Bournemouth University

School of Health and Social Care

End of Life Care Education Project: A Service Evaluation

September 2012

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ISBN - 9781858992921

Acknowledgements

The university team would like to thank the project funder, The Frances and Augustus Newman Foundation and the grant awardees, St Wilfrid's Hospice in Chichester and Sue Nash of Action Learning Teams for commissioning Bournemouth University to undertake this evaluation. Most of all we would like to thank the programme participants for their time and interest in providing information for this external evaluation.

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EXECUTIVE SUMMARY

Introduction and scope of report

Following a successful pilot programme which combined End of Life Care (EoLC) education with leadership skills, St Wilfred's Hospice Chichester, in partnership with Sue Nash from Action Learning Teams were awarded a grant from the Frances and Augustus Newman Foundation to fund a follow-up programme and independent evaluation. The action learning and education development programme for care home leaders focused on improving End of Life Care provision in a care home setting and was delivered over one year. Bournemouth University (BU) undertook the independent service evaluation on behalf of the project team. This report concerns the evaluation element of the project.

Evaluation questions

Following consultation with the education facilitators, two questions were determined to guide the evaluation:

- What are the care home managers' perceptions of the impact of the educational programme on their leadership role in the provision of end of life care in their workplace?
- Has confidence and competence in delivering and facilitating the delivery of end of life care changed over the course over the programme?

Evaluation design

As the evaluation questions sought to explore the effectiveness of learning as well as the relevance of the action learning approach, the evaluation was designed on the basis of a mixed methods approach. Quantitative methods utilised three questionnaires to explore;

- **Demographic data**
- **Assessment of Training Needs** using the Hennessey & Hicks Training Needs Analysis (TNA) Tool (with permission).
- **Assessment of Confidence** using an adapted questionnaire developed by the Advanced Connected Advanced Communication Skills Programme offered under the auspices of the NHS End of Life Care Programme.

Scores from competency documents were also collated.

Qualitative methods involved focus groups, a type of group interview that stimulates interaction between participants in order to generate data. A member of the BU team acted as a facilitator using prepared trigger questions with the goal of eliciting perceptions and

attitudes about the programme and its impact on participants' practice. Participants were encouraged to share their views, to expand on these and others invited to comment. The interaction was audio-recorded (with permission).

Data Analysis

Completed questionnaires were managed and analysed using SPSS (V18.0) for Windows and descriptive statistical analysis was utilised. Reliability analysis (Cronbach's Alpha) was used to screen the TNA and Confidence elements (and sub-categories) ahead of generating scores for these domains. The threshold for reliability was set at 0.7 or above. The focus groups were analysed using a process of thematic and content analysis. This technique is used with qualitative data and involves a process of systematically searching for themes or patterns in the data related to the evaluation questions. Subsequently, these themes are able to provide small thematic case study examples of how the professional development programme has impacted on practice.

Findings - questionnaires

TNA tool (n=6)

The integration of the EoLC competencies indicates the tool has good internal face and content validity. Overall there was an improved perception of performance in role but the results are limited given the numbers of participants and the very slight degree of change evident. However, the results were confirmed and elaborated upon within the focus group data.

Confidence questionnaire (n=6)

Use of the confidence questionnaire indicates that the managers' perceptions of confidence in a range of their abilities related to EoLC increased in all sections. However, given the managers' desire to undertake the programme, perceived confidence in their knowledge and skills *pre-programme* was surprisingly high. An over-assessment of abilities seems likely resulting in a smaller extent of change post-programme. This conclusion is supported by the frequency and strength of comments concerning increased levels of knowledge and confidence as a result of the programme captured within the focus group data.

Competency profile document (n=5)

The competency profile appeared to be a very useful educational tool as it was so closely linked to the programme content. From the perspective of the evaluation however it yielded

limited information. Nevertheless, the competency rating provides confirmation of the scores related to the corresponding areas of the confidence questionnaire.

Findings – focus groups

The perceptions of the focus group participants indicates that the programme offered a valuable opportunity for the development of interpersonal and management skills related to EoLC. Three themes emerged. First communication abilities in terms of leading and managing staff in the provisions of informed EoLC were reported to have significantly developed, alongside an increased sense of self-confidence. Second the style of the programme, which used action learning, resulted in the sharing of practice knowledge and a valuing of actively engaging in support networks. These ways of working were new to the participants. Finally the data indicated that the programme resulted in a sustainable model of education for this particular professional group, firstly perceived more effective management of staff to cascade best practice; second, the skills taught in action learning motivated the participants to continue to meet and share experiences post-programme on a self-managed basis.

Discussion

The evaluation has indicated increased confidence in care home managers knowledge and skills related to end of life care via a number of measures: the confidence questionnaire (CQ), the competency profile and the focus group feedback. The TNA questionnaire also showed some positive movement towards perceived increase in role performance in most domains. As the TNA, CQ and competency profile were linked with the EoLC competencies (DoH, 2009), it is reasonable to assume that improved confidence and perception of competence will have positively impacted on EoLC for residents. In addition, the focus groups provide examples and case studies of improved inter-professional liaison, cascading of knowledge and more proactive communication with residents and families when making decisions about EoLC. This data also indicates that for most participants this educational experience has been both personally and professionally effective, and even for some, life changing.

The evaluation provides support for the link between excellent communication skills, effective leadership ability and better quality provision (Shaw et al, 2007; Thomas and Noble, 2007; King et al, 2008; Shaw et al, 2010; Seymour et al, 2011; Badger et al, 2012). The findings show that this educational strategy appeared to have a positive influence on communication both within the specialty and in general teams when working with colleagues

and residents. Further the link between evidence-based care and confidence to deliver has emerged as very significant factor (Badger et al, 2012). The action-learning model appeared to be a sustainable approach as participants carried on appreciating the benefits of this, with the only cost being staff time. However, the programme length and small group size could be perceived as expensive.

Conclusions

In order to enable high quality EoLC, professional development should equip participants to be able to positively influence not just the individual's immediate team, but also resident's family members, care home owners, and other external stakeholders such as general practitioners (GP) and emergency departments in hospitals. This evaluation provides compelling evidence that an action learning approach to EoLC education can be used to empower middle managers to have positive impacts on EoLC provision through not only increasing specialist knowledge but also enhancing their capability to engage in a confident and informed manner with a diverse range of stakeholders.

Recommendations

Evidence from this evaluation suggests that

- Expertly taught EoLC knowledge and skills is essential for care home managers to fulfil their role effectively
- An action learning approach enables the embedding of specialist knowledge in practice through the enhancement of leadership skills linked to increased self-confidence.
- The EoLC action learning education model leads to sustainable educational outcomes

INTRODUCTION

Nursing care for those reaching the final stages of life occurs in a variety of settings. However, there is an increasing trend towards End of Life Care (EoLC) being delivered in home or home-like settings (DoH, 2008). Consequently, there is an increase in the number of older people dying at home where 'home' is a care home. Care homes operate in a mixed economy of healthcare, and many of these care homes are independently owned and operate in relative isolation from 'mainstream' healthcare provision. This isolation often tends to lead to a lack of investment in education and professional development in EoLC. This increases the likelihood of high staff turnover and a lack of medical cover, both of which can negatively impact on the provision of quality end-of-life care (Hockley et al, 2010).

A recent report from the National End of Life Care Intelligence Network (2012) pulls together information on the care received by people in England in the last 6 months of life. One key finding is that the majority of people would prefer to die in their usual place of residence, whether that is home or care home. However, despite this over half die in hospital. Furthermore, the report shows that specialist EoLC services tend to be accessed primarily by those with a cancer diagnosis, yet 70% of deaths are not cancer related (National EoLC Intelligence, 2012). Consequently, a large number of those who need specialist EoLC services do not access them, which suggests that a large amount of hospital admissions of dying residents from the care home sector are inappropriate.

Although being able to provide a 'good death' maybe a tenuous concept, the advances in end-of-life care provision over the last decade indicates that enabling a 'good death' is an increasing social and political priority (Watts, 2012). However, like many health and social care organisations, providers of EoLC face a series of challenges over the short, medium and long term. These challenges are diverse and far-reaching, and range from increasing staff retention rates to reducing unnecessary hospital admissions. Furthermore, in keeping with many industrialised and resource rich societies, life expectancy has and is set to increase significantly in the UK (WHO, 2012). This has resulted in an increase in the numbers of 'very old' with complex care needs (Cornwell, 2012).

Inappropriate hospital admissions, as well as other facets of suboptimal EoLC in care homes, have been suggested to be as a result of inadequate staff education (DoH 2008). For example, a large amount of palliative care and associated education programmes are derived from cancer care models and may not be directly transferable to those dying in care

homes. Therefore it is important to work closely with care homes to ensure that education is tailored to their situation.

Context for project - West Sussex and St Wilfrid's Hospice Education Centre

The average life expectancy in West Sussex is 79.1 for males and 82.8 for females, and is slightly higher than the UK average (78 for males and 82 for females – WHO, 2012). Therefore, compared to the rest of England, West Sussex has a relatively older population, and projections have indicated that those aged 85 and above will increase by 69% by 2026 (West Sussex County Council and NHS West Sussex, 2010).

In West Sussex there are over 400 care homes (West Sussex County Council, 2012). Many care home personnel have attended St Wilfrid's Hospice Education Centre for study days and longer courses since it opened in 1993. It has become apparent that it takes more than a good knowledge and understanding of EoLC to positively impact on practice. Care home managers also need highly developed levels of interpersonal skills and management expertise to be able cascade this knowledge to front-line staff and to embed these standards within day-to-day care. Effective leadership skills are required to ensure that changes in practice are sustained in the care home environment and developed in conjunction with multi-disciplinary and multi-agency partners such as GPs and district nurses.

Following a successful pilot programme which combined EoLC education with leadership skills, staff of St Wilfred's Hospice, in partnership with Sue Nash, an independent consultant from Action Learning Teams were awarded a grant from the Frances and Augustus Newman Foundation to provide an action learning and education development programme for care home leaders that focused on improving End of Life Care provision in a care home setting. An independent evaluation was built into the project proposal with the aim of evaluating programme outcomes and advising on strengths and limitations to inform considerations of a wider application.

Bournemouth University undertook the independent service evaluation on behalf of the project team. This report concerns the evaluation element of the project. Some background to the project will first be outlined and then the evaluation process and findings are described. This is followed by a discussion and conclusions are drawn, including an acknowledgement of limitations of the approach. Finally, some recommendations are made.

The role professional development and specialist education

EoLC provision in the UK involves a range of specialist and non-specialist stakeholders. For example, these include nurses, GPs, and healthcare assistants. Although the lack of stakeholder co-operation is often cited as a barrier to high standards of care (Seymour et al, 2011), enhancing the quality of integrated provision through co-operation, teamwork and leadership is recognised as being able to provide a solid foundation for good quality end-of-life care (Wowchuck et al, 2007; DoH, 2008; Hewison et al, 2009). As the demand for EoLC services increase, providers must give serious consideration as to how they can ensure dignity in the context of effective and efficient working practices.

Professional development and specialist education that is designed to increase the capacity, skills and leadership of the workforce are regarded as being integral to how providers can meet these challenges. It is becoming increasingly recognised that a collective approach to EoLC training is inadequate. Consequently, professional development in EoLC should be tailored to suit different professional requirements (Green et al, 2011; Seymour et al, 2011; Turner et al, 2011; Shannon et al, 2011; Walling et al, 2011). Focusing on leadership, and enabling opportunities for leaders to develop in EoLC will increase the likelihood of co-operation, teamwork and knowledge dissemination across the EoLC workforce.

The role and purpose of evaluation

Research indicates that well positioned and effective professional development for the end-of-life care workforce is capable of increasing knowledge, levels of communication and collaboration, the ability to form relationships with other stakeholders, and reducing hospital admissions and deaths (Dale et al, 2009; Hewison et al, 2009; Kennedy et al, 2009; Badger et al, 2009; 2012; Hockley et al, 2010). However, the need to innovate, evaluate, analyse and document examples of end-of-life care professional development and its impact is an on-going priority (Dale et al, 2009; Shaw et al, 2010). There has been little evaluative work with care home managers, and especially where an action learning approach to EoLC education has been used.

OVERVIEW OF THE EDUCATIONAL PROGRAMME

The overall project aims were to:

- improve End of Life Care (EoLC) in care homes through education of care home leaders
- develop a sustainable educational model for wider use
- evaluate programme outcomes

Recruitment of Care Home managers/leads for participation in the EoLC education programme commenced in February 2011. The programme itself began with two introductory study days in late March 2011. A Clinical Nurse Specialist in EoLC and an experienced facilitator specialising in personal and organisational team development facilitated the programme.

The programme ran over the course of one calendar year, and was delivered in whole study days at approximately six-week intervals. The usual format of the study days comprised of specialist EoLC education in the morning followed by facilitated action learning focused on team and leadership development each afternoon. The aim was to improve participants' confidence and facilitation skills to educate and support their staff in the provision of good end of life care (see appendix 1). In addition participants attended a 3-day advanced communication skills course.

EVALUATION METHODS

Commissioners demand tangible evidence that professional development opportunities fulfil their purpose in acting to better inform service delivery. In this context, evaluation can provide a means of evidencing and increasing the value of professional development and education. Evaluating the impact of professional development in EoLC is emerging as an increasingly important part of how workforce development is delivered. Whilst specific methods may differ slightly, evaluations of professional development in EoLC tend to use a range of quantitative and/or qualitative methods that are designed to measure provision at stages pre and post to the development intervention. These measures are usually modes or variations of self-assessment (Shaw et al, 2010). However, some studies have used methods, such as action research (Hockley and Froggat, 2006; Badger et al, 2009), in order to make causal inferences.

Evaluation questions

For the purpose of this evaluation, the overall project aims (see page 12) were formulated into the following questions:

- What are the care home managers' perceptions of the impact of the educational programme on their leadership role in the provision of end of life care in their workplace?
- Has confidence and competence in delivering and facilitating the delivery of end of life care changed over the course over the programme?

Evaluation design

> 'Evaluation is concerned at the macro or holistic level of the learning event, taking into account the context of learning and all the factors that go with it… An evaluation is a designed and purposeful enquiry which is open to comment.' (Crompton, 1996: 66)

There are two approaches to evaluation: the scientific approach, which measures specific variables against outcomes, and the illuminative approach, which explores the process of the educational intervention. The first tends to use quantitative methods whilst the latter utilises qualitative methods. As the evaluation questions sought to explore the effectiveness of learning as well as the relevance of the action learning approach, the evaluation was designed on the basis of a mixed methods approach.

Project details

Sample

All participants were volunteers. Purposive sampling was used so that participants would provide data relevant to the project aim (Holloway, 2005). Data was collected from all care home managers who undertook the full programme. As themes began to emerge from the data, theoretical sampling (Glaser and Strauss 1967) was used to explicate these further. For example, issues from the questionnaires were explored in the focus groups.

Whilst the aim was to recruit up to 16 care home managers, only eight commenced the programme. Unfortunately two managers withdrew from the programme after the second study day for personal reasons and their data was withdrawn from the analysis. Therefore, six care home managers completed the programme. All were managers or deputy managers and all but one had a nursing qualification. The mean number of years in post was 2.1 and the size of the care homes involved is reflected in the mean bed number – 27.8.

Exploratory/pilot work

The initial focus group method and triggers were piloted on a previous cohort of care home manager programme participants and this experience influenced the development of the approach for this evaluation. Similarly, the basic structures of the questionnaire has been used widely in other work but was amended to contextualise them more appropriately for this evaluation project. The revised documents were sent to the programme facilitators for comment based on their experience of running similar programmes and adjustments were made to incorporate their feedback. The questionnaires were also revised, contextualised and trialled by the facilitators with some staff within a hospice setting, and appropriate amendments made.

Ethics

As the project is a service evaluation, as opposed to clinical research (NRES, 2009), formal ethical approval was not required. Nonetheless, in order to reflect best practice, all procedures associated with the evaluation adhered to the principles that underpin the guidelines of NHS research ethics. Participation was voluntary and participants were free to withdraw at any time, without giving a reason. All participants were given a participant information sheet (see appendix 2). Care home managers were also given a briefing and offered the chance to ask questions before being invited to sign a consent form. All provided formal consent.

All information collected during the evaluation project was kept confidentially in locked storage and made accessible to the project team at Bournemouth University only. Questionnaires were coded and names removed, as were all identifiers within the focus group data. Participants were made aware that a report would be produced for the Grant holders and the funder, and for academic publication. Participants understood that data would be presented anonymously in all outputs in order to prevent participants being identified. All data including audio recordings will be destroyed one year after completion of the final report.

Data collection

Data collection occurred between March 2011 and July 2012. Detailed field notes were taken and these formed part of the analysis. Three methods of data collection were used: pre and post programme questionnaires, immediate post programme focus group and a 4-month follow up focus group, and analysis of participants' post-programme competency profiles.

Questionnaires

The questionnaire used for this evaluation project involved three distinct elements:
Demographic data including information about the participant and their place of work.

Assessment of Training Needs using the Hennessey & Hicks Training Needs Analysis (TNA) Tool (with permission). Developed in 1996 the TNA consists of 30 core items that relate to tasks that are considered central to the health care practitioners role and these items are organised into five superordinate categories; research/audit, communication and teamwork, administrative/technical, management/supervisory and clinical (Hennessey et al 2006). Working within the parameters of the original questionnaire design, the instrument can be customised for a specific purpose, with the option of adding up to 10 additional items without compromising its psychometric properties. Drawing upon the End of Life Care core competencies for health and social care staff (National End of Life Care Programme, 2009), the TNA was customised for the purpose of this evaluation. A mapping exercise was performed to identify the presence of each competency in TNA and where gaps were detected, additional items were added.

Assessment of Confidence was measured using an adapted questionnaire developed by the Advanced Connected Advanced Communication Skills Programme offered under the auspices of the NHS End of Life Care Programme. 38 items that assessed confidence in dealing with specific end of life care issues in 4 sub-categories; wellbeing and choice, communication, assessment and delivering care and person-centred care. The assessment and delivering care category also divided into 3 further sub-sections; assessing physical symptoms, assessing psycho-social symptoms and implementing physical care. This section also contained three separate items of assessing end of life care planning (i.e. planning end of life care, Gold Standard Framework and the Liverpool Care Pathway).

Following briefing and consent procedures, a member of the BU team distributed and collected the questionnaires. Time was allowed during day one of the programme for this activity. The purpose was to establish base-line measurements prior to the educational intervention. A similar procedure took place on the final study day.

Focus groups

Focus groups are a type of group interview that use interaction between participants in order to generate data. A member of the BU team acted as a facilitator using prepared trigger questions with the goal of eliciting perceptions and attitudes about the programme and its impact on participants' practice. Group interaction is a vital part of the method. Participants are encouraged to share their views, to expand on these and others are invited to comment. In this way the method can be useful to find out what people think about a topic, but also why they think that way, as they seek to clarify their views to others (Kitzinger, 1995). The groups involved all participants and were audio-recorded (with permission). They took place on the last day of the programme and four months later.

Competency profiles

The competency profile was designed by the programme team to enable participants to self-assess competence using the Benner (1984) skills acquisition model, from advanced beginner to expert. The profile incorporates the national End of Life Care core competencies (National End of Life Care Programme, 2009), as well as summaries of the programme content and asks the participant to assess herself at the beginning of the programme and at the end. The profiles were issued to the care home managers by the programme team and used in the action learning sessions during the programme. The participants then sent their competency profile by post to the evaluation team at the end of the programme.

Data Analysis

Completed questionnaires were managed and analysed using SPSS (V18.0) for Windows and descriptive statistical analysis was utilised. Reliability analysis (Cronbach's Alpha) was used to screen the TNA and Confidence elements (and sub-categories) ahead of generating scores for these domains. The threshold for reliability was set at 0.7 or above. DeVellis (1991) states that this is the accepted threshold for accepting internal reliability before summing items.

The focus groups were analysed using a process of thematic and content analysis. This technique is used with qualitative data and involves a process of systematically searching for themes or patterns in the data related to the evaluation questions. This is a flexible approach that yields a rich account of complex data. The data was organised into themes and, where appropriate sub themes were delineated. Subsequently, these themes are able to provide small thematic case studies examples of how the professional development programme has impacted on practice.

It was the intention that the competency profiles would be considered using a process of content analysis. However, the amount of written elaboration of self-assessed proficiency categories was very limited. Furthermore, the documents only appeared to have been scored once towards the end of the programme and not throughout as was intended. Consequently only the scores have been included from this source and analysed descriptively as ordinal data.

Reliability and validity

One major benefit of a mixed methods approach to evaluation is that it enables one approach to compensate to some extent for the limitations of another. The questionnaires and competency documents provided some insight of the efficiency and effectiveness of the educational intervention through the use in the main of recognised measures. Following use in this evaluation, the TNA and confidence elements of the questionnaire were found to be highly reliable with overall alphas levels ranging from 0.935 to 0.987 (see table 1 for breakdown). Given that the TNA tool was customised to reflect the context, within the permitted guidelines, this is a very positive result. This is also true for the confidence element of the questionnaire although it is noted that these items have not been subjected to prior research (as compared to the TNA items) and also not subjected to Principle Components Analysis. However, the high alpha scores for the confidence items are still indicative of a reliable scale.

Table 1; Cronbach alpha scores for each overall scale in round 1 and 2

TNA round1	Current performance	Alpha = 0.935	40 items
TNA round 1	Importance of activity to performance	Alpha = 0.977	40 items
TNA round 2	Current performance	Alpha = 0.981	40 items
TNA round 2	Importance of activity to performance	Alpha = 0.987	40 items
Confidence Round 1	Self confidence in role	Alpha = 0.987	38 items
Confidence Round 2	Self confidence in role	Alpha = 0.969	38 items

The Competency Document was developed essentially as an educational tool. As such no specific measures of reliability or validity are possible. Nonetheless the integration of the EoLC competencies within the competency document indicates that it at least has good face and content validity.

The focus groups generated rich data concerning the impact of the content and process of the educational intervention. Judgement of rigour with such data is judged in terms of trustworthiness to establish rigour without sacrificing the relevancy of context (Denzin and Lincoln, 2008). Trustworthiness is broken down into a number of facets: the term credibility is used to consider issues of internal validity; transferability can be broadly equated with external validity; dependability is related to reliability; conformability is linked to notions of objectivity, that is the consideration of issues of bias.

Credibility refers to the extent to which the participants recognised the experience as their own. On-going reports to the steering group, which included student representatives, invited comment on the development and interpretation of findings. Data source triangulation was used to increase credibility; emerging themes from the first focus group as well as the questionnaires was used to inform the second. Transferability concerns the extent to which the findings 'fit' other settings. The benefit of 'thick' description provided by focus groups is that a critical reader can more readily judge transferability to other contexts. To demonstrate dependability and conformability, an audit trail has been provided to outline the process and product of the enquiry.

FINDINGS

Demographic data

The sample has already been described (see page 14). All participants had managerial responsibilities and therefore were in positions of influence. All but one was also a registered nurse. This factor proved to be of some significance when undertaking the programme, and is discussed later. In addition to personal data, information about the care home managers' workplace in relation to end of life care was sought pre and post programme.

Table 2: Selected EoLC factors in each Care Home

	Pre-programme	**Post-programme**
Home has palliative care register	1	6
Home has designated EoLC lead in home	3	6
Advanced care plans	No	Common
Emergency admissions (range)	2-10	1-8
Number of patients resuscitated (range)	0-5	0-2
Number of patients died within past 2 years (pre)/1 year (post)	5-15	4-11

This data indicates that the programme was effective in raising the profile of end of life care within the care homes. Whilst the numbers of emergency admissions and inappropriate resuscitation episodes remained higher than desired by the managers, the focus group data indicated that this was due to factors such as lack of medical cover and preferences of next-of-kin, rather than inadequate knowledge or policy guidance.

Questionnaire data

Training needs analysis (TNA)

Overall results

The TNA has two parts; A= 'How important is this activity to the successful performance of your job?' and B= 'How well do you consider that you currently perform this activity?' The options ranged from 1= not well to 7= very well. Participants were asked to score all 40 items for importance then for personal performance. The overall pre and post-programme results for the six care home manger participants are shown in table 3:

Table 3: Comparison of overall TNA scores from Round 1 (pre) and Round 2 (post-programme)

R1-R2 TNA A (40 items)

	N	Minimum	Maximum	Mean	Std. Deviation
TNA A Total (importance to role) R1	6	248.00	280.00	269.33	11.89
TNA A Total (importance to role) R2	6	226.00	279.00	264.83	19.67

R1-R2 TNA B (40 items)

	N	Minimum	Maximum	Mean	Std. Deviation
TNA B Total (Current performance) R1	6	183.00	269.00	226.50	29.22
TNA B Total (Current performance) R2	6	183.00	271.00	240.00	34.69

The comparison of results of A (importance to role) pre and post-programme indicated a negligible drop in scores, so small that it could simply indicate one person scoring one or two items at 5 instead of 6 for example. A change was not anticipated but the results at least indicate the participants used the tool consistently, which suggests high reliability.

The comparison of results of B (current performance) pre and post-programme indicated a small increase in scores, mean increase of 13.5. Whilst positive, this is not a significant result. This is reflected in minor changes across the five sub-domains: the greatest increase was in the domain 'clinical task', followed by 'administration' then 'research and audit', 'management and supervision', and finally 'communication and teamwork'. A more improved performance in role post-programme might have been anticipated; however as the participants scored themselves relatively highly pre-programme there was in fact little room

for improvement. It is possible that the pre-programme scores were somewhat inflated as the participants 'may not have known what they did not know.' Overall Pre and Post-programme performance is rated lower than perceived importance of the activities captured in each domain.

Sub-domain 1. Clinical tasks

This section focused on clinical practice related to EoLC and included items mainly associated with compassionate and non-judgemental assessment, treatment, management and evaluation of care. There were 10 items, which participants scored for importance then for personal performance.

Table 4: Comparison of Clinical task sub-domain scores pre (R1) and post-programme (R2)

R1-R2 TNA A (10 items)

	N	Minimum	Maximum	Mean	Std. Deviation
CTaskTotalA_R1	6	65.00	70.00	69.00	2.00
CTaskTotalA_R2	6	58.00	70.00	67.50	4.72

R1-R2 TNA B (10 items)

	N	Minimum	Maximum	Mean	Std. Deviation
CTaskTotalB_R1	6	46.00	70.00	58.33	8.71
CTaskTotalB_R2	6	49.00	70.00	62.50	8.31

The comparison of results of A (importance to role) pre and post-programme showed a negligible drop in scores. The comparison of results of B (current performance) pre and post-programme indicated a small increase in scores, mean increase = 4.2. An improved performance in role post-programme might have been anticipated, although this is small because the participants self-scored highly in this domain pre-programme, somewhat surprising given they were presumably undertaking the programme to develop such knowledge and skills. The results indicate possibly that despite customisation the tool was interpreted too generally.

Sub-domain 2. Administration

This section focused on administrative activities including paperwork and use of information technology. Although related where possible to EoLC (e.g. operating according to guidelines

for the Mental Capacity Act), activities were quite generic though very pertinent to the care home manager role. There were only 4 items.

Table 5: Comparison of Administration sub-domain scores pre (R1) and post-programme (R2)

R1-R2 TNA A (4 items)

	N	Minimum	Maximum	Mean	Std. Deviation
AdminTotalA_R1	6	24.00	28.00	26.67	2.07
AdminTotalA_R2	6	22.00	28.00	26.33	2.42212

R1-R2 TNA B

	N	Minimum	Maximum	Mean	Std. Deviation
AdminTotalB_R1	6	19.00	25.00	21.83	2.64
AdminTotalB_R2	6	20.00	27.00	24.50	2.59

The results of A (importance to role) pre and post-programme are virtually unchanged. The results of B (current performance) pre and post-programme indicated a small increase in scores, mean increase = 3.3. Overall the participants rated themselves highly in all areas post-programme.

Sub-domain 3. Research and audit

The research and audit sub-domain encompassed skills involved in the critical appraisal of published evidence and application to practice through to collecting and analysing own data. These are generic skills for clinical leaders and an understanding is important for the provision of evidenced-based care. The 9 items could be applied to any clinical context.

Table 6: Comparison of Research and Audit sub-domain scores pre (R1) and post-programme (R2)

R1-R2 TNA A (9 items)

	N	Minimum	Maximum	Mean	Std. Deviation
RATotalA_R1	6	49.00	63.00	58.17	5.27
RATotalA_R2	6	48.00	62.00	56.50	4.93

R1-R2 TNA B (9 items)

	N	Minimum	Maximum	Mean	Std. Deviation
RATotalB_R1	6	37.00	55.00	46.17	6.43
RATotalB_R2	6	33.00	57.00	48.67	9.56

The results of A (importance to role) pre and post-programme have dropped negligibly. The results of B (current performance) pre and post-programme indicated another small increase in scores, mean increase = 2.5. Overall the participants rated their performance in this domain at the lowest level compared to all others pre and post programme whilst also rating its importance very highly. Some increase may reflect the requirement to access and appraise resources throughout the education programme.

Sub-domain 4. Management and supervision

This sub-domain sought to capture skills related to self-management and organisation of others, including supervision and working within organisation constraints. The 7 items reflected generic skills for clinical leaders. However, some contextualisation was possible through linkage to the EoLC core competences related to evaluating EoLC services and linking this to resource implications.

Table 7: Comparison of Management and Supervision sub-domain scores pre (R1) and post-programme (R2)

R1-R2 TNA A (7 items)

	N	Minimum	Maximum	Mean	Std. Deviation
ManSupTotalA_R1	6	47.00	49.00	48.33	1.03
ManSupTotalA_R2	6	41.00	49.00	47.33	3.14

R1-R2 TNA B (7 items)

	N	Minimum	Maximum	Mean	Std. Deviation
ManSupTotalB_R1	6	34.00	49.00	40.16	4.86
ManSupTotalB_R2	6	33.00	49.00	42.50	6.53

Again the results of A (importance to role) pre and post-programme showed a negligible drop in scores. Also the results of B (current performance) again indicated a very small increase in scores, mean increase = 2.4. Not surprisingly perhaps most care home managers self-rated very highly in this area pre and post programme. Looking at the raw data 2 of the 6 managers were less assured in their abilities and so this increased the range somewhat in this sub-domain.

Sub-domain 5. Communication and teamwork

This section focused on a range of inter-personal and collaborative activity, ranging from effective working relationships with colleagues and external stakeholders, as well as building appropriate therapeutic relationships with residents and families. There were 10 items.

Table 8: Comparison of Communication and Team working sub-domain scores pre (R1) and post-programme (R2)

R1-R2 TNA A (10 items)

	N	Minimum	Maximum	Mean	Std. Deviation
CTTotalA_R1	6	63.00	70.00	67.83	2.64
CTTotalA_R2	6	58.00	70.00	68.00	4.89

R1-R2 TNA B (10 items)

	N	Minimum	Maximum	Mean	Std. Deviation
CTTotalb_R1	6	49.00	70.00	61.33	7.61
CTTotalB_R2	6	52.00	70.00	63.50	6.98

The results of A (importance to role) pre and post-programme are virtually unchanged and the results of B (current performance) pre and post-programme show a marginal increase in scores, mean increase = 1.6. Overall the participants rated themselves highly in all areas pre and post-programme but also identified this area as highly important.

Summary: TNA results

Despite attempts to customise the tool, it may have been too generic for the intended purpose. The link to the EoLC competencies indicates the tool has good internal validity, in terms of face and content validity. However the results from this tool are limited given the numbers of participants and the very slight degree of change evident. However, these results will be revisited when comparisons are made with other data, in particular the qualitative data from the focus groups.

Confidence questionnaire

Overall results

The aim of the Confidence Questionnaire for care home managers is to enable self-assessment of confidence in a number of areas related to EoLC. The 10-point likert scale ran from 1 (not at all confident) to 10 (very confident). In addition three items in section 3 required yes/no responses. The questionnaire is divided into four sections:

1. Wellbeing and Choice (7 items)
2. Communication (16 items; 8 related to personal confidence, 8 related to confidence in care home staff)
3. Assessment and care planning (19 items) including End of life planning initiatives (3 items)
4. Person centred care (4 items)

Table 9: Comparison of Confidence Questionnaire overall scores pre and post-programme.

	Pre-programme Mean (Std. Dev.)	Post-programme Mean (Std. Dev.)	Mean increase
1. Own confidence in well-being and choice	53.5 (6.71)	62.0 (4.14)	8.5
2.Own confidence in communication	62.6 (12.90)	69.5 (9.02)	6.9
3.Managers confidence in communication by staff	50.8 (8.34)	61.5 (9.50)	10.7
4.Own confidence in assessing and delivering care	160.0 (23.50)	178.5 (10.44)	18.5
5.Own confidence in person centred care	33.0 (5.25)	35.8 (3.71)	2.8

Overall the results show that in all sections confidence has increased following the educational programme. Given the participant numbers and the score ranges, these results do not indicate statistical significance, but nonetheless they are positive. The greatest increase taking into account item numbers (per section) was section 3, manager's confidence in communication by staff, which shows a mean increase of 10.7 for the sum of the 8 items included. Improved confidence may have been anticipated post-programme but it is important to note that overall managers confidence in their EoLC knowledge was quite high prior to the programme in all sections prior to the programme (e.g. 33/40 for own confidence in person centred care), indicating some lack of insight and/or inappropriate over inflation of scores. This will be considered further in relation to the focus group data.

Section results

The well-being and choice section explored how confident the care home manger felt in promoting aspects of well-being in residents from a holistic perspective – for example physical, emotional, and financial well-being. This includes the promotion of dignity and anti-discriminatory practices. Comparison of results pre and post-programme show an increase in mean scores of 8.5. Brief comments in support of the selected score were invited. Absence of pressure injuries for example was given as evidence of physical well-being and details of staff training around dignity and resident/family satisfaction surveys was suggested as ways of monitoring dignity.

The small section related to person centred care asked managers to rate their confidence in terms of delivering care as well as self-awareness around the physical and emotional burden of providing EoLC and maintaining personal well-being. Comparison of results pre and post-programme show a marginal increase in mean scores of 2.8.

The Communication section results differ in that on a range of eight topics the care home manager is asked first to rate their confidence and then to score their perception of the confidence of care home staff on the same topics. Aspects of communication included assessment, patient cues, recognising residents' concerns, dealing with challenging behaviour in residents and colleagues. In all cases managers rated themselves higher than the care home staff, a mean score difference of 11.8 pre-programme, falling to an 8.0 mean score difference post-programme. The difference is to be expected, but is not as great as might be anticipated given the education and experience differences between the groups. Overall both sets of results showed an increase in confidence, the greatest increase related to perceptions of care home workers (see table 9).

The assessment and care planning section comprised two sub-sections; one explored some specific issues around advanced EoLC planning (see tables 10 and 11).

Table 10: Comparison of Confidence Questionnaire end of life care planning questions pre and post-programme.

	Pre-programme		Post-programme		Yes/No
	Mean	Std. Dev.	Mean	Std. Dev.	
1. How confident do you feel about leading your team to help residents plan end of life care?	6.00 (N = 6)	1.90	8.83 (N = 6)	1.17	n/a
2a Is your care home registered to operate the Gold Standards Framework?	n/a		n/a		Yes = 2 No = 6
2b If yes, how confident do you feel in leading your team to implement the Gold Standards Framework?	9.00 (N = 2)	2.83	7.50 (N = 2)	0.71	n/a

3a Does your Care Home use the Liverpool Care Pathway?	n/a	n/a	Yes = 4 No = 2
3b If yes, how confident do you feel in leading your team to implement the Liverpool Care Pathway?	7.75 (N = 4) 2.06	8.75 (N = 4) 1.29	n/a

The question about evidence was intended to elicit comment but this was often limited. Some participants cited cost as one reason why the Gold Standards framework was not operated. Others stated that some lack of support from GPs and family members acted as barriers to the implementation of the Liverpool care Pathway.

The second sub-section asked detailed questions about confidence in assessing a range of physical symptoms such as pain and anorexia and assessing psycho-social symptoms such as anxiety and loneliness. Implementing care to deal with physical symptoms was also covered.

Table 11: Comparison of Confidence Questionnaire assessment and care planning scores pre and post-programme.

	Pre-programme Mean (Std. Dev.)	Post-programme Mean (Std. Dev.)	Mean increase
1. Confidence in assessing physical symptoms; (7 items) Managers	60.0 (8.24)	66.6 (3.20)	6.6
2. Confidence in assessing psycho-social problems; (5 items)	41.0 (7.32)	46.1 (3.86)	5.1
3. Confidence in implementing physical care (7 items)	59.0 (8.46)	65.6 (4.22)	6.6

This area of the questionnaire related very closely to some of the core EoLC content of the programme. However the means indicate that participants were fairly confident in their abilities in these areas prior to programme commencement. There was however an increase in confidence in these areas post-programme. Whilst this is positive, the results suggest that some over-inflation in perception of confidence pre-programme might have been a factor; this issue was specifically explored in the second focus group.

Summary: Confidence Questionnaire results

Use of the confidence questionnaire indicates that the managers' perceptions of confidence in a range of their abilities related to EoLC increased in all sections. However, given their desire to undertake the programme, confidence pre-programme was high, leading to some possibility of over-assessment of abilities that may have affected results. Similarly confidence in care home staff improved post-programme.

Competency profile document

Participants' self-assessed personal competence in four areas of EoLC practice; communication, advanced care planning, psycho-social and physical care. Performance was rated against 4 descriptors - advanced beginner, competent, proficient and expert. Comments justifying the rating were invited but rarely used. Consequently, ordinal data only is provided. The profiles were issued to the care home managers by the programme team and used in the action learning sessions during the programme. The intention was that they were completed at regular intervals throughout. In this way developing competence could have been measured. However, whilst they were used regularly for referral purposes, they were typically only completed once towards the end of the programme, and one care home manger did not complete the profile at all.

Table 12: Competency profile rating showing highest rating frequency per area

EoLC competency area	Rating all participants
Communication	Proficient
Advanced care planning	Proficient
Psychosocial care	Expert
Physical care	Proficient

Upon completion of the programme, this limited evidence indicates that the care home managers felt proficient in communication, advanced care planning and physical care. Additionally, care home managers considered themselves as experts at psychosocial care competencies.

Summary: Competency Document results

The competency profile appeared to be a very useful educational tool as it was so closely linked to the programme content. From the perspective of the evaluation, it yielded limited information. However, these competencies do add confirmation to the scores to the corresponding areas of the confidence questionnaire.

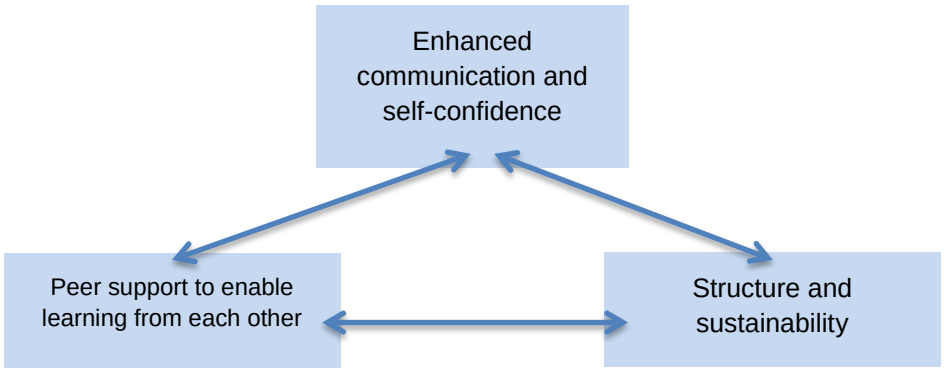
Focus group data

The aim of the focus group was to try to illustrate and 'unpack' the story behind the questionnaire scores. The first focus group involved all participants and occurred on the last day of the programme. By this point the group had worked together for a year and it was hoped this would facilitate participation. All participated but the group was dominated by 4 voices. The second focus group occurred 4 months post-programme. The group had continued to meet independent of the programme leaders and the participants appeared to be very relaxed with each other, as can illustrated in that all managers participated actively in the discussion. One participant did not attend due to on-going health issues.

Themes

Whilst issues received different emphases at certain points, some common themes emerged and therefore the findings from both groups will be presented together.

Diagram 1: Focus group themes



<u>Theme 1: Enhanced communication and self-confidence</u>

The group indicated that participating in the programme had positively increased their levels of communication. Being able to communicate on an interpersonal level was central to perceived increases in knowledge, confidence and competence. Importantly however, the group also suggested that most had enacted procedures to cascade the knowledge to their staff. One participant stated;

> *"…I've been able to cascade information as part of palliative care…[the] information I've learnt from everybody…I bring that into meetings. Which we sort of do quarterly and we also have a monthly meeting just for our palliative care register that we've now got in place as well."* *Participant 3*

The group suggested that being able to rehearse and explore challenging aspects of communication in an action learning environment increased their confidence and impacted positively on care home staff's practice knowledge and competence. For example some staff were reluctant to move to palliative care when more 'aggressive' (if inappropriate) treatments were available. This involved the manager in education, negotiation and team management skills to ensure good quality end of life care.

Evidence from the focus group suggests that managers perceive themselves to be much more confident after attending the programme. In many cases this confidence was perceived to directly impact on their ability to communicate with end-of-life care notably to external stakeholders. For example, a number of managers indicated that they felt increasingly able to engage more proactively with GPs and family members around EoLC issues. This included discussing advanced care plans much sooner than they previously would have done. For example, one manager commented;

> *"I think I'm more confident to take on GP's particularly to get things sorted out earlier rather than waiting until they're in the last couple of weeks of life, so we get that sorted much earlier now. Which I definitely didn't do eighteen months ago…our staff weren't clear what to do, whereas now it's very black and white. So and it's discussed between residents and family so it takes out that doubt you know the 'should we, shouldn't we thing'."* *Participant 2*

Similarly, another manager commented;

> *"…now I have more confidence in telling them [GPs and relatives] that's not the case and you know to give IVs is not always appropriate, so um yeh I think this training gave me more confidence."* *Participant 4*

These examples indicate that managers' perceive that the programme has had a positive impact on their ability to communicate with a range of stakeholders. These stakeholders include fellow professionals, residents and family members. This was reported to have occurred in the cascading of information to colleagues, to being increasingly able to explain sensitive care decisions, and in designing advanced care plans. Attendance on the programme was suggested as making these areas of good practice much more likely to occur.

Data from the confidence questionnaires suggests that confidence in EoLC competencies was strong before the programme. However, during the second focus group participants offered three reasons as to why they thought that baseline confidence levels were skewed. Firstly, managers admitted to feeling a pressure to always be confident in their day-to-day working life. For example, one manager remarked that "managers don't like to admit … they're not experts at everything". The culture was that as the person 'in charge' they were expected to 'always have the answer'; this made them reluctant to admit to not knowing or not being confident. Secondly, the content of the programme had made managers more reflective, and thus gradually more aware and realistic of strengths and weaknesses. One manager commented;

> *"I think maybe it's made us all a bit more honest as well…They (we) think 'yeh, yeh, we're confident, we're confident' and then you get something like this (the education programme) and you think 'actually I don't really know this' you know some things you think actually I do know. But other times you think actually I'm not quite as confident as I thought I was so, and that sort of brings it home to you."*
>
> *Participant 1*

The course content links in to the third reason. It was suggested that discussing and being more reflective in self-assessing strengths and weaknesses required the group to be able know and trust one another. This mutual trust was suggested to take time to embed. On the other hand, upon entering the programme participants did not feel able to trust one another. Not wishing to appear less able, this may have made them report inflated levels of confidence. However, as the next theme indicates, the mutual trust that did develop enabled the group to support and learn from each other, creating more honesty and ultimately more positive outcomes for all.

Theme 2: Peer support to enable learning from each other

The group agreed that, prior to the EoLC education programme, the nature of their roles often meant that they felt isolated. Consequently, creating a support network acted as a significant motivation for the participants to attend and participate. One manager commented;

> *"I mean a big part of this [the benefits] is that we've got a support network out of this."*
>
> *Participant 4*

Being with people who understand their world created an environment where the care home managers felt they could share issues and gain support to resolve them. A central principle of action learning is that participants should discuss and reflect on issues that have arisen from their experiences of practice. One manager stated that discussing practice issues with peers, as opposed to with senior managers, was comforting;

> *"…Quite often there's, y'know, somebody else [who] doesn't know something that you do know and you can ask. Whereas you know at big Managers' meetings you know you're never going to be the one who puts their head above the parapet and says 'actually I don't know the answer to this, It's been really important to me, 'cos you don't want to look like the one that's failing, or the one that can't cope."*
>
> *Participant 1*

The manager continued, and suggested that the small group dynamic was very conducive for learning through the sharing of practice knowledge. This suggestion was made because it was said to be easier to get to know and trust a smaller number of people. It was suggested that being able to create support networks in an action learning environment, and the sharing of practice knowledge, helped to build confidence and competence. One participant commented that;

> *"…it's [action learning] given me confidence. We've had quite a few problems in the home where I've been and I didn't know really how to deal with that issue. But through the action learning…it's um helped me to solve problems. Especially staffing issues."*
>
> *Participant 4*

Being able to shape the learning content by discussing issues brought about by their own experiences was seen as extremely valuable. The dynamics of discussing and offering solutions to real problems was valued, especially in a confirmatory sense. One manager commented;

> *"…it's quite good to know that…you're not as clueless as you sometimes think you are!"*
>
> *Participant 3*

Participant's unanimously felt that the support of a peer network was positive, and that the confidence gained through these supportive interactions served to increase or confirm competence.

Concerns around not participating enough were raised by a manager in the group who was not from a nursing background because, "you've all got lots, lots more experience." *(Participant 5).* However, three other managers in the group (from nursing backgrounds) suggested that this diversity actually enriched the action learning discussions. In one of the manager's own words, "you see it in a different way. We probably gain from you telling us how you see a problem…" *(Participant 2).*

The group discussed a variety of practice issues and the data illustrated how views, ideas and experiences that originate from different professional backgrounds serve to enrich discussion. Areas of mutual interest included; (1) their different perspectives on staffing levels and (2) the use of a resident dependency tool, (3) the use of personal care charts, (4) experiences of working relationships with GPs and other professional stakeholders and (5) methods of providing specialist care to patients with dementia.

Theme 3: Structure and sustainability

The programme tended to focus on what was described by one participant as *"real nursing home issues" (Participant 5),* not only about care but also about managing care. Interestingly, the group indicated that they were not initially aware of what action learning involved. Initially the sole motivation was increasing knowledge in relation to EoLC.

The format of the programme (10 full days over 12 months) was suggested as a structure that would maximise the likelihood of the programme having beneficial outcomes. This was favoured by participants and it was suggested that half days would be inadequate. According to one participant;

> *"…because you'd go into work in the morning and there's always something isn't there that you'd struggle to get out for 1o'clock or 2o'clock."* *Participant 2*

The group unanimously appreciated that attendance on the programme enabled them to have a degree of detachment from their working environment in the company of others who understood 'their world'. The focus group participants suggested that the programme was appropriately aimed at managers, and not owners. The managers felt a sense of security when only talking to their peers;

"'Cos I think it is because we felt safe talking that we have shared things that we probably wouldn't have done if we'd had any fears of it being repeated."

Participant 2

Although it was recognised that to keep discussions on task, and to provide adequate emotional support required a skilled facilitation team, the group indicated that they would carry on meeting independently. The group intended to meet on a quarterly basis. Whilst in retrospect the group appreciated the benefits of action learning they agreed that there was some confusion initially as to what was involved. Indeed a lack of palliative care input initially led manager's to question the value of the programme and whether they should continue to attend. Consequently, the group suggested that future programmes would benefit from a member of a previous programme advocating the value of action learning. One manager commented;

"I think if you're told by someone that it's worth doing this, 'cos the first day you do sort of think, you think I don't really know if I do want to do this for a whole year and I don't really understand." *Participant 2*

The proposed role of an advocate illustrates not only that managers hold the programme in high regard, but that they envisage that the programme could and should continue. Furthermore, the second focus group illustrated how the participants shared and reflected on practice knowledge. This occurred under no direct action learning facilitation, and suggests that the principles of action learning may be sustainable and continue in the groups forthcoming meetings when no direct action learning facilitator will be present.

Summary

The perceptions of the focus group participants indicates that the programme offered a valuable opportunity for the development of interpersonal and management skills. Confidence and competence was suggested to increase by sharing knowledge and by engaging in support networks. The managers were able to provide two substantive areas of impact in their day to day work that they attribute to their attendance on the programme. The first area is that improved communication is suggested to have led to managers becoming more confident in many areas of their work. Secondly, it can be suggested that learning from others and the sharing of practice knowledge seems to have led to an increased sense of reflective practice. Participants began to illustrate how practice knowledge was shared during exchanges in the focus group.

There was some discussion as how to position the programme in the future. This discussion centred on whether to refer to the programme as a series of workshops, and the extent to which *action learning* should be explained in the context of *palliative care*. The idea of involving a member of a previous programme was advocated to talk to a new intake about the content of the programme, and how the programme had impact on their practice.

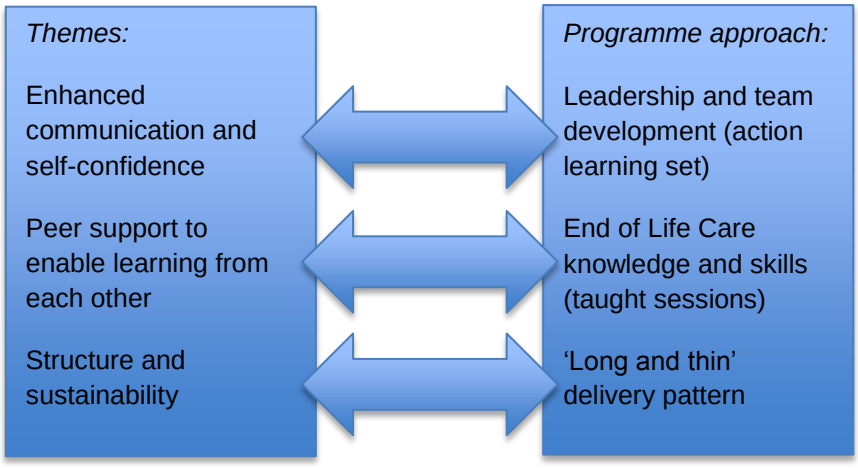
A consideration for future programmes might be for the action learning facilitators to cultivate participants as ‘action learning leaders’. Attempting to create this role may mean that it would be increasingly likely that the principles of action learning would carry on after the formal facilitation had concluded.

DISCUSSION

The evaluation has indicated increased confidence in care home managers knowledge and skills related to end of life care via a number of measures: the confidence questionnaire (CQ), the competency profile and the focus group feedback. The TNA questionnaire also showed some positive movement towards increased perception of role performance in most domains. As these were linked with the EoLC competencies (DoH, 2009) as was the CQ and competency profile, it is reasonable to assume that improved confidence and perception of competence will have positively impacted on EoLC for residents. In addition, the focus groups provide examples and case studies of improved inter-professional liaison, cascading of knowledge and more proactive communication with residents and families when making decisions about EoLC. This data also indicates that for most participants this educational experience has been one of the most personally and professionally effective, and even to some, life changing.

Specialist EoLC knowledge and skills education delivered by subject experts was highly significant in this positive outcome. However it also seems clear that the mode of programme delivery had as much pertinence as the content, namely the use of action learning and the programme structure. Diagram 2 illustrates how the focus group themes can be linked with the programme approach.

Diagram 2: Focus group themes and programme approach



Leadership and team development through action learning

The application of action learning (AL) and action research (AR) is beginning to become increasingly prominent in health and social care. Both approaches are based on the proposition that professional development will be enhanced by subjects reflecting on and working through their own work related problems. Working on this basis ensures that "…new

knowledge is generated from, and relevant for, them." (Hockley and Froggatt, 2006: 837). The benefit in this context was that a group of people in similar roles were brought together to learn. The focus on communication and self-awareness related to their leadership role enabled them to see the connection between these transferable skills and acted to improve practice. A further benefit is that they were a relatively disempowered group given their workplace isolation and perception as a devalued group within the health and social care community and even in wider society.

EoLC managers in all sectors work within finite resources, and this can cause conflict in regards to providing the best possible care. Subsequently, a premium is placed on interventions or exercises that will lead to more efficient and effective working practices. This evaluation suggests that specialist education provided care home managers the knowledge to articulate their arguments, across a range of EoLC issues, more effectively. For example, this evaluation suggests that the action learning programme helped the managers to gain confidence in their abilities. They were empowered to use the subject knowledge they were gaining more effectively at different levels - personally, with team members and stakeholders, from owners to GPs and hospital colleagues.

End of Life Care knowledge and skills taught sessions

A key strength of the programme approach relates to the combination of content and delivery process. Building on the group dynamic developed through the use of an action learning approach, the participants appeared to engage in collaborative learning in two respects. They were exposed to expert subject knowledge and then encouraged to apply this to their context and in doing so helped to shape the learning agenda. This sharing helped to generate trust between the participants that enabled them to share their challenges without fear of ridicule and then to formulate and share solutions. This was particularly effective for the one participant who was not a nurse. The notion of what constituted a learning resource seemed to be expanded to include expert tuition, written and web sources *as well as* one another's experiences and indeed resources. This was facilitated by the provision of space to meet within the hospice setting, for self-facilitated groups post-programme.

'**Long and thin' delivery pattern**

The programme structure of 10 sessions spread over 12 months appeared to work well for the participants. Because they were the key clinical leader in their workplace, they

appreciated ‘getting away’ in order to be ‘inaccessible’ in order to focus on their own learning. The ‘long and thin’ programme structure also meant that there was time between sessions for participants to reflect on their learning and to put into action any strategies that had been agreed in the action learning in order to improve EoLC. Reporting back on progress was a key feature of the action learning approach; developing listening and non-judgemental communication skills when contributing to these discussions are essential and transferable skills to improve EoLC. The approach seemed successful for the educational programme but it also acted to equip the participants with skills to use post-programme, thus contributing to the sustainability of learning.

The group was small (6 participants). The size of group depends on the topic (Redmond and Curtis 2009) and some authors suggest 6-10 participants (Morgan 1997; Bloor et al 2001). Morgan (1997) advises that a small group (eg. 6) should be used when participants are able to contribute meaningful discussion and interact with each other, as is the case with this present study. The optimum number for an action learning set according to Revans (2011) is 4-6 participants. Certainly the managers’ felt this group size promoted trust. Although the positive and long-term effect appears to be positive, the down-side of this is that this educational model is relatively expensive.

General issues

The evaluation provides support for the link between excellent communication skills, effective leadership ability and better quality provision (Shaw et al, 2007; Thomas and Noble, 2007; King et al, 2008; Shaw et al, 2010; Seymour et al, 2011; Badger et al, 2012). The findings show that this educational strategy appeared to have a positive influence on communication both within the specialty and in general teams when working with colleagues and residents. Further the link between evidence-based care and confidence to deliver has emerged as very significant factor. These issues affect the way people work (Badger et al, 2012). However, just as important is the improvement in EoLC knowledge that was illustrated in the focus groups and to some extent within the competency profile. More concrete evidence was apparent in the greater implementation of palliative care registers, use of the Liverpool care pathway, identification of lead EoLC within Care Homes and advanced care planning post programme.

The data would seem to support the value of this educational programme for both participants and ultimately for residents receiving EoLC. The action-learning model

appeared to be a sustainable approach as participants carried on appreciating the benefits of this, with the only cost being staff time. However, the programme length and small group size could be perceived as expensive, yet it is necessary to develop these important transferable skills. The EoLC specialist education could be delivered in a much shorter period but the value would be compromised. On the other hand, action learning could reap similar benefits regardless of the educational topic as to an extent the subject simply provides a hook for this powerful educational technique.

Limitations

The evaluation was planned for 16-18 manager participants. In the event the programme recruited 8, which then declined to 6. It was not intended to generalise from the data given the sample size and whilst smaller than intended, judgement of transferability to other settings is possible. The focus groups in particular yielded some rich and insightful data about this under - researched staff group. One of the programme facilitators also retired during the evaluation but was immediately replaced and this factor does not appear to have affected the educational experience.

Policy documents have been relatively prescriptive in outlining the professional competencies that the end-of-life care workforce should attain (DoH, 2008; Skills for Care et al, 2012). Yet, models that evaluate the effectiveness of nurses' professional development remain relatively generic and non-specialist (Hennessy and Hicks, 1998; Hicks and Hennessy, 1997; 1998; 1999; 2000; 2001). Evaluation models and research and methodologies that specifically evaluate the impact of end-of-life care professional development can be regarded as a relatively new area of study.

The use of the TNA was in part prescribed prior to the evaluation, due to on-going work within the educational setting. Whilst the tool has excellent reliability and has been extensively used, including for education evaluation, this evaluation indicates that is was somewhat too generic for the intended aims. The participants as very experienced managers tended to rate themselves very highly in most aspects of the tool, despite attempts at customisation. The focus on research and audit was thought to lack relevance initially but interestingly this appeared to dovetail well with the promotion of evidence-based practice within the programme.

The confidence questionnaire was used in the pilot work and so was again prescribed. It could be argued that many self-assessment tools can lead to a tendency to over rate oneself and this may explain why the pre-programme scores were higher than expected. However, there was still an increase in confidence across all measures post-programme. This is strengthened by the fact that during the focus group managers did admit to feeling a pressure to always be confident in their day-to-day working life. This may have affected the pre-programme results as well as the fact that they 'did not know what there was to know'. Some redesign of the questionnaire would be necessary if used again to eliminate a number of closed questions followed by comments.

CONCLUSIONS

This service evaluation of an End of Life Care Education Programme, sought to answer the following questions:

- What are the care home managers' perceptions of the impact of the educational programme on their leadership role in the provision of end of life care in their workplace?
- Has confidence and competence in delivering and facilitating the delivery of end of life care changed over the course over the programme?

This evaluation indicates that learning specialist EoLC knowledge and skills is essential to improve care in care homes. However whilst very valuable it is not enough on its own. In order to enable high quality EoLC, professional development should equip participants to be able to influence not just the individual's immediate team, but also resident's family members, owners, and other external stakeholders like GPs and emergency departments in hospitals. This evaluation provides compelling evidence that action learning can be used as a tool toward empowering middle managers to have positive impacts on EoLC provision through enhancing their capability to engage with a diverse range of EoLC stakeholders.

Recommendations

Evidence from this evaluation suggests that

- Expertly taught EoLC knowledge and skills is essential for care home managers to fulfil their role effectively
- An action learning approach enables the embedding of specialist knowledge in practice through the enhancement of leadership skills linked to increased self-confidence.
- The EoLC action learning education model leads to sustainable educational outcomes

FUTURE RESEARCH AND EVALUATIONS

Future evaluation work could usefully build upon this project but be designed to demonstrate actual as opposed to perceived impact on practice through the use of an action research approach, as this dove tails well with the action-learning philosophy.

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Appendix 1: Programme outline

	Date	Topic
Day 1	28th March 2011	The National Agenda in End of Life Care (1)
Day 2	29th March 2011	Communication Skills (2)
Day 3	16th May 2011	Self-Care (10)
Added as a one off to this programme	20th,21st and 22nd June 2011	Connected Advanced Communication Skills Course
Day 4	4th July 2011	Managing Pain (5)
Day 5	22nd August 2011	Assessing and managing nausea and vomiting (6)
Day 6	6th October2011	Assessing and managing breathlessness (7)
Day 7	15th November 2011	Fatigue-Anorexia-Cachexia (8)
Day 8	6th January 2012	Advance Care Planning (3)
Day 9	7th February 2012	Mental Capacity Act and End of Life Care (4)
Day 10	26th March 2012	Palliative Care Emergencies (9)

Appendix 2: Participant Information Sheet

End of Life Care Education and Evaluation Project

Information about the study for Care Home Managers

We would like to invite you to take part in our education service evaluation project. Before you decide, we would like you to understand why the project is being done and what it would involve for you. You will also have the opportunity to ask any questions on 28th March, 2011.

The purpose of the project is to evaluate the outcomes of the End of Life Care Education Programme for Care Home Managers. You have been invited to take part because you are undertaking this programme, but participation is entirely voluntary. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

The project runs for 18 months. You will be asked to:

- complete two questionnaires before the education programme commences and two on completion. You will also be asked to give an information pack including a questionnaire to care home staff directly involved in end of life care.
- participate in two focus groups (1 hour maximum each), one on the last day of the programme and the other 6 months after completion. These groups will be audio-recorded.
- submit your 'End of Life Core Competencies' Profile document for review at the end of the programme. This will be returned to you within two weeks.

All information which is collected about you during the course of the evaluation will be kept strictly confidential, in locked storage and made accessible to the research team at Bournemouth University only. Questionnaires will be coded and names will be removed. A report will be produced for the Hospice and the funder of the study and an article will be written for publication in an academic journal. However in all cases no care home or individual will be identified. All data including audio recordings will be destroyed after completion of the final report in October 2012. No potential risks or disadvantages have

been identified in seeking your participation apart from the time commitment involved. The benefit of participation is that we hope the project will help inform end of life care education for those working in care homes.

The project is being funded by The Frances and Augustus Newman Foundation. This is a charity which funds medical research projects. The project has an independently chaired steering group, whose role is to monitor the conduct of the project. The study is being sponsored by St Wilfrid's Hospice, Chichester. The School of Health and Social Care at Bournemouth University will independently evaluate the End of Life Education Programme. As the project is a service evaluation as opposed to clinical research, formal ethical approval is not required but none the less the study procedures will adhere to the principles underpinning current NHS research ethics guidelines (http://www.nres.npsa.nhs.uk/).

If you have any queries or require further information about the evaluation, please do not hesitate to contact Janet Scammell from Bournemouth University (01202 962751; jscammell@bournemouth.ac.uk) who will be happy to speak with you.

Thank-you for reading this information.

Jenny Buckley, St Wilfrid's Hospice
Sue Nash, Action Learning Teams
Dr Janet Scammell, Bournemouth University