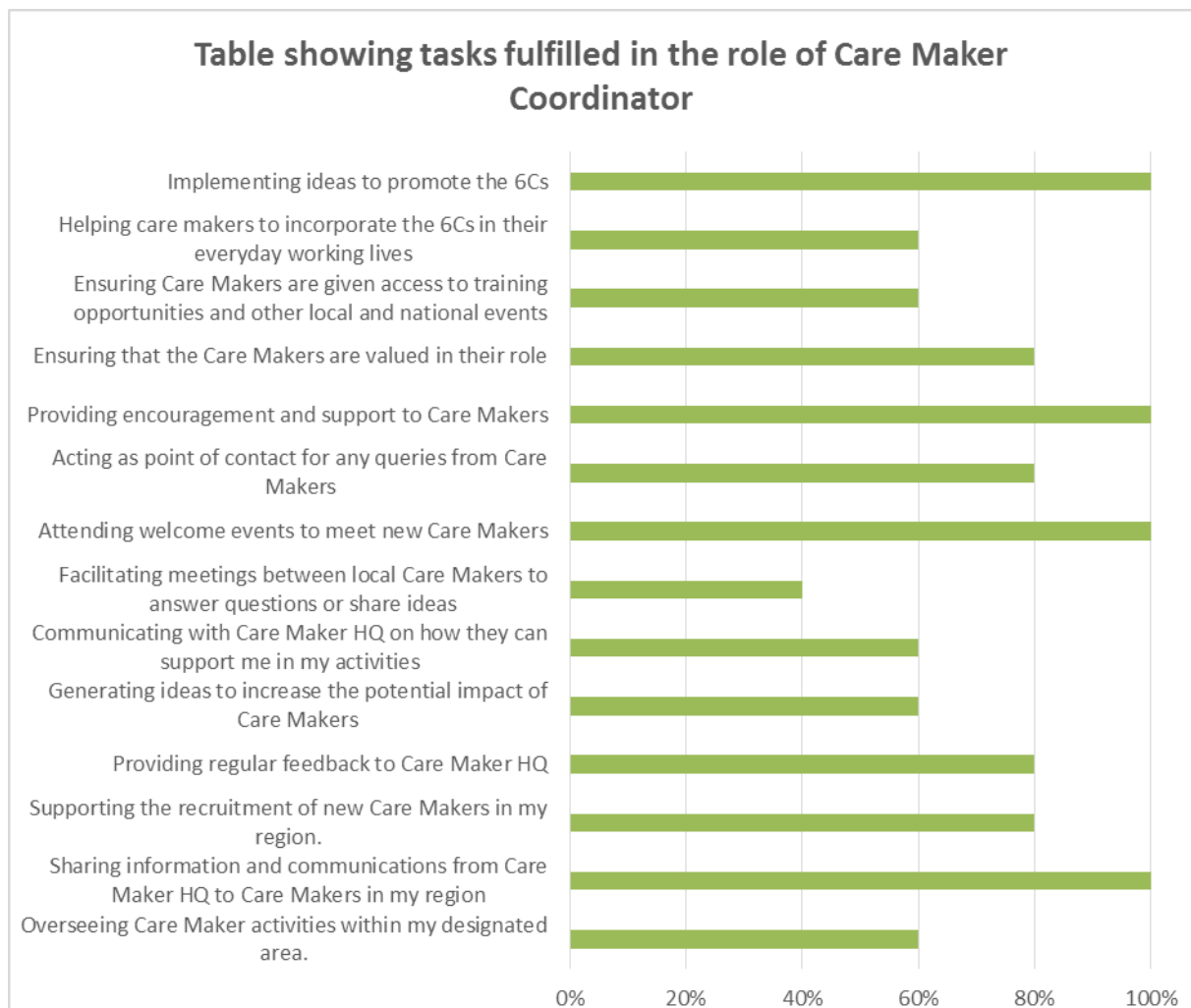
4.3.1 Reasons for taking the role

When asked 'What circumstances led to you accepting/taking the role of CMRC', responses highlighted the attraction of the '*networking opportunity*' the CMRC role offered (RCQ4; R7) and the chance to support or champion other Care Makers (RCQ2; RCQ7). The potential to '*make a difference*', both locally and further afield (RCQ7) was also cited as appealing. Other motivating factors included the opportunity to further embed the 6Cs into health care practices (RCQ2) and the encouragement of a fellow Care Maker (RCQ6).

4.3.2 The role of CMRC

Responses to an inquiry about the role of the CMRC (respondents were required to select tasks that their role involved from a list of options provided) illustrated the range of duties undertaken by CMRCs. Please see figure 9 below. Five different categories were selected by 100% (n=5) of the respondents who answered this question: 'Providing encouragement and support to Care Makers'; 'Implementing ideas to promote the 6Cs'; 'Attending welcome events to new Care Makers'; 'Sharing information and communications from Care Maker HQ to Care Makers in my region'. Four categories (n=4) respectively were selected by 80% (n=4) of respondents: 'Providing regular feedback to Care Maker HQ'; 'Supporting the recruitment of new Care Makers in my region'; 'Acting as a point of contact for any queries from Care Makers'; 'Ensuring that the Care Makers are valued in their role'. Following this, five categories were selected by three respondents: 'Overseeing CM activities within my designated area'; 'Generating ideas to increase the potential impact of Care Makers'; 'Communicating with Care Maker HQ on how they support me in my activities'; 'Ensuring Care Makers are given access to training opportunities and other local and national events'; 'Helping Care Makers to incorporate the 6Cs in their everyday working lives'. Lastly, the category of 'Facilitating meetings between local Care Makers to answer questions or share ideas' received 40% (n=2) of responses. Though respondents were invited to highlight any other tasks or duties they performed in their role as CMRC, no examples were provided.

Figure 9: Respondents duties in the role of Care Maker Regional Co-ordinator (n=5)



4.3.3 Benefits of the role and examples of good practice

When asked about any benefits experienced in undertaking the role of CMRC, responses fell into four main areas. The first of these related to the encouragement and support that CMRCs were able to provide to both colleagues and/or other Care Makers. As one CMRC noted:

‘It enables me to support my peers and help them to explore their range of talents’. (RCQ3)

A second type of response referred to the opportunities for development that being a CMRC had provided:

‘It helps to develop my leadership skills’. (RCQ6)

A third common response highlighted the useful networking opportunities that being a CMRC had offered. Lastly, being a CMRC had enabled CMRCs to have a positive

impact on 'healthcare opportunities' (RCQ5) and to 'work with others to see how [to] implement and improve ideas' (RCQ2).

When asked about examples of successes and good practice experienced since commencing the role, some CMRC highlighted the benefits of delivering presentations that enthused colleagues about the programme's aims (RCQ5). Another described that several 'really proactive' Care Makers in their region had provided excellent examples of positive action generated by individuals' involvement in the programme (RCQ4). The same respondent also noted:

'I think the program[me] has been a real success whether it continues long-term or not. I do not know if this time next year, there are only 50 active care makers doing great things, I will be one of them'. (RCQ4)

4.3.4 Views of support

Views of support received since beginning their role were slightly mixed. Whilst some spoke positively about the support they had received – from Care Maker HQ, fellow Care Makers and CMRCs, work colleagues and Trusts they were based in (RCQ2, RCQ4, RCQ5, RCQ6) - one respondent also commented:

I am [a] bit frustrated about the lack of commitment or communication regarding other Regional Co-ordinators that seem to have vanish[ed] from the face of the earth'. (RCQ3)

4.3.5 Views of the Care Maker programme: impact and sustainability

CMRCs were asked their opinions of the Care Maker programme's relative success in three distinct areas. The first of these saw respondents provide feedback on the programme's ability to positively affect values and behaviours of health and social care staff to become more patient focussed – 60% (n=3) agreed that it had with 40% (n=2) strongly agreeing. The second area on which CMRCs' opinion was canvassed related to the programme's capacity for encouraging a greater awareness of Compassion in Practice and the 6Cs; 100% (n=5) strongly agreed that it had. One hundred percent (n=5) also indicated that they agreed that the programme had been successful in impacting on policy and practice. Additionally, it was felt that the programme had 'enabled' the shop floor to be heard and created 'new leaders' (RCQ5).

CMRCs were also asked how confident they were of the Care Maker programme being sustainable in the long-term. Forty percent (n=2) were 'somewhat confident', with 20% (n=1) being 'very confident', 'confident' and 'not very confident' respectively. The respondent who was not very confident felt that there was need for the programme to have more structure and support (RCQ5); another thought it would be 'disappointing' to see the programme wind down, but argued that the impact of the programme may be of long-term value on those it has engaged:

'I don't think this is a bad thing. I think the CM program[me] has been a real asset to nursing but I suspect that it may have served its purpose. My feeling is that those that have been a part of the program[me] have benefited and this

will have been a vehicle to inspire those that have not participated to understand how getting involved in this kind of improvement can help'. (RCQ4)

4.3.6 Challenges of the role

When asked about challenges faced as a CMRC, one respondent specifically mentioned that they had not faced any as yet (RCQ6). Another cited technical difficulties with their computer, a lack of support (at times) and feeling overwhelmed with allocated tasks and other commitments (RCQ5). Other respondents felt that the size of the area they were responsible for was '*somewhat prohibitive*' (RCQ4) and a lack of communication between parts of the programme was also mentioned (RCQ3), though no further details were provided. Tackling each of these challenges was recommended in any future attempts to improve the Care Maker programme.

4.4 Care Maker Intern Interview Findings

Telephone interviews were conducted with five Care Maker Interns. The data from the interviews is discussed under the following themes which emerged during analysis: impact on clinical practice; personal and professional development; challenges to the role; supportive communities; and the way forward.

4.4.1 Impact on clinical practice

Enthusiasm for improving clinical processes and outcomes for the patient was often linked, and identified as a motivator for applying for the Internship. This was visible in references to the underlying ethos of providing care in accordance to the 6Cs:

'The gist of it is the compassion in practice and the 6Cs as a practical application of that. So that particular area, philosophy of care, obviously you know struck a strong chord with me'. (Interviewee (I)1)

Indeed, the same individual spoke how the 6Cs could promote more holistic healthcare and thus effective practice:

'...pushing the compassionate side and helping colleagues to work in a more rounded way... If you make a bit more time with people to get it right in terms of care and support... you are making time to save time because, inevitably, the person feels safer and more comfortable'. (I1)

The holistic approach that Interviewee 1 saw as central to compassionate care also involved a '*relationship-based*' approach to healthcare practice that invested time getting to know service users' circumstances, needs and wishes. The same practitioner also spoke of how such an approach would be used to accommodate the insights of carers and their significant others which could be fed into care plans and delivery.

Moreover, it was acknowledged that individuals were already delivering care in accordance with the 6Cs. For instance, Interviewee 3 considered that compassionate care had been integral to her nursing degree course and had inculcated the requisite attitudes and practice as a matter of routine:

'When I joined the [Trust] they were in the early stages of, of rolling out the 6Cs to the Trust and introducing it to staff, so to me, but to me that was something that was already embedded in my practice'. (I3)

The Care Maker Intern role had also served to validate the need for incorporation of the 6Cs into healthcare thought and practice:

'I think the whole thing [Care Makers Campaign] has been about validation of the way of working and about supporting that'. (I1)

Other illustrations of the positive impact on clinical practice that the Care Maker Intern research projects delivered were provided. These included examples of dissemination to colleagues and recommendations for clinical practice, though below we identify some of the obstacles to this.

4.4.2 Personal and Professional Development

Interests in service improvement were frequently linked to opportunities for self-development and although motives varied, common themes were expressed. The ability to conduct research, in particular, represented a key motivation for applying to be a Care Maker Intern. The prospect of gaining a research scholarship (and more) was particularly attractive:

'I thought the internship would give me a bit more of a grounding in research, a bit more of an insight and give me the opportunity to, kind of, expand on what I learnt at undergraduate really'. (I4)

'I suppose my real reason for, for becoming a Care Maker was to undertake the NHS England and Health Education National Care Maker Clinical Scholar Bronze Award, so I hadn't actually heard of a Care Maker until I looked at this application'. (I3)

The Care Maker Interns identified an increased level of research knowledge and skills as a result of the scholarship. Improved level of confidence and expertise, in relation to research, led to a number of development opportunities based upon the Intern's research project. The interviewees undertook a number of opportunities resulting from the Internship. These included a research paper submitted to a journal, research proposal, an audit proposal, presenting at conference, and access to teaching sessions and study days. The benefits to an individual's CV were also recognised:

'...one of my objectives and goals as part of the project would be to try and publish the piece of work'. (I4)

A further positive outcome of being a Care Maker Intern was the opportunities it provided for critical reflection on clinical practice and unpacking professional identity. For example, Interviewee 3, described her application for the role as reflecting, *'...what I am about as a nurse.'* Further, as Interviewee 3 explained:

'You will also need people who will pioneer it [compassionate care] and create conversations about where we are going wrong 'cause at the end of the day, we are not perfect and it doesn't mean we are practising these (6Cs)'. (13)

Such critical reflection had also led to improved awareness of the limitations of current practice and consideration of more creative ways of delivering the service:

'Particularly for me it made me quite mindful of my own practice [identification of study details], so it kind of made me a bit more mindful of what I was doing and made me think outside of the box a little bit more'. (14)

Building on this, Interviewee 1 recognized that the quasi-campaigning and disseminating functions of the Care Maker Intern role had encouraged him to consider more strategic appreciation of use of infrastructural and staff resources, especially support from managers, to improve healthcare practice.

Furthermore, it was recognised that conducting research projects in their specific domain of expertise/service area could propitiate more critical approaches that could challenge and question ingrained practice when it was not the *status quo*.

'I'm questioning everything we do now, and how we measure our quality outcomes'. (12)

'The opportunity to reflect on my own practice and actually question a bit more why we do what we do and actually are we delivering care under the 6Cs and challenging that a bit more I suppose. I think maybe a more critical appreciation of it and how it's implemented'. (13)

4.4.3 Challenges to the role

Interviewees' critical thinking also identified diverse barriers to fulfilment of the Care Maker Intern role. These obstacles reflect resource and cultural factors. Lack of time, shortages of staff, emphasis on clinical targets, and resources, were considered significant:

'I even hear myself saying that sometimes that "oh I've only got, there's so many hours in a day that I can actually do this" '. (13)

Lack of time also seemed a factor in terms of constraints in relation to the Internship and how it affected the type of project pursued and the methodology used.

The impact of a culture of constant change and climate of uncertainty evident within the working environment were also seen as barriers to embedding any recommendations from the research scholarships. As a result, any initiatives developed by the Care Maker Intern role and the potential impact on practice could be relegated when staff are overstretched:

'I'd sit and discuss these issues [related to compassionate care] but feel that it won't be taken on board... the constant change is unsettling and doesn't enable people to embed things that they've found, or want to implement... feels like maybe like people don't want to be bothered with anything else'. (12)

Interviewee 3 adopted a different strategy to cope with lack of staffing but at some personal cost. She described *'battling'* with the balance i.e. between her clinical duties and the Care Maker Intern role - the latter being *'done in my own time'*.

Examples of challenges were identified such as staff anxieties and reactions to changing priorities in practice, such as the increase in dementia, and the need to adapt services accordingly:

'Some of the people I work with say people with dementia shouldn't be here... but the reality is that people... have these complex conditions... clinical, organic and mental health... and I think... Care Makers is a pioneering thing, though there is still work to do to embed that ethos throughout'. (I1)

As implied in the statement above, there are attitudinal barriers to efforts being made by Care Maker Interns to encourage adoption of the 6Cs into consciousness and practice. But, these were also linked to staff/funding shortages. Indeed, having been inducted into the 6Cs during her nursing degree, Interviewee 3 was surprised that what had become '*common sense*' to her was a novel concept or category in her present workplace. The lack of awareness about the importance of the Care Maker role was reported as a potential risk resulting in a general lack of support.

4.4.4 Supportive communities

One of the consistent themes emerging from the Care Maker Intern interviews was the value placed upon networking opportunities, exchanging good practice within and beyond the individual's organization, and in particular meeting with other Care Makers and other Care Maker Interns.

This was seen as valuable to some, not only in terms of providing mutual support but also as a source of inspiration. It was also recognised how these relationships would be useful in terms of future research projects.

Support networks spanned across different clinical environments from the acute to primary care settings. They also included the Higher Education sector in terms of the mentorship provided by academics for the research projects. The importance placed upon building these support networks in order to share knowledge and good practice was recognised. Indeed one of the elements of being part of this supportive community was the importance of engagement with other colleagues and care providers.

It was recognised that there were differences in this experience which depended on an individual ability to access support. For example a constraining factor was geographical distance:

'We are quite isolated so geographically it's quite hard to get to events.....maybe an idea would be to have more regionally organised things'. (I1)

One way to overcome this was to utilise various social media and communication methods such as Twitter, Facebook and Skype.

'I find Twitter an excellent resource as you have the Twitter hash tag so that's a good place'. (I1)

Use of social media was crucial for this interviewee who used it strategically to overcome restrictions on arranging face-to-face meetings in rural areas where services were geographically dispersed. Colleagues within this Twitter hub shared

links as well as thoughts, which meant that Twitter provided ‘a repository of [written] information’ on which colleagues could draw. This use of social media was consistent with methods of networking used by Care Makers with 66% of the total respondents in the Care Maker Questionnaire identifying that they have communicated with other Care Makers via social media.

A crucial part of this supportive network was the Care Maker Interns’ experience of managerial support. The Interns interviewed seemed to have a positive experience of this and valued the element of the scholarship which provided for protected time to undertake the research. But there was also some uncertainty as to the extent with which any suggestions would be acted upon by management:

‘I’ll go to them [management] and I can sit, sit with them and discuss these issues, but I really feel that it won’t be taken on-board’. (I2)

4.4.5 The way forward

The Care Maker Interns interviewed were positive about their experiences of the role. The scholarship was identified as a springboard to other initiatives and events to highlight the Interns research projects and promote wider dissemination of the role.

For example, at a strategic level, for Interviewee 1, the Care Maker Intern role had proved useful in motivating colleagues to acquire knowledge and skills through ‘Dementia Champions’ – an intensive, six-day leadership training programme for healthcare professionals developed by the Alzheimer’s Society. The same practitioner also reported how the Care Maker Intern role had encouraged him to develop an array of strategies that included: developing a professional network; engaging local media; involving the public in decision-making about services; and encouraging others to take up the intern role to disseminate ideas and good practice in nursing homes and the acute care sector as well as local and general hospitals.

At a more personal level, interviewees spoke of possibilities for self-enrichment and advancement in terms of developing their research skills which would enable them: ‘...to explore aspects of compassion in practice’ (I3). For Interviewee 1, this involved consideration of how nurses’ and health workers’ experiences and insights could be translated into ‘tailored training and education’ to ensure that the 6Cs could become integral to everyday healthcare practice.

Other interviewees spoke of opportunities for study at a higher academic level, this was seen as the viable next stage, with interviewees already indicating that they were submitting applications for Masters and PhD study.

Barriers to accessing these courses did however exist in terms of funding and eligibility:

‘My plan was to get funding from the NIHR [National Institute for Health Research] to do a secondment through your employer, where your role is backfilled by the NIHR, so financed by them and you get your salary to complete the Masters, but unfortunately because of resourcing and staffing levels at my current place they won’t let me do it’. (I4)

This led to a concern about a need to plan for future advancement, and have a more developed career progression after completion of the Internship. Reinforcement regarding previously identified factors, such as funding/staffing constraints, was also apparent:

'I think it's going to make my work life a bit sad really when I go back, because I'm quite worried. I'm really quite worried about them saying "right you've done your course now, now get back into your box"'. (12)

'It's disappointing from an organisation point of view because the internships [are] there to support people in becoming clinical academics. The funding is there. I'm sure I'm not the first person this has happened to, but there must be some disconnect between employers letting people go and develop. Obviously it's of personal benefit, but in terms of workforce development, you know, no one else in my team has done anything like that and I feel like it would bring a lot to the team'. (14)

4.5 Case studies

4.5.1 Case study A

Case study site A was a large NHS Foundation Trust responsible for providing hospital services and a growing number of speciality and community services in the North of England. Nine semi-structured telephone interviews were conducted with key stake holders, who were employed in a variety of roles in the NHS Trust. Key themes constructed from the data included: the perceived impact of the Care Maker programme within the organisation; involvement with the Care Maker Programme; motivation for becoming a Care Maker; the benefits of being a Care Maker; networking activities.

4.5.1a The perceived impact of the Care Maker programme within the organisation

The Care Maker programme had a high profile within the Trust and participants suggested it had caught the imagination of people, had excited them and had energised a renewed level of enthusiasm for nursing and health care. The Care Maker programme was seen as a way of ensuring that compassionate care remained a key priority especially within busy clinical environments. Indeed it was seen to encourage people to examine and reflect on their own practice particularly in relation to interpersonal skills and was described as '*resetting our culture and values*' (Case Study A Interview (CSAI)1). Some described it as an opportunity to highlight positive areas of their work, as the following illustrate;

'I think it's given people a bit of an excitement it's given people insight to actually look at their own practice I think it highlights the positive areas of work within the Trust and where people have been shown to be demonstrating compassion. And I think it has made people more aware of their own practice'. (CSAI4)

'I think in the context of everyone's jobs, very busy lives, lots of challenges, I think it just brings in that opportunity for reflection'. (CSA11)

The Care Maker programme and the core values that underpin the 6Cs were seen as a valuable opportunity to stimulate discuss and frame key messages. Indeed it was suggested that within some specialist clinical areas it had been a used as a tool to enhance team motivation and communication skills, as the following illustrates;

'It has been received really well, particularly by mental health inpatient wards and our dementia wards and older people's mental health team. They have really embraced it and used it as part of their team motivation in defining what they do. It has been really positive for our organisation'. (CSA12)

'I think it's developed a network of like-minded people, whether nurses agree with it or don't, it's been a platform for discussion (and) ... used it as a tool to reinforce messages'. (CSA13)

Within the Trust the Care Maker programme was seen to be closely aligned to other important patient experience work streams such as 'hello my name is.' One participant described how this initiative had become standard practice for administration and telephone receptionists who are often the first point of contact for service users:

'We've incorporated the Care Maker programme and the "hello, my name is," campaign. It goes hand in hand, starting that connection and getting rapport with our service uses and carers'. (CSA13)

4.5.1b Involvement with the Care Maker Programme

Participants were variously engaged with the Care Maker Programme and all welcomed the opportunity to volunteer when membership was first extended from nursing students to qualified and registered staff. Many of the Trust staff who had become involved in the Care Maker Programme did not regard being a Care Maker as an additional responsibility but rather regarded it as intrinsic to their organisational role, as illustrated by the following comment:

'Well I think fits in to my wider role here, to ensure the 6Cs are embedded into the recruitment of volunteers'. (CSA11)

For many it was regarded it as an opportunity to frame their practice, to promote the core values of nursing and the importance of compassion in practice and articulate what nurses do:

'I think it's part of what we do. It's not an add on, it just enables us to be nurses and to be Care Makers and try to cascade it, promote the 6Cs and promote its values. It is not additional work but is part and parcel of what we do'. (CSA12)

4.5.1c Motivation for becoming a Care Maker

Many participants were motivated to become a Care Maker as they felt a personal commitment to the 6Cs and person centred care and felt that the key messages accorded strongly with their own professional values and beliefs:

'One of the main reasons why I applied just looking at the 6Cs and what it meant, it sort of fitted in with my ethics and my values in relation to my work here'. (CSA16)

Similarly, for some, becoming a Care Maker gave them an opportunity to reaffirm their motivation for becoming a nurse and to reinvigorate their passion for and pride in their work:

'I volunteered to be a Care Maker because I'm a clinical manager, but I am a nurse, and I came into nursing to help people have a better quality of life. You know that's about having a relationship with them, it's about giving them support at times when they need it, and that's very much about why I'm here, and why I turn up for work every day. The Care Maker initiative just reinforces what I actually believe in'. (CSA17)

'It reinforces my integrity and my passion ...and the reason I get out of bed every morning ... Because I'm really proud to be a nurse'. (CSA18)

Those in leadership roles described a strong belief that nurse leaders should be positive role models, enacting the highest standards of care, thus enhancing job satisfaction and helping to promote public confidence:

'Being a Care Maker reinforces how important it is for me to be a positive role-model and to lead by example, and also to really make a difference, so I think for me being a Care Maker provides that satisfaction'. (CSA18)

'Well personally, it is part of my role but even if it hadn't been it would have volunteered I really do believe in the 6Cs, I believe (that) we need to role model, that it's about professionalism, and the picture that we give the public. It instils confidence in the services that we're delivering'. (CSA13)

4.5.1d The benefits of being a Care Maker

At an individual level undertaking the role of care maker was described as an opportunity to commit to the values articulated within the 6Cs, demonstrating this within their own professional practice. This gave individuals a renewed sense of pride in their work as the following illustrates:

'It's about gaining pride in being a nurse and pride in making sure that we adopt the 6Cs and we treat people with respect and dignity'. (CSA15)

Those in leadership roles described being a Care Maker as an opportunity to be an ambassador and role model for compassion in practice, promoting positive values and behaviours in themselves and others:

'I think we are such good ambassadors of compassion in practice that that's how I want to manage and support my team. Being a Care Maker provides a real, you know, not just a guide but a structure really in terms of the

management team embodying those values. It's something that's close to my heart. I have a great team who have promoted it incredibly well. I'm really proud of what we have been able to achieve'. (CSA12)

A key benefit was also described as the sense of being part of a wider community of like-minded people within and across the organisation. It provided opportunities for greater visibility and a stronger voice in organisational meetings. The Care Maker programme was seen to bring diverse people with a common agenda together, ultimately to contribute to a more compassionate working environment for Trust staff as well as service users, creating connections between people that might not have otherwise existed:

'You get a real sense of being part of something wider in the organisation and I think because it brings in a cross section of staff from what is a very diverse organisation together, there's something about the linkages that it creates, the connections with other members of staff you wouldn't maybe normally have'. (CSA11)

'I think it gives you a bit more visibility within the organisation ...and the ability to promote it with your colleagues and with your patients and with the wider circles and other professionals that are within the organisation as well. Certainly there is an awareness within the organisation of who are Care Makers and you know they have badges and stuff like that... a lot of the Care Makers are non-clinical staff and it's fantastic to see that'. (CSA14)

4.5.1e Networking opportunities

Within the Trust the Care Maker programme was promoted at organisational meetings such as the Annual General Meeting (AGM) and Care Makers were visible at the Nurses Celebration Day and other similar events. Most participants in Care Maker roles felt they had opportunities to network with others in the role and many suggested they used social media such as Twitter to communicate with others. Care maker meetings were scheduled by the Care Maker lead and a quarterly newsletter, called a '*Virtual Huddle*', was produced to promote Care Maker activities and events:

'It's a newsletter basically, it demonstrates what people are doing within the Care Maker role, and people can chat, people can send things in to show case what they're doing'. (CSA13)

Overall, participants felt that the Care Maker programme was well established within the Trust. Ensuring the programme was well embedded at ward level and within the roles of team leaders was seen as essential for maintaining drive and enthusiasm. A key challenge discussed in relation to the programme was the need to ensure its sustainability as suggested here:

'So, I think that's the stage we are at with it. Things can sometimes happen quite slowly in the NHS so I think we just have to keep talking about it, keep raising awareness, keep promoting it and just letting it be part of who we are and what we do'. (CSA12)

4.5.2 Case study site B

Case study site B is a community based non-profit organisation delivering adult community health services. The organisation operates in a unique setting in that it delivers NHS Services but is run independently from the NHS. Services include but are not restricted to Community Hospitals, District Nurses, Community Matrons, Specialist Palliative Services and Acute Care at Home Services. Participants who contributed to the case study were all Care Makers and were employed in a variety of roles including a Matron of a Community Hospital, a Nurse Practitioner, a District Nurse and a Clinical Facilitator. Four semi-structure telephone interviews were conducted. Themes constructed from the information provided include; the perceived impact of the Care Maker programme within the organisation; involvement with the Care Maker Programme; networking activities; Enhancing the Awareness of the Care Maker Programme.

4.5.2a The perceived impact of the Care Maker programme within the organisation

Participants reflected on whether they believed the introduction of the Care Maker programme had impacted positively within the organisation. Engagement throughout the Trust, including at Board level, helped to embed the concept of everyone contributing to the patient experience:

'I've championed a lot of my dementia champions to become care makers because they make a massive difference to people's lives every day; and it's not just about nurses, I think, it's about everybody who works in the NHS. I think my chief executive's about to become a Care Maker, and I've got some of my board members to join as well'. (Case Study B Interviewee (CSBI)1)

'Yes I think so, yes, 'cause certainly at our AGM [Annual General Meeting] our Director of Nursing, Deputy Director and Chief Exec signed up to become Care Makers, .and certainly their pledges on the day were very, very passionate, and so yes, I think we are supported'. (CSBI2)

A number of participants gave examples of how the Care Maker programme and the 6Cs had contributed to values and behaviours:

'When I go into clinical areas to work with the nurses. I can definitely see that people are embracing the concept of 6Cs and what they should be doing. I'm certainly seeing all of them in practice. Whether I can honestly say that's down to the Care Maker programme, I don't know. But I've definitely seen an improvement in lots of things'. (CSBI5)

The Care Maker programme has contributed to a supportive culture of prioritising patient safety. In terms of challenging examples of poor practice an example is provided here:

'We have an instant reporting system... and people are actually being encouraged to come forward and actually speak up if they see anything or may experience anything that they feel shouldn't be happening'. (CSBI5)

4.5.2b Involvement with the Care Maker Programme

Participants were variously engaged with the Care Maker programme. One participant was very active at a national and local level, recruiting others to the role and promoting the programme visually with a community hospital. She had been in a Care Maker role for over two years and had presented at the organisational AGM:

'I have recruited a number of Care Makers... I have done an AGM with my colleague last year to raise the profile.... I have a banner that I put up in my hospital which talks about the Care Makers agenda and why we're doing it'. (CSBI1)

Another aspect related to how an educational role embedded the core Care Maker values into staff training and induction:

'I've actually designed a three-hour session around the 6Cs that I deliver on induction. And then in all the other training that I deliver I always discuss the 6Cs and incorporate them into the training sessions and where possible make sure that they (staff) are embedding the 6Cs in everything they do'. (CSBI4)

All participants described how they had inculcated the Care Maker agenda and role with their existing clinical roles:

'I'm a District Nurse and I've gone into a role as a Community Nurse Lead I'm involved in trying to get students nurses into GP practices ... I do Team Meetings in GP practices... I'm working with practitioners all the time ...and so I see my role as a Care Maker just goes with that ...embedding all of those core values within everything that I do'. (CSBI3)

Most participants viewed the programme as extremely valuable to revisit the essence of nursing and the importance of fundamental and personalised care. In doing so it was seen to give the public a positive understanding of current nursing values:

'It's given people a bit of a vehicle to move things forward.... to me, it means going back to your roots with nursing. It's fundamental care that we give to patients—personalised. And I think that this programme has really highlighted that. I think the other thing it's done is it's enabled the general public to have a closer view of what we think and the essence of nursing really, which has really helped'. (CSBI1)

One participant was inspired to become a Care Maker after meeting nursing students in the role at a National conference. She was struck by their energy, enthusiasm and commitment:

'I think I was one of the first qualified nurses to become a Care Maker. I was just astounded by the vitality and the enthusiasm and passion of the Care Makers that I met that were student nurses'. (CSBI1)

Another participant also described her reaction to meeting enthusiastic students in the Care Maker role, who demonstrated a commitment and desire to influence positive change:

'What was very obvious from that initial meeting was these are young enthusiastic nurses who are just about to qualify, who can have a great influence over the future of nursing'. (CSBI2)

For others the motivation for to become a Care Maker was to be recognised as part of a movement for cultural change and be a role model for others. A key element of this was a deeply felt personal affinity with its core values:

'I've got a, a really keen interest in keeping the person at the centre of everything that we do, and I just felt that I really want to be part of this movement'. (CSBI3)

Participants spoke passionately about what being a Care Maker meant to them personally and the opportunities it had afforded. One participant in particular described how as a Care Maker she had been invited to take part in national Care maker events and conferences, through which she had met senior nurses:

'I worked with lots of very high profile names of nursing, just sit [ting] and have a conversation with and work with. So, for me, it's been absolutely brilliant because, living all the way down in [county], you don't really get an opportunity to see many people ...senior executives team in nursing, in the NMC [Nursing and Midwifery Council]'. (CSBI1)

Participants described the pride they felt in being a Care Maker and the satisfaction they gained from feeling a sense of belonging to a wider community of people with the same values and commitments:

'It's about being part of a group and belonging isn't it, really ... to a group of people, like-minded people who are ambassadors, and who have the same values'. (CSBI3)

4.5.2c Networking opportunities

This point was developed further when participants described the networking opportunities within their organisation. One participant was actively involved in national Care Maker events:

'Across my organisation, I know all the other Care Makers. But I probably have more contact with the Care Makers that I've met through (—) who live all over the U.K. — which is absolutely great. We connect quite a lot through Facebook, which is really nice'. (CSBI1)

Others agreed that networking opportunities were limited but did recognise the value of regular contact with other Care Makers within the organisation:

'I've joined the blog a couple of times but other than that, I just tend to, when the bulletins come through and things like that I read through them and read what other people are doing but I haven't actually got regular contact with particular people'. (CSBI5)

4.5.2d Enhancing the Awareness of the Care Maker Programme

When considering how the Care Maker programme could be enhanced participants were aware not just of their professional isolation from each other but also the geographical isolation of their organisation. Having more locally run events was seen as a way of gaining wider engagement:

'I think a lot of things are run centrally. I would love to see something run closer to home, in [county], which would be absolutely brilliant—I'd love us to have a [county] event. A lot of opportunities happen around the London area, and Manchester, you know, the bigger places, and I do understand that. But it would be nicer to see something raising the profile in the [county]—I would really like that 'cause there's a lot of passion there that we almost have to go out of our county to sort of talk about it, which is disappointing really'. (CSB11)

It was also suggested that having a dedicated person to lead the programme locally would be helpful to be a central point to promote local networking opportunities and would ensure that the programme was understood and embraced at the level of the clinicians delivering care. This was seen to be particularly important to engage non NHS organisations such as care homes:

'I wonder if it needs to come to another level ... obviously as nurse leaders we've become involved but it needs to be embedded in clinicians that are at all levels ... There's still work there that could be done to help that ... I think it needs somebody with dedicated time to actually raise awareness to all levels of nursing. I think student nurses probably have had that but I don't know about practitioners, Healthcare Assistants, general nurses, practice nurses. I don't know really truly if people are aware ... I think that they're aware of the 6Cs now, but I'm not sure if they're aware of the values of a Care Maker'. (CSB13)

'I think we need to reach into other organisations other than NHS. As I've alluded to before care homes have no idea what a Care Maker is, they don't know about the Care Maker programme, so if I wasn't in there visiting them they'd would still have no idea'. (CSB12)

This point was echoed by other participants who recognised the benefits of bringing people together to raise the profile of the work that was going on in relation to the Care Maker programme locally:

'I think if there was a way of finding through the Care Maker programme, what other people in my area were Care Makers, that probably would be quite helpful. It would be easy to make contact. I think if we could get together as a group, we could be more innovative and come up with ideas and share ideas and concepts. Then we could cascade them out in our workplaces'. (CSB15)

5 DISCUSSION

All four data collection phases have identified common themes that provide a valuable insight into the establishment and potential sustainability of the Care Maker programme. Study participants have reported a full commitment to excellent person

centred care. The Care Maker role has validated inherent professional practices and provided a foundation for individuals to share best practice by embedding the 6Cs into everyday practice. Findings demonstrate that the Care Maker programme has supported and helped to underpin the nursing, midwifery and care staff strategy, 'Compassion in Practice' (Cummings and Bennett, 2012). The programme has provided opportunities for Care Makers in two distinct ways: to enhance quality of care in their own workplaces; and develop their own professional practice. As reported in the study findings, Care Makers do rely heavily on support structures within their own organisation and through wider networking groups. In some cases these support structures and networking opportunities were reported to be variable, identifying one key aspect that should be focussed upon when considering the sustainability of the programme.

The vast majority of respondents were proud to be a Care Maker, upholding the key principles of the programme (NHS Employers, 2015). The majority of respondents felt that being a Care Maker had made them think differently about the way that they work and that the role had enabled them to be enthusiastic about delivering high quality care. The role of Care Maker had enhanced their awareness of how to deal with difficult situations. They also felt that it had given them the opportunity to voice concerns about lapses in compassionate care and to challenge staff who do not provide positive care.

Respondent Care Makers felt strongly that they were able to act as an ambassador for the 6Cs and compassionate care in practice. Although the majority of respondents felt they had the personal ability to influence changes in practice, they were less positive about their influence on decision making at local and national level. This may be linked to the majority of Care Maker respondents reporting that they were unable to attend either national or local Care Maker networking events. Less than half of the Care Maker respondents felt that they had the appropriate resources to be able to fulfil their Care Maker role effectively. A minority of respondents felt they had sufficient time to fulfil their Care Maker role effectively. Managerial support for the role was also found to be variable. Some Care Makers felt they had sufficient support, while others felt they did not have the necessary support to fulfil their role effectively.

All Care Maker Regional Co-ordinators who responded to the questionnaire item indicated that they agreed that the programme had been successful in impacting on policy and practice. Additionally, it was felt that the programme had '*enabled*' the shop floor to be heard and created '*new leaders*'.

Care Maker Interns who participated in the interviews were positive about their experiences, although more support and recognition of their work would be welcomed. Opportunities to develop skills to reflect on their clinical practice while increasing their research knowledge were particularly appreciated. This scholarship was identified as a springboard to other initiatives and events to highlight Intern's research activity and promote wider dissemination of the role. Personal development and the facilitation of potential academic careers were particularly valued by participants.

5.1 Limitations of the project

The response rates and engagement throughout the study were variable and should be considered when interpreting the findings and recommendations. Initially, the evaluation was designed with a view to gain responses from a total population of approximately 1400 Care Makers. However, it became apparent that in December 2014 Care Makers were asked to re-commit to the role and the number of care makers were therefore reduced to 692 Care Makers in post (April 2015, rising to 708 in May 2015). The online questionnaire was therefore sent out to all 692 Care Makers and responses were received from 258, a 37.3% response rate. The Care Maker Regional Co-ordinator questionnaire was sent out to all 11 co-ordinators in post at the time and responses were received from 7, giving a response rate of 63.6%. Of the eight interns approached to take part in the interviews, five responded to take part in the interviews.

It is also worth noting that the initial objective was to undertake four case studies. NHS Employers provided the evaluation team with 4 case study sites that were selected to be geographically representative. NHS Employers provided the evaluation team with contact details of a nominated gatekeeper at each site who was responsible for the identification of key informants. Two out of the four sites failed to identify any key informants. Of the two remaining sites that took part in the case study, one was particularly proactive in recruiting participants. There was full engagement in making a contribution to the study from participants at this one site. The other site had limited engagement where recruitment was challenging and variable. No firm conclusions can be generated from the variable response rates across the study population but these should be noted and kept in mind when interpreting findings.

Research and Development approvals and permissions were sought and granted from three NHS Trust sites and one Higher Education Institution (please see appendix 6 for approvals dates).

5.2 Recommendations

The overarching recommendation of this evaluation is that there is evidence which supports the value of the continued development of Care Maker programme by NHS England. This evaluation has revealed a wide range of benefits to those individuals involved in the programme. The data collected as part of this evaluation showed that respondents had gained increased levels of job satisfaction by being part of the Care Maker programme alongside experiencing a range of personal and professional development opportunities. One of the significant aspects of the Care Maker programme seems to be its potential not only to inspire the individuals involved but also the wider workforce. This contributes to the development of reflection upon clinical practice and in turn a greater willingness to help initiate changes in both working practices and in culture. As such this appears to make the Care Maker programme a valuable tool in delivering change and improving standards of care within the NHS in England.

The Care Maker programme has helped deliver national policy at a local level. This can most clearly be illustrated by the centrality of the 'Compassion in Practice' agenda and the 6Cs within the Care Maker programme. A strong theme throughout the data within this evaluation was the significance of the 6Cs to those involved within the Care Maker programme. The 6Cs were consistently referred to as the driving ethos for Care Makers to take up the role and a key motivator for their practice. This is significant as it shows that the Care Maker is an important vehicle by which to deliver the national 'Compassion in Practice' strategy. As delivering care with compassion is an integral part of providing high quality patient care, the data collected suggests that the Care Maker programme helps contribute to overall improvements in standards of care.

Although this evaluation has shown many positive aspects of the Care Maker programme it has also revealed some areas where improvements are needed in order to ensure its sustainability. The next sections will discuss recommendations to address each of these areas of concern under the following headings: consistency of induction; raising awareness; importance of time and accessibility; non-engagement and disengagement; opportunities of Internship.

5.2.1 Consistency of Induction

Data, as part of the qualitative responses to the Care Maker questionnaire, revealed that some individuals had different experiences of induction to the Care Maker programme. The need to provide a standard induction in a timely manner once an individual has been accepted as a Care Maker is important. This is in terms of providing materials in relation to the Care Maker programme and its current activities, events to access, any promotional resources which could be used within clinical environment to highlight the programme to other staff, patients and visitors to the hospital and also to identify the individual as a Care Maker. This would help sustain that initial enthusiasm the individual Care Maker has after completing the sign-up process. Although this was done in many cases there were some examples given of differences in this induction process across the country. Induction materials could also be available online alongside the development of online teaching packages and self-study packages which could be completed by Care Makers. The availability of these materials online would help ensure some equity of access the country and contribute towards the Continuing Professional Development of Care Makers.

5.2.2 Raising awareness

Increasing awareness of the Care Maker programme could help promote its goals and contribute to its sustainability. Raising awareness of the 6Cs and influencing clinical practice at a local and national level were key aspects of the Care Maker programme. An important part of being able to achieve this is to promote understanding of the programme both within and outside the clinical context. This could be done by a national media campaign to promote recognition of the initiative and its successes. This active promotion strategy has the potential to increase awareness from the wider public as well as those working within the NHS in all

capacities. Social media is valued by many Care Makers and its use could be further developed to reach beyond the Care Maker network to inform the wider population of the programme. A range of local promotional activities could help increase knowledge about the programme, for example foyer stands, posters, celebration events, local mini-conferences, recognition on staff meeting agendas, and prominence within new employee inductions.

5.2.3 Importance of time and accessibility

One of the threats to the Care Maker programme this evaluation has recognised is the importance of having sufficient time to carry out the role and to be able to attend relevant training and events. Data from the Care Makers showed that attending Care Maker events at a local and national level were valued. However, it was recognised that a lack of time given the workload pressures of frontline care and having enough staff so individuals are able to attend such events was an issue. In addition developing and promoting new initiatives and ways of working to improve care required time which, in the busy context of clinical care, was scarce. One of the ways that this could be addressed is to link being part of the Care Maker programme much more closely to appraisal systems. This could provide managers and staff with the opportunity to formally plan out time required and help ensure a more strategic approach to develop the role. Protected time to carry out the activities which might enhance the Care Maker role could be allocated. These activities might include facilitating teaching sessions for other staff, focussing on providing leadership for changes to improve care and benchmarking between other clinical areas to share good practice. This approach would also provide some 'added-on' value to being part of the Care Maker programme by being linked to appraisal, Personal Development Planning, and potentially contributing to evidence to support professional revalidation processes.

5.2.4 Non-engagement and dis-engagement

A further risk to the Care Maker programme which this evaluation has helped highlight is the risk of non-engagement and disengagement at trust and individual level. Evidence for this concern follows from the awareness that out of 1462 original Care Makers only 708 recommitted to the role showing approximately half did not reengage with the programme. Whilst the reasons for this are unknown as this population were not part of the evaluation this shows a level of disengagement. In addition of the 692 total population of Care Makers only 258 responded to the Care Maker questionnaire, a response rate of 37.3%. Again whilst it is difficult to know the reasons for this non-response rate and as such unwise to make firm conclusions based upon it, it is important to recognise as a potential concern of lack of engagement. More strikingly perhaps was the non-engagement by two of the four NHS Trusts who were chosen by NHS Employers to take part in the case studies. In order to sustain the Care Maker programme nationally further thought is required as to the reasons behind such levels of disengagement and non-engagement. The data from those involved in the programme who responded revealed an overall positive picture of the programme's benefits. Yet it does seem that there are variations

nationally in the level of engagement in the programme. One way to address this is to open a dialogue with those Trusts and Higher Education Institutions who have not engaged thus far with the programme, in order to try and ascertain their reasons. In some cases this might be as a result of local pressures, a lack of awareness of the programme or an uncertainty as to whose remit the programme comes under at a strategic level within the Trust. It also must be noted that two of the Trusts approached as case studies responded appropriately and provided valuable data to contribute to this report. This suggests that there might be specific issues causing a lack of engagement with the Care Maker programme at a local Trust/Higher Education Institution level. A first step to address this would be a non-judgmental approach to the individual Trusts/Higher Education Institutions to try and ascertain what the barriers might be and strategies that could be used to overcome them. Furthermore, any future Care Maker recommitment exercises could provide a mechanism for feedback as to the reasons why the individual was not taking up the role again. This information would help in the development of strategies to address the barriers to being part of the programme and help with its sustainability. This evaluation also showed some indication of regional differences in the experiences of individual Care Makers. Table 4 which analysed responses to the Care Maker questionnaire revealed that the North West, East of England and London performed better in comparison to the overall average results for responses. The reasons behind any regional differences were not explicitly investigated as part of the remit of this evaluation. However, the Care Maker questionnaire did show some regions of the country performed better than others in each of the questions. An appropriate starting point would be to have an open dialogue with Care Maker Regional Co-ordinators to help with understanding the reasons behind this.

5.2.5 Opportunities after Internship

The Care Maker Interns valued the opportunity to conduct a specific piece of research and have protected scholarly time to achieve this goal. The mentorship element which accompanied the Intern programme was also appreciated and provided guidance to help complete the projects. The Interns were exposed to networking opportunities and mutual support from fellow Interns along with the personal and professional development which accompanied their additional research skills. Each of the projects focussed upon an area of clinical practice and contributed to enhancement of standards of care. A dialogue between those overseeing the Care Maker programme, Higher Education Institutions and National Institute for Health Research could help map a clear research and career pathway for those Interns who want to further develop in terms of academic and clinical research. This would help ensure a more co-ordinated transition from the completion of the Care Maker Internship to further academic qualifications, research opportunities or roles within the Trusts.

The key recommendations of this evaluation can be summarised as follows:

Key Recommendations

1. Given the evidence that supports the value of the Care Maker programme there would be benefits to its continued support from NHS England.

2. Ensure that the ethos of the 6Cs remain at the heart of the Care Maker programme to help contribute to improving standards of care.
3. Continue to develop a fully comprehensive national standardised Induction process for Care Makers.
4. Initiate a national media campaign to raise awareness of the Care Maker programme.
5. Embed the Care Maker initiative for those involved as part of their individual appraisal and Personal Development Planning process.
6. Investigate the feasibility to develop an allocation for protected time to carry out the Care Maker role.
7. Open dialogues between NHS England and those Trusts and Higher Education Institutions who might not have engaged as fully in the programme thus far, in order to identify potential barriers.

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7 APPENDICES

7.1 Appendix 1

CARE MAKERS EVALUATION MARCH 15

Personal experience of being a Care Maker

Thank you for accessing this questionnaire which is part of an evaluation project (commissioned by NHS England and led by a research team from Edge Hill University) to explore the impact of Care Maker Programme.

We really appreciate you sharing your experience of being a Care Maker. All information you submit is anonymous, unless you choose to identify yourself on the survey. Any data we receive will be anonymised to ensure that you cannot be recognised from it.

Thank you.

1. Please state your agreement level with the following statements;

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Being a Care Maker has enabled me to develop professionally.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being a Care Maker has enabled me to be enthusiastic about delivering high quality care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being a Care Maker has enabled me to think differently about the way I work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being a Care Maker has helped to increase my confidence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am proud to be a Care Maker.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being a Care Maker has increased my job satisfaction level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please feel free to expand your answer:

2. Please could you explain what being a Care Maker means to you personally?

Please give examples:

Opportunities in the role of Care Maker

CARE MAKERS EVALUATION MARCH 15

3. Being a Care Maker has given me the opportunity to;

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
help people stay independent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
improve health outcomes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
focus on what matters to patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
provide a positive patient experience.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
incorporate the 6Cs in my every day working life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
deliver patient centred care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
implement ideas to promote the 6Cs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
raise awareness of the importance of communication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
deliver better care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
deliver more compassionate care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
be innovative/creative in the delivery of care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
improve services for patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
identify ways of being more compassionate.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
challenge staff who do not provide positive care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
voice concerns about lapses in compassionate care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
enhance my awareness of how to deal with difficult situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please provide examples:

4. Has the Care Maker role provided you with any other opportunities that you wish to share with us?

Networking

5. How do you network with other Care Makers? (Please tick all that apply)

- Social media
 National events
 I do not network
 Local events
 Email

Other (please specify):

CARE MAKERS EVALUATION MARCH 15

6. Have you been able to attend local Care Makers networking events?

- Yes
 No
 Not available or Not offered

Please feel free to expand your answer:

7. Have you been able to attend national Care Makers networking events.

- Yes Not available or Not offered
 No

Please feel free to expand your answer:

Leadership

8. As a Care Maker I have been:

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
able to strengthen my voice in the university and/or workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to influence standards of care delivered.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to lead by example.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to inspire others around me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to encourage more people to become Care Makers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to influence decision making at a local level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to influence decision making at a national level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to change practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
able to deal more effectively with difficult situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
act as an ambassador for the 6Cs and compassionate care in practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please provide examples:

Support

CARE MAKERS EVALUATION MARCH 15

9. Please rate your agreement with the following statements:

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
As a Care Maker I have felt supported in this role by my colleagues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a Care Maker I have felt supported in this role by my manager.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had sufficient time to be able to fulfill my Care Maker role effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had access to the appropriate resources to be able to fulfill my Care Maker role effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Please provide examples of where you have or have not been supported. Please also let us know if you need any additional support to enable you to fulfil your Care Maker role:

Demographic Information

11. What is your age?

- 18-21 31-40 Over 50
 22-30 41-50 Prefer not to say

12. What is your gender?

- Male Trans
 Female Prefer not to say

13. Professionally are you?

- Pre-registered Registered Unregistered

14. What is your professional group?

- Nurse Allied Healthcare Professional
 Doctor Social Care Worker

Other (please specify)

CARE MAKERS EVALUATION MARCH 15

15. If a student, what year of study are you currently in?

Year 1

Year 3

Year 2

I am not a student

Other (please specify)

16. What is your highest level of Educational qualification?

Secondary school level education

NVQ

Masters

Diploma

Degree

Doctorate

Other (please specify)

17. In which region of the country do you work as a Care Maker?

North West

East of England

South West

Yorks & Humber North East

London

West Midlands

East Midlands

South East

18. What is your ethnic group?

Other (please specify)

This survey is now complete. Thank you for your time.

If you have a concern about any aspect of this study, or you would like more information, you can contact Dr Jeremy Brown at Edge Hill University (brownjm@edgehill.ac.uk). If you wish to contact someone independent of the evaluation team please contact Professor Clare Austin (austincl@edgehill.ac.uk).

7.2 Appendix 2

CARE MAKERS COORDINATOR SURVEY 2015

Thank you for accessing this questionnaire which is part of an evaluation project (commissioned by NHS England and led by a research team from Edge Hill University) to explore the impact of Care Maker Programme.

We really appreciate you sharing your experience of being a Care Maker Coordinator. All information you submit is anonymous, unless you choose to identify yourself on the survey. Any data we receive will be anonymised to ensure that you cannot be recognised from it.

Thank you.

***1. What is your professional group?**

- Nurse
- Doctor
- Allied Health Professional
- Social Care Worker
- Academic
- Other (please state below)

Other:

***2. What circumstances led to you accepting/taking the role of Care Maker Coordinator?**

CARE MAKERS COORDINATOR SURVEY 2015

*3. What does your role as Care Maker Coordinator involve? (Please tick all that apply):

- Overseeing Care Maker activities within my designated area.
- Sharing information and communications from Care Maker HQ to Care Makers in my region
- Supporting the recruitment of new Care Makers in my region.
- Providing regular feedback to Care Maker HQ
- Generating ideas to increase the potential impact of Care Makers
- Communicating with Care Maker HQ on how they can support me in my activities
- Facilitating meetings between local Care Makers to answer questions or share ideas
- Attending welcome events to meet new Care Makers
- Acting as point of contact for any queries from Care Makers
- Providing encouragement and support to Care Makers
- Ensuring that the Care Makers are valued in their role
- Ensuring Care Makers are given access to training opportunities and other local and national events
- Helping care makers to incorporate the 6Cs in their everyday working lives
- Implementing ideas to promote the 6Cs

Other (please specify):

4. Please state any benefits to being a Care Maker Coordinator:

CARE MAKERS COORDINATOR SURVEY 2015

5. Please tell us about the support you have received, including where it came from and what other support would have been useful:

6. If you did not receive any support, please expand on why this was the case:

***7. From a strategic point of view, do you feel the Care Maker programme has been successful in:**

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) Positively affecting values and behaviours of health and social care staff to become more patient focussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Encouraging a greater awareness of Compassion in Practice and the 6 Cs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Impacting positively upon policy and practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please add any other areas of impact:

CARE MAKERS COORDINATOR SURVEY 2015

***8. How confident are you that the Care Maker programme will be sustainable in the long-term?**

- Not confident at all
- Not very confident
- Somewhat confident
- Confident
- Very confident
- Completely confident

If you are not confident the Care Maker programme will be sustainable, please expand:

9. Have there been any particular challenges you have faced in your role as Care Maker Coordinator (and if so, how have you addressed these)?

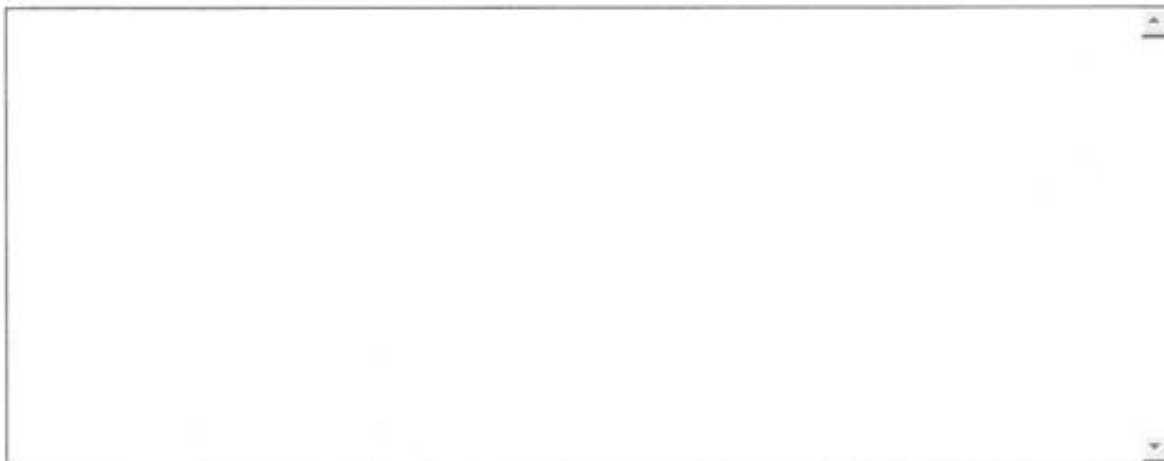
10. Please share any successes or examples of good practice:

CARE MAKERS COORDINATOR SURVEY 2015

11. Please suggest any improvements that could be made to the Care Maker programme:



12. We are interested in hearing anything else you may like to share with us regarding either the Care Maker programme or your role as Care Maker Coordinator. Please use the space below for any other information you wish us to note.



This survey is now complete. Thank you for your time.

If you have a concern about any aspect of this study, or you would like more information, you can contact Dr Jeremy Brown at Edge Hill University (brownjm@edgehill.ac.uk). If you wish to contact someone independent of the evaluation team please contact Professor Clare Austin (austincl@edgehill.ac.uk).

7.3 Appendix 3

Intern semi-structured interview schedule

Who/what role?

What kind of workplace? Locate self in workplace structure/any managerial role

How long intern?

Why apply?

Expectations? Fulfilled?

Any impact on their area of work? Probe for positive and negative.

How planning to develop role? What planning next?

(Care Makers questionnaire to use as the structure)

What were the benefits of being an intern?

Anything else?

7.4 Appendix 4

Case study interview schedule

What is your involvement with the Care Maker Programme?

Do you think it is a valuable programme?

Why did you volunteer to become a Care Maker?

Has the Care Maker Programme met your expectations?

What does being a Care Maker mean to you personally?

Do you think the Care Maker Programme has made a difference to your organisation or area of practice?

Can you think of an example where the Care Maker Programme has impacted on an aspect of practice?

Do you think the role is well supported in your organisation?

Do you think the role is well recognised?

Do you have contact with other Care Makers in your organisation?

Do you have contact with Care Makers nationally?

Are you aware of any difficulties in the Care Maker plan or any ways in which it could be improved?

7.5 Appendix 5

Edge Hill University
St Helens Road
Ormskirk
L39 4QP

Michelle Mello
Nursing Directorate
NHS England

Dear Edge Hill University

2 March 2015

I am writing to discuss arrangements for the upcoming Care Makers programme evaluation.

Care Makers have given permission for us to store and use their contact details for the sole purposes of the Care Maker programme, and as such, this extends to the act of evaluating and reviewing progress of the programme.

The only data we will be seeking from the Care Makers, for the purposes of this evaluation, is for the purposes of gathering their views and opinions of the Care Maker programme. We do not anticipate that the data collection will involve anything that would be categorised as sensitive i.e. patient related.

You will be working under the same terms and conditions of our strategic plan, following any data protection and confidentiality requirements.

We therefore do not need to obtain any special permissions from individuals, Trusts or organisations, to approach Care Makers directly in relation to evaluation.

Please accept this letter as authorisation to proceed with this project.

Kind regards

Michelle Mello
Head of Commissioning
NHS England

7.6 Appendix 6

Table 5: Table showing dates that permissions to conduct the study were provided by Case Study sites

RESEARCH SITE	DATE PERMISSION RECEIVED
Case Study A (NHS site)	13.4.15
Case Study B (NHS site)	17.4.15
Case Study C (NHS site) (No data collected)	14.4.15
Case Study D (Higher Education Institute) (No data collected)	13.4.15

7.7. Appendix 7: Demographics of Questionnaire Respondents

Table 6: Age of Respondents

Age	Response Count	Percent
18-21	12	4.7%
22-30	37	14.3%
31-40	68	26.4%
41-50	63	24.4%
Over 50	37	14.3%
Prefer not to say	3	1.2%
No response	38	14.7%
Total	258	100.0%

Table 7: Gender of Respondents

Gender	Response Count	Percent
Male	27	10.5%
Female	186	72.1%
Trans	2	1.0%
Prefer not to say	2	1.0%
No response	41	15.4%

Table 8: Professional Status of Respondents

Professional Status	Response Count	Percent
Pre-registered	40	15.5%
Registered	139	53.9%
Unregistered	39	15.1%
No response	40	15.5%

Table 9: Professional Group of Respondents

Professional group	Response Count	Percent
Nurse	161	62.4%
Allied Healthcare Professional	30	11.6%
No response	67	26.0%

Table 10: Highest Educational Qualification of Respondents

Qualification	Response Count	Percent
Secondary School Level Education	8	3.1%
Diploma	45	17.4%
NVQ	12	4.7%
Degree	107	41.5%
Masters	38	14.7%
Doctorate	3	1.2%
No response	45	17.4%

Table 11: Ethnic Group of Respondents

Ethnic Group	Response Count	Percent
White, British	184	71.3%
White, Irish	4	1.6%
Other White background (please specify below)	3	1.2%
Mixed, White and Black Caribbean	1	0.4%
Other mixed background (please specify below)	1	0.4%
Asian or Asian British, Indian	2	0.8%
Asian or Asian British, Pakistani	1	0.4%
Asian or Asian British, Bangladeshi	1	0.4%
Other Asian background (please specify below)	1	0.4%
Black or Black British, Caribbean	3	1.2%
Black or Black British, African	7	2.7%
Other Black background (please specify below)	1	0.4%
Other ethnic group	1	0.4%
Other (please specify)	5	1.9%
No response	48	18.6%