skillsforcare

NHS Health Education England

Guide to evaluating new roles

Created on behalf of the Kent, Surrey & Sussex Role Development Group – July 2019

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1. Introduction to this guide

Recent years have seen new ways of working and roles emerge as consideration is given to the delivery of new services or changing the way a service is provided. This can mean enhancing people's roles, for example, delegating health tasks to non-registered staff, as well as the development of new roles, such as Care Navigator or Trusted Assessor.

This guide, developed on behalf of the Kent, Surrey & Sussex Role Development Group, includes examples of how some projects have or plan to evaluate role development.

In an appendix to this guidance (Appendix A), information on how to implement a new or enhanced role covering areas, such as workforce planning and considering the skills mix, is included.

2. Evaluating role development

Evaluation is about assessing whether your project / programme is being delivered effectively and efficiently. It measures the outcomes and impacts from your activity to assess whether the intended goals are being achieved.

Evaluation:

- Provides an objective assessment of a project, in this case developing a role.
- Can involve the process of determining the value or importance of the role.
- Collates reliable and useful information, which can be used to inform decision-making, such as the ongoing commissioning of that role.

Having a framework to structure a project can help when it comes to developing a business case, as well as considering what measures could be useful to support evaluation; for this guide, a logic model is used.

A logic model is an explanatory model or 'roadmap' that sets out what you intend to achieve and how your project/programme will get there. It can help those involved in project management – not just to plan for evaluation, but to plan for a successful project or programme.

Providing answers to the logic model questions using monitoring and evaluation evidence can demonstrate the impact of the role by capturing the:

- Inputs - including the resources, contributions, and investments
- Outputs - the activities, services, events and products, and
- Outcomes - the results or changes which are directly linked to the activities.

By identifying inputs, outputs and outcomes, questions can be answered, such as:

- What resources are required to successfully design and implement a new role?
- What needs to be in place to ensure the new role has an impact on the identified problem?
- Who benefits most from this new role?
- What is the long-term impact of the new role?

Handy hint when considering role evaluation

You will need to demonstrate that it is worth your organisation continuing (and scaling up) the innovation.
I have often found that we can rush into projects enthusiastically, and realise too late that we are not gathering critical data, and it is too late to do it retrospectively… Think through what questions any business-case review panel will ask in a year or two's time and give appropriate weight to these, e.g., cost-savings, as well as quality improvement.

A set of questions to inform the development of a logic model and a template to capture this is provided in Appendix B.

Some completed examples of logic model templates covering role development are also provided (see Appendix C) and include:

- Clinical Technologist Role
- Peer Support Worker in Mental Health
- Right Skills, Right Place
- Primary Care Receptionists as Care Navigators
- Lead Practice Nurse Facilitator
- Trusted Assessor
- Pre-employment Co-ordinator
- Nurse Associate – local and national project
- Enhanced Recovery Project

3. Developing a logic model covering role evaluation

The next section takes you through some key questions when completing the logic model, with some examples from local role development projects provided.

a. Identifying the situation / issues to be addressed

This section helps to capture the rationale for developing a role and provides the evidence to support this. For each question (in the blue lines), there are some examples provided by local role development projects. The words highlighted in red are the methods used by the projects to capture this evidence.

Clinical Technologist	Care Navigator	Lead Practice Nurse Facilitator	Peer Support Workers in Mental Health	Trusted Assessor
Q1. What problem is the new role trying to resolve and why? What is the evidence to support this?				
Nurses and health care assistants (HCAs) were using valuable time they could have spent caring for patients, carrying out tasks, such as chasing, cleaning and ordering medical equipment. The staff survey results showed that 64% of nurses and 72% of HCAs spend more than an hour a week on non-patient care activities. These activities took more than two hours for 23% of nurses and 29% of HCAs needed on the ward.	The demand on GPs and other practitioners is increasing. When we analysed practitioners' workload, a large proportion of GPs' and nurses' time is taken up by signposting / referring to others.	There is a shortage of practice nurses, with a high proportion due to retire. We need to attract nurses into primary care; our workforce data confirmed these numbers and staff exit and student nurse interviews revealed themes in terms of why people were leaving or not considering working in primary care.	Peer support is defined as a reciprocal process of giving and receiving help, founded on the key principles of collaboration, respect and shared responsibility (Mead, et al., 2001). Themes emerging from our local consultation events included people wanting to gain access to peer support.	The acute wards within the hospital reported that there were delays in transfers of care for certain people. A focus group with the team identified that a number of people were ready for discharge but were not able to return home.
Clinical Technologist	Care Navigator	Lead Practice Nurse Facilitator	Peer Support Workers in Mental Health	Trusted Assessor
Q2. What causes the problem?				
The use of equipment to support health care is a key feature now; however, tasks, such as chasing, cleaning and ordering medical	The increasing demand on primary care, along with patients being used to asking to see a GP or practice nurse, rather than	Working independently as a practice nurse can be daunting, particularly when you are a new nurse. This means that more	Although we have a range of experts by experience, we do not have a scheme to develop peer support.	When we looked at delayed transfers of care figures, and the associated issues, there were delays in people gaining

equipment is taking up practitioner's time.	presenting with their concern and being signposted to other services that could help.	development and support opportunities are needed then the existing staff can provide.		assessment to go back to or enter care homes.
Q3. Who is affected by the problem?				
Our staff turnover was at x% amongst HCA and nurses. During a staff conference, some stated that the least satisfying part of their job was carrying out tasks not related to patient care.	Other service providers, through stakeholder meetings, identified six core areas that could be managed through direct contact with other practitioners / services rather than through the GP or practice nurse patients and primary care staff.	Existing primary care staff, student nurses (as they consider their career options) and registered nurses who are considering returning to work or changing their role.	People within the services and those we consult with, and mental health support teams.	Patients' length of stay is in some cases longer than needed and this can impact on areas of their physical health, well-being and confidence.

Clinical Technologist	Care Navigator	Lead Practice Nurse Facilitator	Peer Support Workers in Mental Health	Trusted Assessor
Q4. Who cares if the problem is resolved?				
Staff on the wards, succession planners in terms of career development into clinical engineer roles, commissioners and transformation leads, patients and carers in terms of contact time with staff.	GPs, practice nurses and other primary care staff, patients and carers, CCG commissioners.	Primary care staff are already under pressure, so we do need to attract in new nurses, patients and carers.	People who use services, community, mental health workers, commissioners, recovery college approach, partner organisations.	Patients moving from hospital and their carers, hospital discharge teams, care homes managers, Local Care Association, Local Authority adults social care, acute ward staff, CCG and LA commissioners.
Q5. What does the evidence (from research and experience) tell us about the problem?				
Feedback from recruitment and career events suggests that the NHS is not always seen as a career option for people from technical / engineering background. We undertook a literature review to see what research might be relevant.	Care Navigation and signposting has benefitted other areas, such as s similar project in Wakefield.	National figures show that there is shortfall of primary care nurses. National Audit Office report.	Peer worker-based interventions reduce psychiatric inpatient admission and increase service user empowerment (Gillard, et al., 2013).	Any delay can affect patient's well-being and health - '10 days in hospital leads to an equivalent of 10 years aging in muscles of people over 80' (Kortebein, et al., 2007).

Q6. What is happening that you have no control over which might impact on the development and implementation of the new role?

Themes from the role development projects included:

- Mindful of impact on other professionals who may feel threatened by new role.
- New roles need to have people interested to be able to recruit to.
- Developing new roles can have unintended consequences of taking staff away from existing but vital roles.
- Education - having the capacity to offer courses to support role development.
- People having the time to engage with the development work as they are already under pressure.
- Recruitment to any role can be a problem and so it needs to link with wider initiatives.
- Not seeing new roles in isolation but creating career pathways, underpinned by education pathways/escalators.
- New roles need to be line managed/supported, and project management is required to support the team in embracing the new role. New roles can't just be 'parachuted' in and left to it.

Q7. What you felt would / would not have happened in the absence of this role development?

Themes from the role development projects included:

- Already under so much demand, so something needs to give.
- Timely discharge, recognition and prevention of problems.
- Wider impact, such as spend on agency.
- Image of certain jobs as having career opportunities could impact on recruitment.

Get some people together and ask them to complete unfinished questions, such as "We have a problem with…", "We need a role that can…" and "Staff need to develop their skills in…"

These can then be checked out with others and rated in terms of

To keep it focused on people, consider what they would be saying if we got this role right, for example, "I have one person who I know is co-ordinating my support", "The staff are able to provide what I need where I am", and "My discharge from hospital went well".

This might be helped by also referring to the use of 'I statements' within the National Voices narrative.

b. Inputs, processes and activity

This section identifies the resources and activities required to design and implement the new role.

Q1. What people, financial, organisational and community resources are required to support this work?

Examples from role development projects were:

- Project support time, including areas, such as analyst time – to produce the data.
- Steering group and co-production.
- HR support to develop job profiles, training, recruiting and mentoring.
- Funding for role / pilot, including on costs.
- System support to capture indicators and data.
- Partnership work to engage others in the role development.
- Stakeholder engagement / communication.
- Linking with commissioners to support sustainability.

Q2. Who needs to be involved in the delivery of the project, including any specific expertise they contributed?

Examples from role development projects were:

- Governance issues were particularly important to address early.
- What are the risks and ways to mitigate these?

- How can this role be supported?
- Key decision makers need to be on board – especially if there is a need to escalate problems.
- Having the right representation in steering and project groups, especially practitioners.
- Co-produce with people rather than imposes.

Q3. What you will be doing to develop and implement the new role?

Examples from role development projects were:

- Engage with people to clarify the problem / situation.
- Start to define what the role might look like.
- Research to see what has already be done by others.
- Identify what success would look like and what we need to measure.
- Pilot the role and capture the information needed in terms of effect.
- Collate, evaluate, promote and celebrate what has been achieved.

Handy hints when considering inputs, processes and activity

Engagement and building relationships are key; this can also take time. We've had real success with 'engagement-based redesign', i.e. engaging staff in identifying parts of their role they least enjoy, and thinking through who could take these activities on – and would enjoy them, or would see it as a career opportunity

It was important to involve people that could consider the governance needed right from the start, so we were able to delegate some of the tasks that the role might provide

Right from the start, consider how the role might be sustainable in terms of funding, development and recruitment

c. Identifying and measuring the outputs - key, short-term, quantifiable deliverables.

Q1. What key, short-term, quantifiable deliverables are you expecting?

Examples from role development projects were:

- Reducing the number of days patients had to wait in a ward before they had an assessment for their discharge to a care service.
- Increasing the number of trainers and assessors we have developed.
- Increasing the number of patients who are signposted by the receptionist to another more appropriate service.

- Number of people recruited and developed into the role.
- Increasing the availability of peer support.

Q2. What are the indicators that need measuring?

Examples from role development projects were:

- The length of stay from having been deemed clinically fit for discharge from **several** wards involved in the pilot.
- The number of trainers and assessors that are in contact with the role and then sign up to the register.
- Coding done by the receptionist that is then attached to the patient to follow their pathway through the service.
- Follow selection of candidates and ask interviewees how they heard about the role.

Handy hints when identifying and measuring the outputs

Once you have identified the output, consider how you might measure so that you have a baseline of data

Look for any national work that has been carried out to see how others have approached this

NHS England New Care Models

d. Identifying the short-term outcomes – within 6-12 months of implementing the new role.

Outcomes are the intermediate effects of the role, and the role development projects often adopted a 'before and after' or a 'with and without' approach.

Q1. What benefits do you hope to see within 6-12 months of implementing the new role? What are the expected intermediate effects?

Examples from role development projects were:

- The savings in terms of time and costs, as staff not repeating their current training when they move employers.
- New practice nurses feel more confident and supported in their role.
- People involved in discharge are starting to see an effect in terms of the role.
- People are more aware of the variety of jobs that are available in health and social care.
- Patients report having access to peer support and can identify the difference this has made for them.

Q2. What might be the indicators of these?

Examples from role development projects were:

- Work with HR to select a cohort of new staff who have come with recent training and then see how not repeating training has saved in terms of time and costs and their own satisfaction.
- Ask new practice nurses to rate their confidence and level of support at key points in their employment.
- Identify three key measures of success and then get people to rate these.
- Provide testimonials from key people involved.
- Ask people how they found out about the job during evaluation.
- Staff engagement / satisfaction, retention.

Handy hints when identifying the short-term outcomes and measures

We collated what data / information we needed to gather and then circulated this through key groups to see what was already available and what we needed to develop

We found a report from another project that had linked outcome goals to outcome measures which was useful as a point of reference when thinking about what we measured

Review your overarching corporate objectives/metrics and see how the project will feed into those?
Think about a mix of qualitative and qualitative data?

e. Identifying the medium-term outcomes - 2-5 years after the role is implemented.

Q1. What benefits do you expect to see 2-5 years after the role is implemented?

Examples from role development projects were:

- Staff are more satisfied about their support and development.
- Discharge is timely and processes are streamlined and effective.
- We have saved money in terms of 'bed days' saved.
- There is a role that meets what it was set up for and career development opportunities to match.
- We have improved our performance rating.

Q2. What might be the indicators of these that need measuring?

Examples from role development projects were:

- Staff turnover has **reduced,** and results of staff survey indicates level of satisfaction with job and support offered.
- Monitoring of delayed transfers of care show reduced time waiting for assessment.
- Testimonials from those involved indicates improved experience of discharge.
- Calculations of return on investment.
- Measures against the Key Performance Indicators for the project.
- CQC rating or other QA measure.

f. **Identifying the impact / long-term outcomes (at the sector level)** – 5 years' time after the role is implemented.

Q1. What benefits will be seen at sector level in 5 years' time?

Examples from role development projects were:

- Less admissions to acute services by having skills that can support prevention and people staying in the community.
- Increase in productivity and less duplication and delay.
- Services been places for career development.
- People moving from seeing a practitioner to more self-help.

Q2. What would the world look like if we didn't have this new role?

Examples from role development projects were:

- Constantly 'firefighting' rather than really dealing with the issues.
- Increasing demand on existing staff and the strain that is put on them and reflected in staff turnover and sickness absence.
- Patients' well-being and independence affected.
- We lose the expertise of patients.

Q3. What fundamental intended or unintended change might occur as a result of role development activities?

Examples from role development projects were:

- Practitioners moving into mentoring and development roles rather than direct patient care.
- Allows those with more complex care requirements having more time and attention.
- Attracting people from different backgrounds and experience to health and social care.

Handy hints when identifying longer-term outcomes

Get people in the roles to identify what success might look like and then they will be more likely to capture that information – 'we get peer support workers to identify what they have achieved during supervision they capture the "sparkles"

Keep reminding yourself what this was all about and that can keep things on track

4. Methods to support role evaluation

An evidence search into the methodologies for evaluating the effectiveness of enhanced / upskilled or new roles is inserted below (Deshmukh, 2018). This highlights several studies where mixed methods were used to undertake evaluations. We have provided a useful guide on how to search for methodologies here.

Handy hint - when considering what to measure as part of the evaluation

Consider a balance of measures that cover financial, service, client / patient and workforce

The following section captures a few of the methods used in the evaluation of local role development projects**.**

a. Using existing data sets

When considering role development, the following data sets were identified as useful when gathering baseline data, benchmarking and identifying the costs of delivering services:

- NHS Digital – a national data set collected from care records and information on systems and organisations on specific areas of health and care. This is used to inform policy and monitor and improve care.
- NMDS-SC - is an online database based on the adult social care workforce. It is the leading source of workforce intelligence and holds information on approximately 25,000 establishments and 700,000 workers across England.
- NHS England – Delayed Transfer of Care Data – this Monthly Situation Report collects data on the total delayed days for all patients during the month.

- Unit Costs for Health & Social Care - the Personal Social Services Research Unit provides data on costs per service per day for a range of NHS and social care services. It can be used to support the calculation of savings.

b. Using questions

- Closed questions – can be defined by pre-set, multi-choice responses or numerical answers, making them easy to analyse but more rigid in terms of the information gained. Closed questions might ask respondents to rate something using a range. It is essential to clearly explain what each number in the range means, for example:

1 = strongly agree, 2 = agree, 3 = disagree and 4 = strongly disagree.

Some examples from role development projects were:

- We asked staff to rate their confidence to carry out an activity before and after role development:

  Q1. How confident do you feel about…?

  A visual analogue scale would be used to measure confidence, asking the respondent to click on (for online surveys) or circle (for paper surveys) the number that bests rates their level of confidence.

  1_____2_____3_____4_____5_____6_____7_____8_____9_____10

  Not confident at all   Extremely confident

- *We asked patients the following question in terms of discharge:*

  Q2. To what extent do you agree with the following statement: 'I am as involved in discussions about my care and treatment as I want to be'?

  1 = strongly agree, 2 = agree, 3 = disagree, 4= strongly disagree

- We asked stakeholders to identify three statements that would indicate success to them and then got them to rate these before and after the project, in terms of how much success they had achieved on a scale of 1 to 10.

- Open questions – are used to obtain lots of feedback and potential ideas but do require a thematic analysis and are as easily quantifiable.

Some examples from role development projects were:

- In your opinion, what have been the main advantages of developing this role?
- What do you feel are the main areas this role could support you in?
- How do you think this role could be developed further?

Handy hint on presenting the results of open questions

A word cloud is a graphical representation of word frequencies. The larger the print, the more frequent the word was used by respondents. A thematic analysis is required to contextualise these words, but this can also be a way of visually representing themes from open-question responses.

c. Developing surveys

In survey questionnaires, whether paper or online, the questions will require planning to ensure that the results are useful and meaningful. Surveys can be cost effective; getting to large numbers of people in a short-time period and they can be easily analysed. However, they require careful planning and communication if they are to gain a high-response rate and meaningful data.

Packages exist to support survey administration, such as Bristol Online Survey, Survey Monkey, Google Forms or there are other free survey tools here. Please ensure you contact your Information Governance team prior to designing, as they can advise you which is the most suitable for your organisation.

Handy hints for creating a survey

1. Work with a small team to identify all potential questions and think about how these could be interpreted to ensure they can gain appropriate answers.

2. Keep your survey brief – only ask questions about what you really need to know to encourage specific feedback and make it a manageable task.

3. Do not ask two question in one. Split multiple questions into single questions to avoid confusion or long questions. This is also important as it makes analysis and interpretation of answers clearer.

4. Use different question styles as appropriate – open (when you cannot predict the answers), closed (scales / tick boxes when you can predict answers and you want to know about specific issues).

5. Don’t use leading language in the survey questions (e.g. ‘please tell us how much you enjoyed the function today’ - this presumes that people did enjoy the function. Instead, ask ‘please tell us about your experience of the function today?’).

6. At the beginning of the survey, give clear instructions how to complete the survey and reiterate what will happen with the responses. Give people an indication of how long it will take them to complete the survey. Add in a deadline for completion, e.g. ‘the survey will be closed on [date]’. Also thank the respondents for taking part and let them know what the benefit of their feedback is, e.g. ‘Your feedback is very important to us as we will use it to…’ You also need to put a statement complying with current data protection regulations, a large part of which is informed consent to take part in the research. An example is provided below as a handy hint.

7. Consider respondent’s accessibility – paper, ICT, font, colour, etc.

8. At the end of the survey, thank respondent and re-confirm use and confidentiality.

Handy hint – statement regarding data protection

Your responses will be treated in confidence and processed by (name of organisation) in accordance with the General Data Protection Regulations. No personal information will be provided to anyone beyond the team conducting the data analysis. Any reports will be based on combined data only and will not contain any personal information. Any personal data collected will be disposed of within 24 months of the close of this survey.

Do you agree to take part based on the above?

a. Yes
b. No

At any stage in the future you may advise us that you would like to withdraw this consent, at which time any identifiable and attributable data will be deleted from our files.

d. Using focus groups

Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data. Although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly use group interaction as part of the method. This means that instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each other's experiences and points of view.

The method is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think, but how they think and why they think that way.

Focus groups were originally used within communication studies to explore the effects of films and television programmes. They are now a popular method for assessing health education messages and examining people’s experiences and understandings of diseases / illnesses and of the health service and are an effective technique for exploring the attitudes and needs of staff. Find out more about choosing focus groups here.

e. **Capturing Return on Investment (ROI)** – The Public Services (Social Value) Act, 2012 describes the statutory requirement for all public bodies and all public services to have with regards to economic, social and environmental well-being, which means that the consideration on the ROI in role development is vital.

- Economic benefits - which result in improved economic performance for the services, for example, the number of bed days saved.
- Socio-economic benefits - which result in measurable economic benefits to society, for example, increase in employment and career progression.
- Social benefits - which provide improvements that cannot always be measured in monetary terms, for instance, a programme that results in participants having improved self-esteem.

The social value calculator may be relevant to some projects. This calculator was commissioned by the Sustainable Development Unit (SDU) for the Health and Social Care System and was developed by the Social Value Portal. It is intended for organisations operating within the health and social care system that would like to capture and quantify some of the environmental and socio-economic benefits (social value) associated with their operations, procurement, service design and commissioning decisions.

Although the financial ROI can be expressed in several ways, it is usually presented as a percentage or cost / benefit ratio (Phillips, 2005). You can view an example of ROI for an apprenticeship scheme here.

Many role development projects considered whether there was value for money in the new role and linked this with measures, such as reduction in inpatient bed use.

For example, we were aware that some patients were waiting 5 days for an assessment by the care home even though they had been deemed medically fit for discharge. When setting our potential return on investment, we wanted to reduce that to 1 day, which meant:

- Trusted assessor carried out 2 assessments per day
- Potential reduction of 40 bed days per week - 160 per **28-day** month
- Cost per acute bed in x hospital is £158.
- For the Trusted Assessor predicted activity, this works out at approximately £330,000 per year (40 days x 52 weeks x £158 per day).
- There is evidence for this in similar projects - e.g. Lincolnshire Trusted Assessor Project annually there were 439 referrals and 340 Assessments Completed. This led to 304 discharges, saving 735 days, with a total saving of £400K (Net).

Handy hints when considering value for money

Do research on other projects - we found that the Centre for Mental Health has published a report Peer support in mental health care is it good value for money including guidance on how to work out the costs, so we didn't have to start from scratch

f. Using testimonials and case studies to capture outcomes and learning

Many role development projects have provided case studies to demonstrate the outcome for the people involved.

- An example template to structure your case study is available as Appendix D.
- Some case studies are included as Appendix E.

g. Developing an overall report

Although different reports are required for varying audiences, there are some general tips to help you when developing your project report.

Handy hints for developing an overall report

1. Present as the logic model to show situation, activities, outputs and outcomes.
2. Set out, in bullet points where possible, the good practice and key learnings from the project.
3. What the most successful parts of your project were.
4. What the most challenging parts of your project were and how you overcame them / how others could address them in the future.
5. What benefits you identified.
6. What changes or other effects results from your achievements.
7. What you would recommend to other employers considering a similar approach.
8. If the project was not as successful as first hoped, why was this and what would you do differently?
9. Describe why you think your project delivered added value and describe any unexpected positive impacts.
10. What might be the next steps?
11. What would you recommend to others?

You will find a template here, which you might find useful when presenting your evaluation.

Having a visual poster to summarise the role development can also be useful. An example can be found here.

5. Appendices

Appendix A –

The Skills for Health Six Steps Methodology to Integrated Workforce Planning is a framework that can support the planning needed when developing roles.

The Six Steps are:

Step 1: Defining the plan
Step 2: Mapping service change
Step 3: Defining the required workforce
Step 4: Understanding workforce availability
Step 5: Planning to deliver the required workforce
Step 6: Implement, monitoring and refresh.

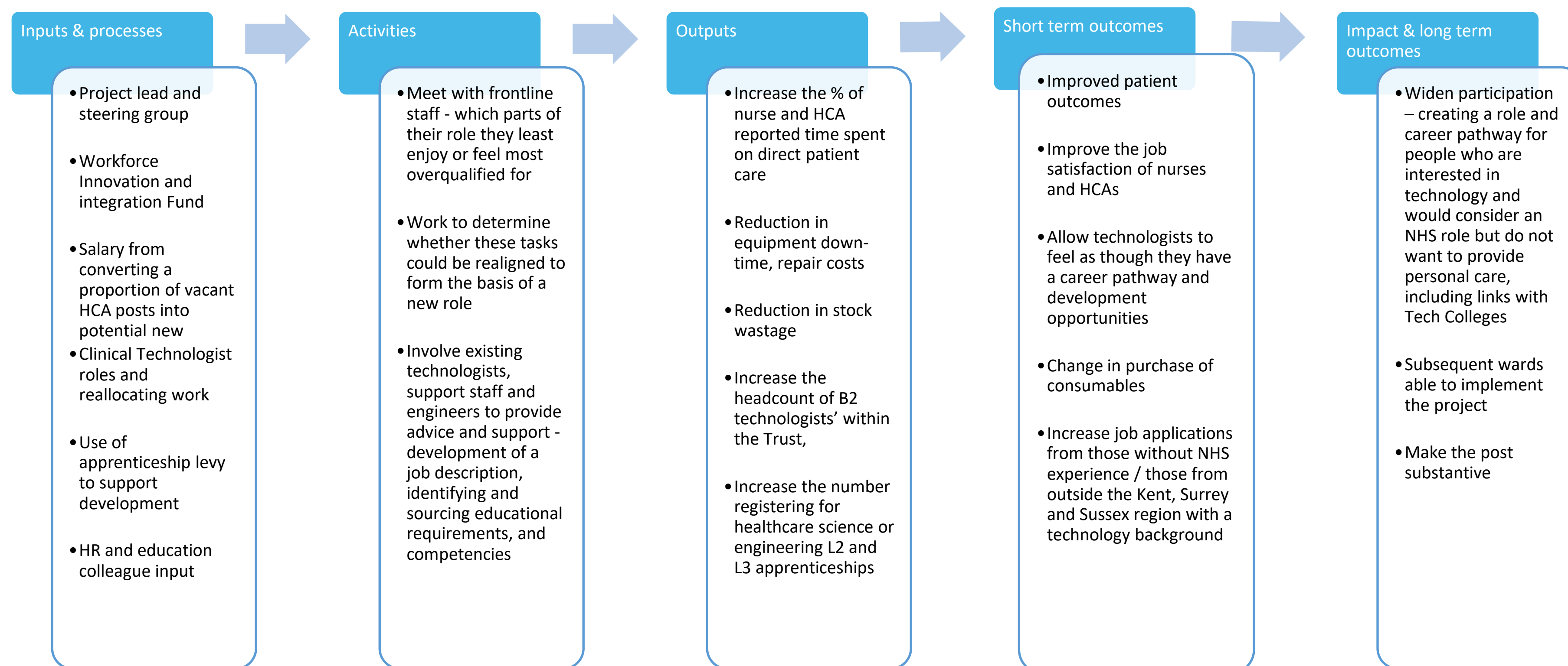
Appendix B –

Questions can be viewed here and template to develop a logic model can be viewed here.

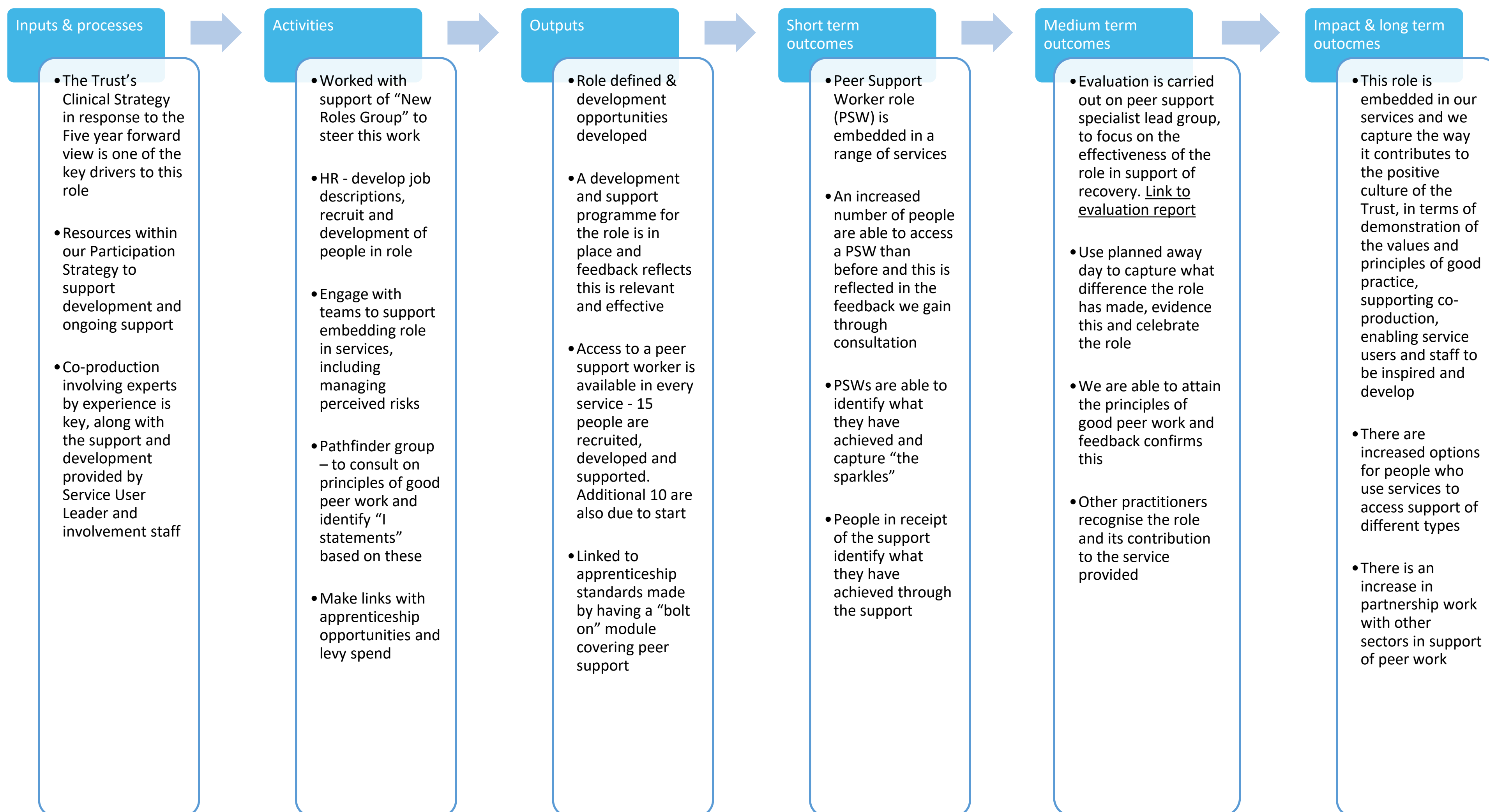
Appendix C –

Examples of role development projects presented as logic models have been provided.

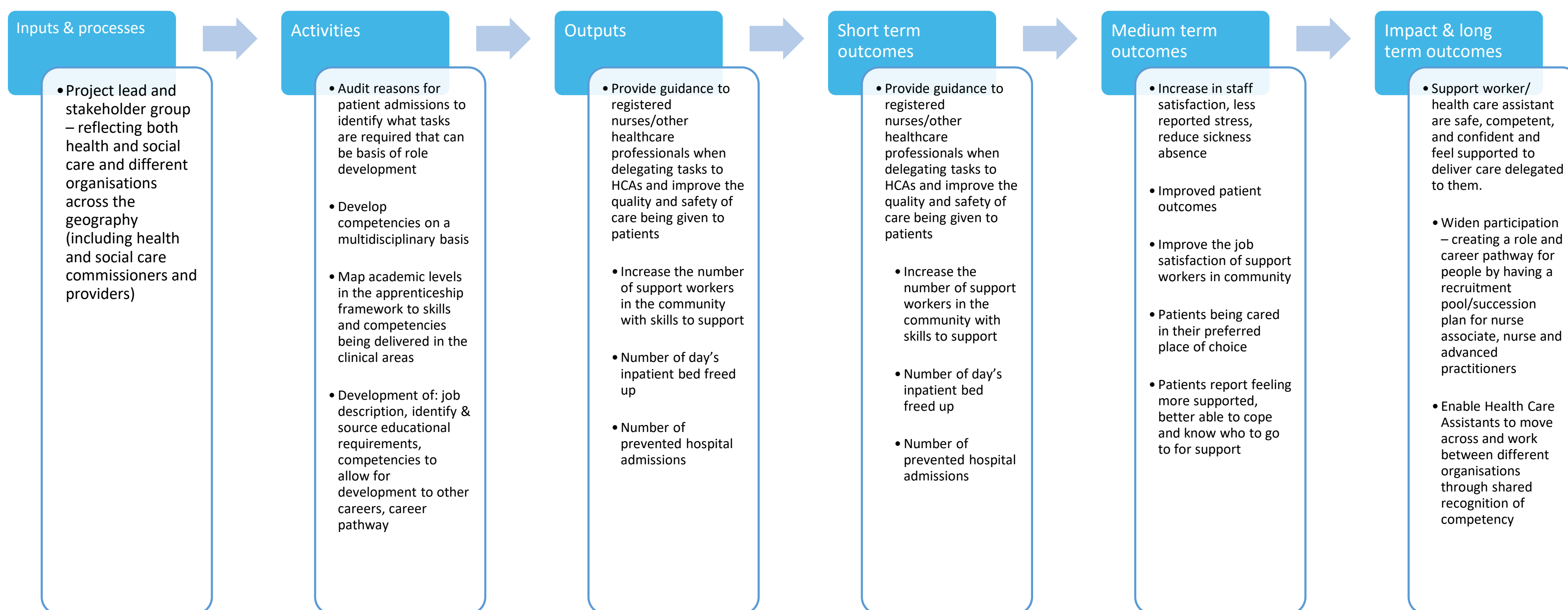
Clinical Technologist Role - Situation: Nurses and healthcare assistants (HCAs) were using valuable time they could spend caring for patients by chasing, cleaning and ordering medical equipment needed on the ward. During a staff conference, stock and equipment management tasks were mentioned frequently as roles that could be delegated to others. There is a Band 2 role assisting with stock management, but no career progression and there is a Band 5 and 6 technologist and engineering roles with a limited pool to recruit from.



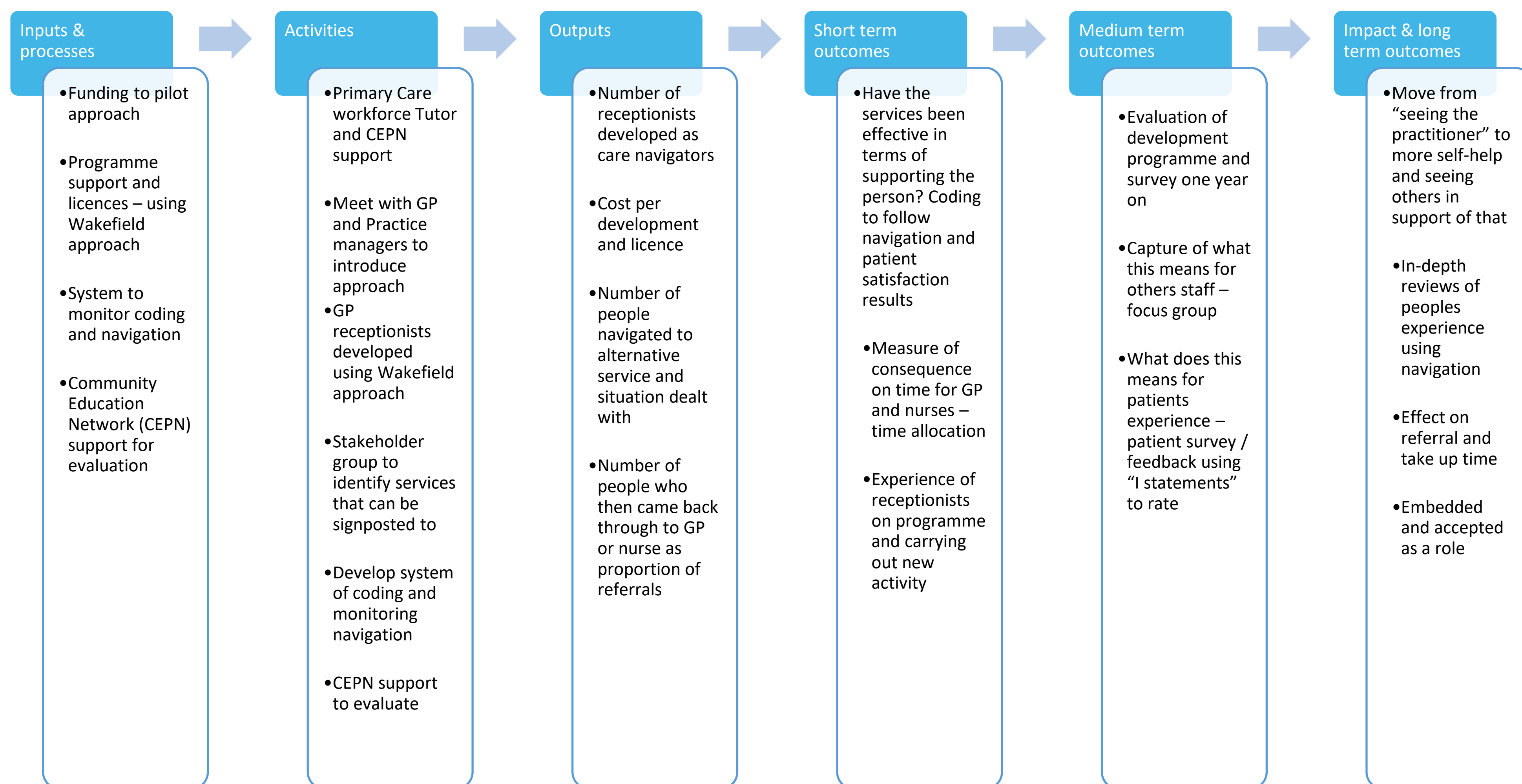
Peer Support Worker in Mental Health – Situation: Peer support is defined as a reciprocal process of giving and receiving help founded on the key principles of collaboration, respect and shared responsibility (Mead, et al., 2001). National research has identified that having access to someone who understands, from a point of having "lived experienced", can contribute to a person's recovery and our local consultation included requests that access to peer support should be made available.



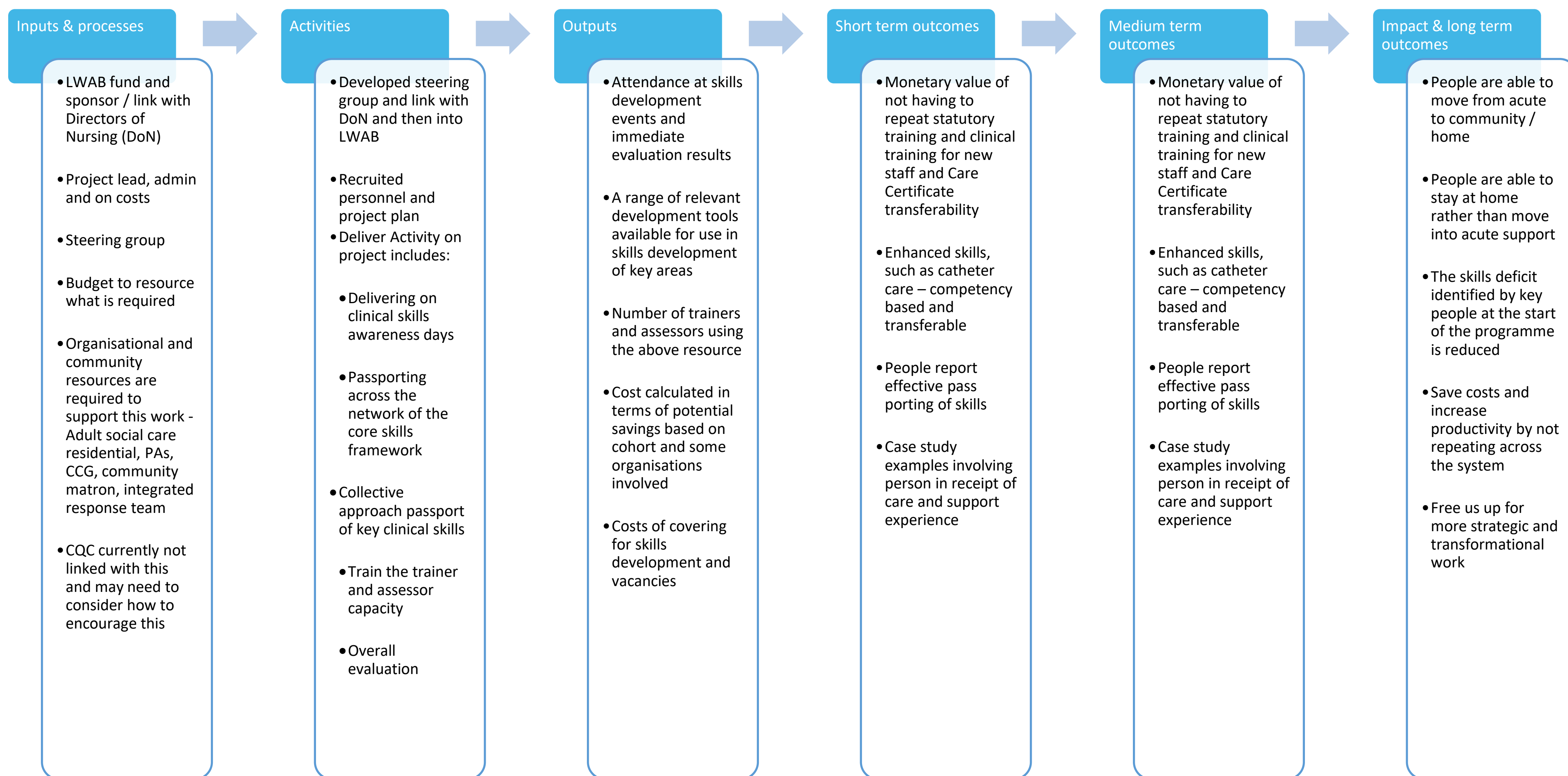
Right Skills, Right Place project - Situation: It has been identified that some patients are in hospital who could potentially be cared for in other / more appropriate care settings, if staff with competences were available. There could also be the potential to avoid hospital conveyance / admission / readmission.



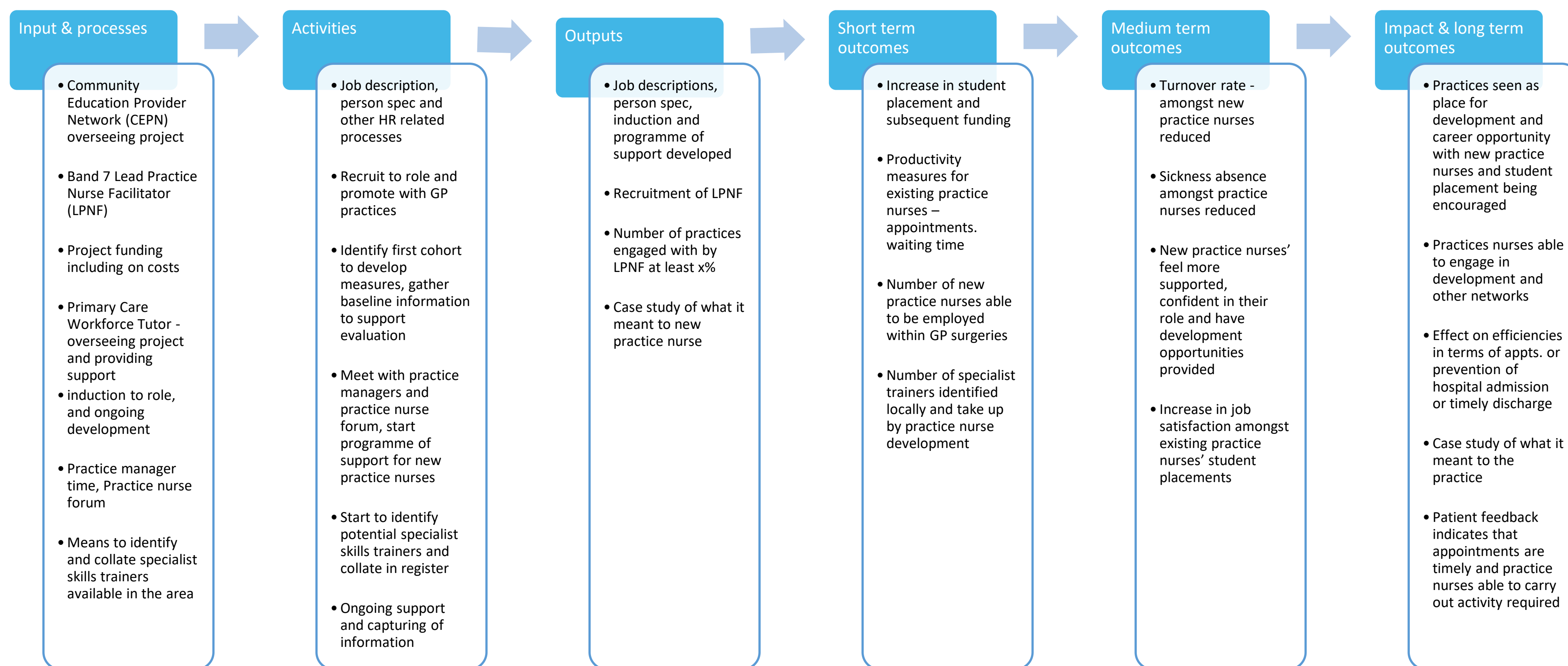
Primary Care Receptionists as Care Navigators - Situation: The demand on GP's and other practitioners is increasing and their time can be taken up signposting to other sources of support. Wanted to move to approach where people present for help with their condition rather than "to see a GP or nurse". Integrated care model - changing culture and moving to person most appropriate to support - shift for people to think more lateral and more willing to self-help. GP and nurses time could be freed up to support more complex care requirements.



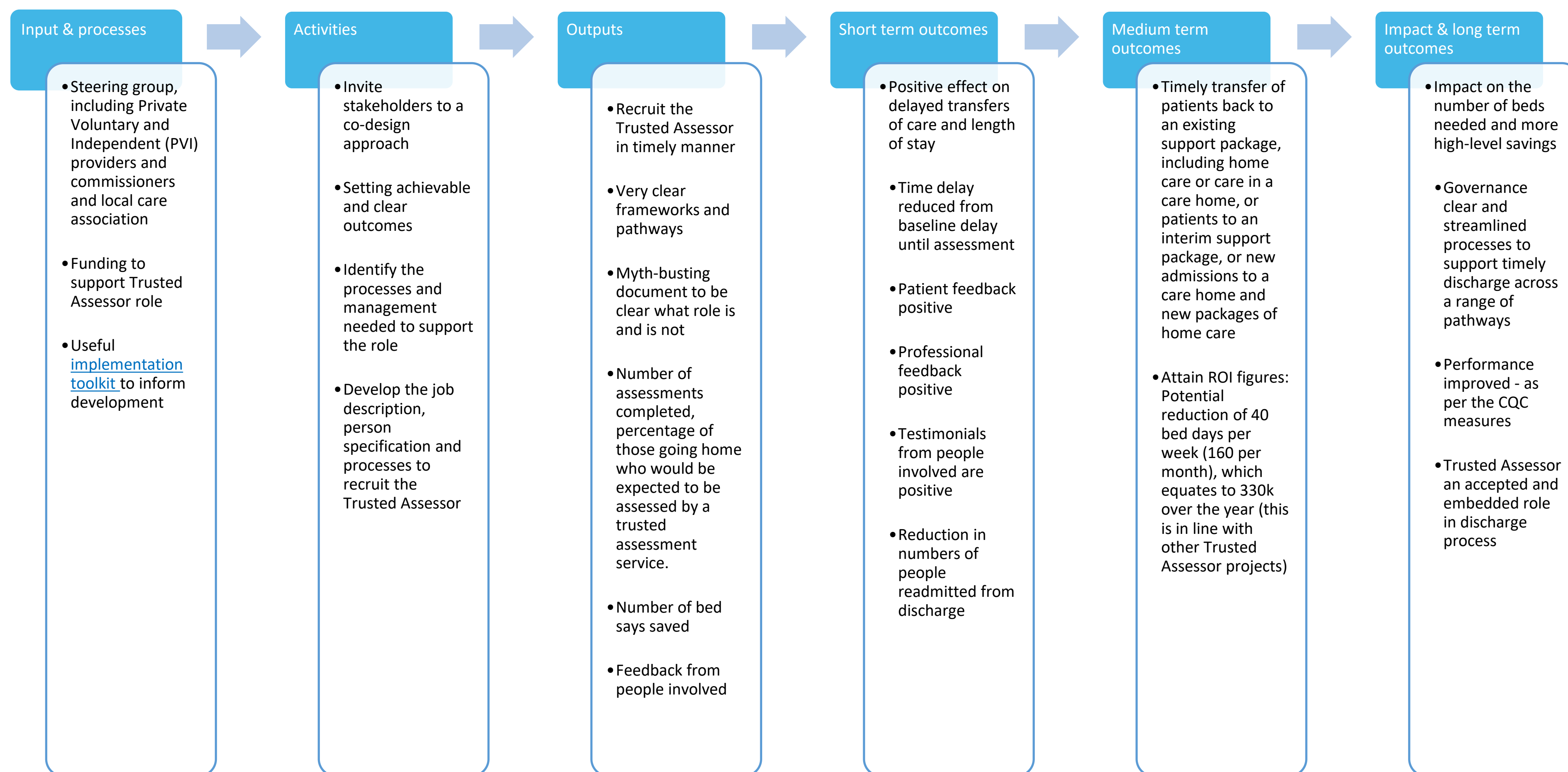
Clinical Skills Development Programme - Situation: Identified that there is a gap in knowledge and skills related to certain clinical activities – to support the management of complex care and the movement of people between care environments – need staff with the right skills in the right place at the right time. Providers of care services find it hard to access the right training and are uncertain what should be covered. Future care requirements might mean that more complex care is delivered outside of acute hospitals.



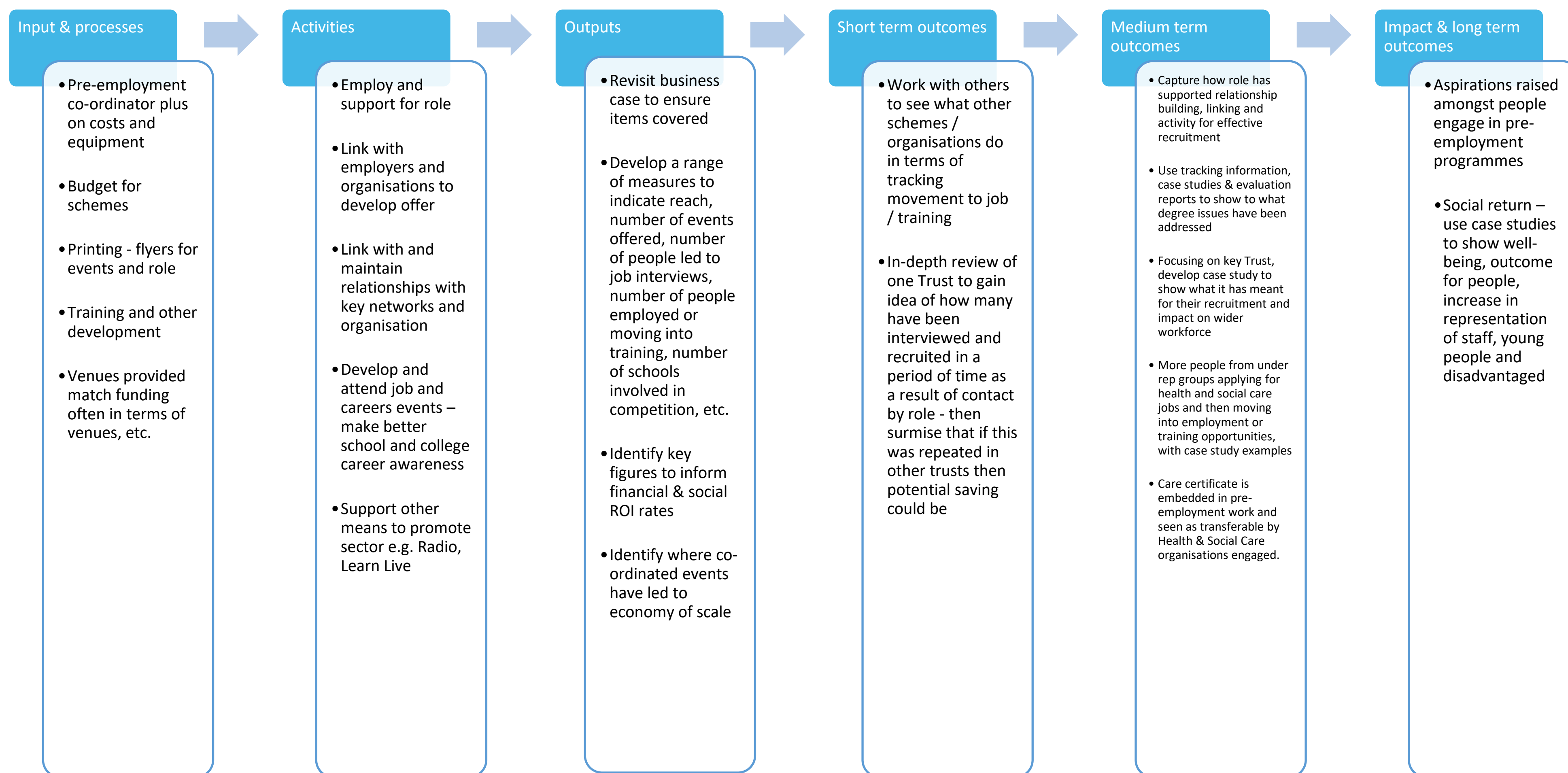
Lead Practice Nurse Facilitator - Situation: Lack of practice nurses and high percentage due for retirement (vacancy rate & workforce figures), attracting and keeping new practice nurses has been difficult (turnover rate in first year and feedback from new practice nurses), lack of local training to support some specialist skills needed by practice nurses (cost and availability of courses).



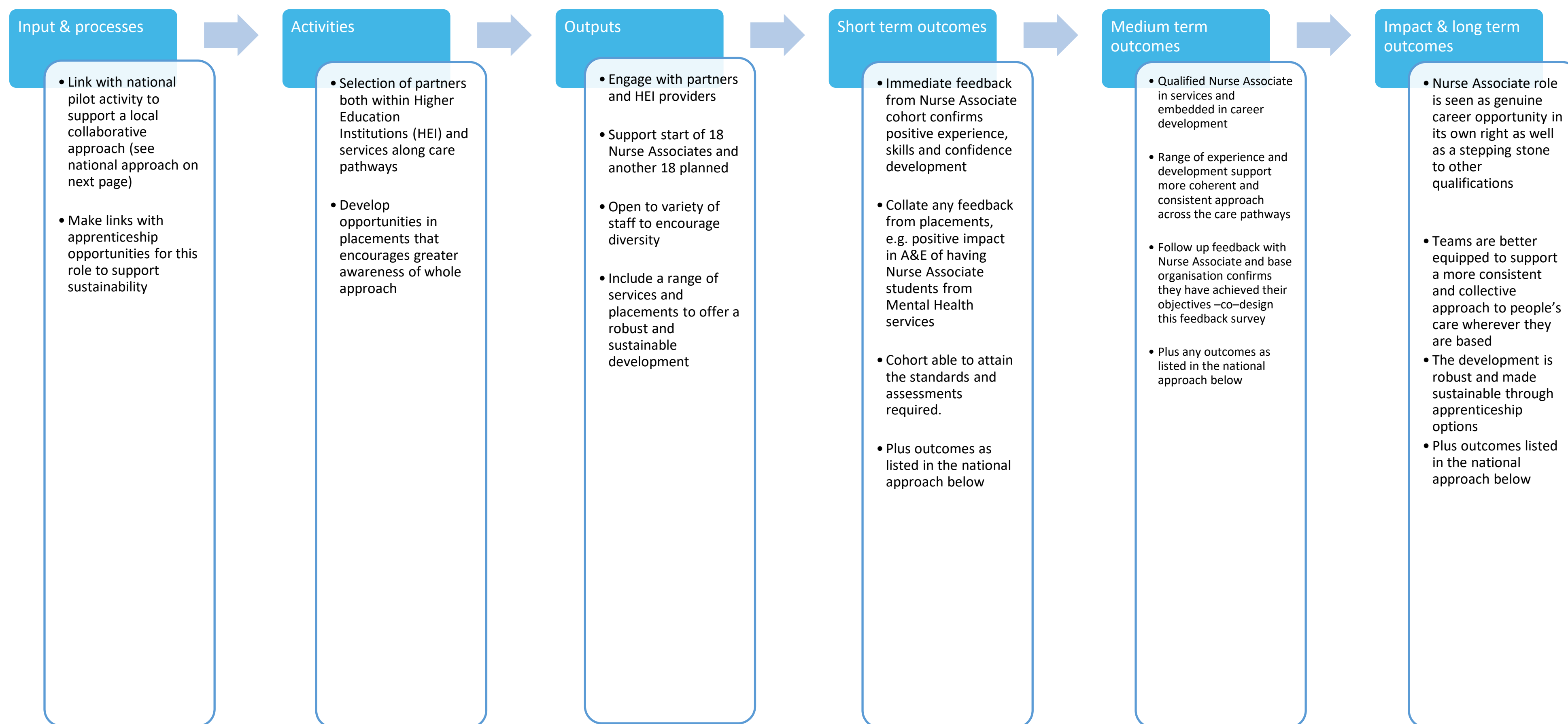
Trusted Assessor - Situation: We have delays in transfer from acute hospital to care homes. We needed to speed up response times so that people can be discharged in a safe and timely way. With a trusted assessor, we hoped to reduce the numbers and waiting times of people awaiting discharge from hospital, helping them to move from hospital back their care home in a timely, effective and safe.



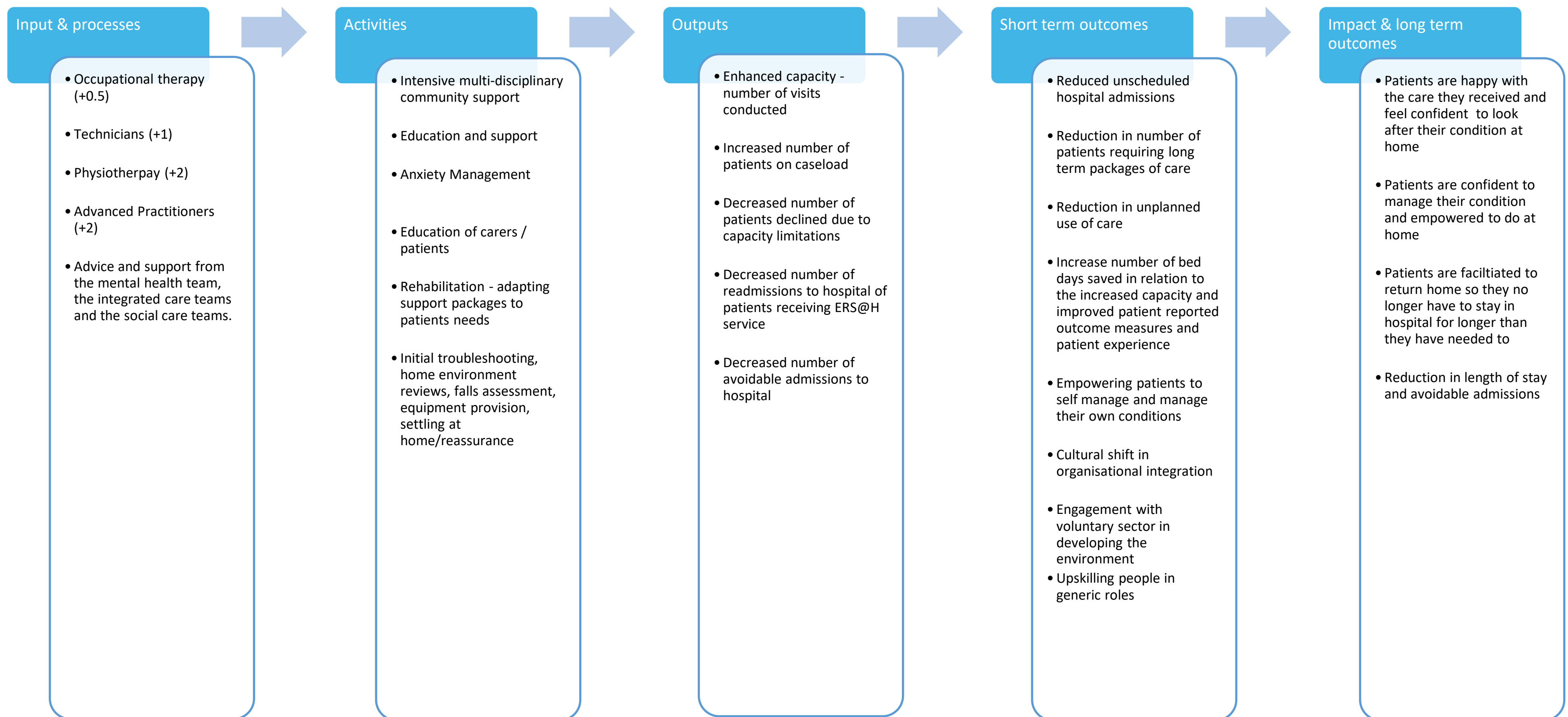
Pre-employment Co-ordinator - Situation: Want to encourage more people from disadvantaged / under-represented groups to consider & gain jobs in health and social care. Vacancies & age of current workforce means a number will retire. Helping people with the right values to gain employment – offering work experience as an option. Need to increase attraction to jobs and take up from interviews. New roles development and keeping track of these opportunities as jobs in health and social care.



Nurse Associate – Local Project Situation: There is a career gap between Health Care Assistant and Band 5 Registered Nurse role. Having the opportunity to be part of the pilot meant we could influence the development of this qualification and bridge this career gap. It also provides the opportunity to work with partners to develop this role across the care pathways, supporting a more consistent and collective approach to people's care.



Nurse Associate Programme – this is an example from national programme by North East Hampshire and Farnham Vanguard – more details can be found here.



Appendix D –

Case study template can be viewed here.

Appendix E –

Two articles have been provided to promote the value of new role and share the learning across Kent, Surrey & Sussex.

Case Study 1

Brighton and Sussex University Hospitals (BSUH) Trust is embarking on a project to recruit more clinical technologists as part of a major investment in staff development to help staff and managers work together to improve patient care.

John Caisley (Left) has been a Clinical Technologist for nine years and is based in the neonatal intensive care unit. He's pleased to hear that more technologists are planned.

John Caisley clinical technologist: "In critical care, clinical technologists are pretty much essential but it's good to know that more are going to be introduced in other areas. It's a great job. I like the fact that I'm helping people to help others."

John started out as a health care assistant and then qualified and worked as a nurse. But he finds being a clinical technologist more satisfying: "I feel more effective being able to support the nurses. It gives me a sense of worth and fulfilment."

The BSUH Trevor Mann Baby Unit deals with around 800 admissions a year and John looks after the equipment that includes ventilators, incubators and various monitors. He also checks to make sure there's enough stock and identifies if new pieces of equipment are needed. **"**It's challenging and stimulating," John said: "Some days I'm taking pieces of equipment apart and the next I'm checking over spreadsheets on a computer."

Mainly, he said, he tries to determine whether a piece of equipment is faulty or whether the problem is a training issue - that it's not being used properly. He used to wear a badge that asked, 'Have you tried turning it off and on?' until the pin fell off with over-use. But, he explains, sometimes with very high-tech equipment, users can forget or overlook some of the more basic, simple things.

He said he finds his nurse training helps him to not become emotionally involved when he's surrounded by tiny babies needing very specialist care "Because of my nursing background, I'm able to keep that degree of separation,".

But he never loses sight of the work that goes on in. Often when he passes the wall of photos of the babies who've been on the unit, he's grateful that his own children are well, and he's reminded of all those who've gone on to lead healthy, happy lives.

Case Study 2

Dyrrick Diaz, AMU Clinical Technologists and Craig Marsh, AMU Ward Manager at BSUH (left to right)

Ward Manager Craig Marsh almost shudders when he thinks back to the time before he had clinical technologists on the Acute Medical Unit **(**AMU**)** at Brighton and Sussex University Hospitals (BSUH) Trust.

Now 18 months on, with two dedicated clinical Technologists working alternate shifts, stock on the unit is well-ordered and stored, and the equipment and relevant parts are clean, available and ready to use.

"It's made a huge impact," said Craig: "Individually these are small jobs, but they make such a difference to other members of staff and to the smooth running of the unit."

He gives as an example the blood sugar machines. These can't be used, even in an emergency, unless they've been quality-control checked within the previous 24 hours. Before the clinical technologists arrived, Craig said it was often literally at the 24th hour, that a member of staff would have to go and have a machine checked.

He said all the staff can see the improvements the clinical technologists have made. Now, if a piece of equipment does go missing, nurses on the unit don't have to run around the hospital trying to track it down.

Craig and his colleagues decided a couple of years' back that they wanted to introduce several improvements and they identified that there were problems with stock management and equipment monitoring. They agreed to have two dedicated clinical technologists.

It’s an innovative role at BSUH and currently there are just a handful. But this is changing with plans to introduce more as part of a major, trust-wide initiative to help staff and managers work together to improve patient care.

The aim is to introduce 10 ward-based clinical technologists across the trust over the coming year and provide them with a structured career and education pathway, monitor their competencies and measure their impact. It’s expected that benefits will include time savings for other members of staff, reduced stock wastage and increased equipment availability, with fewer pieces of equipment being sent away for repair.

Acute respiratory unit matron Linda Hooper said: “We know that cleaning, stock and equipment duties can take up a lot of health care assistants’ time. Having dedicated clinical technologists on the ward will free up their time and ensure that the equipment is ready to use and available when it’s needed.”

Holly Reid, project lead, said: “This is an exciting project being rolled out across the trust and we hope it will become the blueprint for best practice across the region.”

Dyrrick Diaz is one of the AMU clinical technologists stated: “We’re here to help the nurses, to make their work easier. I can see that it really helps to have the equipment ready when they need it. It leaves the nurses more time to spend with their patients and that’s how it should be. I find it very fulfilling.”

Previously, Dyrrick said, the ward cannula trolley had been used as a place to dump things staff no longer needed. Occasionally, even now, if one of the doctors leaves something on the trolley, Dyrrick will have a quiet word. He admits being a little over-zealous when it comes to making sure things are in order and no one in AMU is complaining.

6. References

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