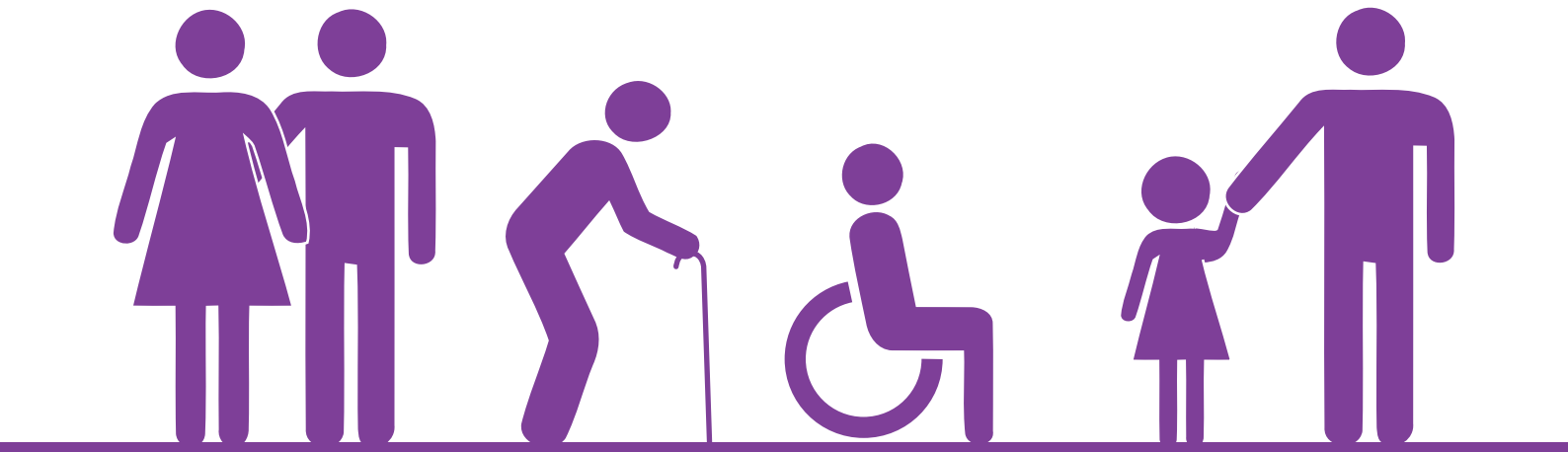
# CLIC Clinical Nursing Skills
# Programme Evaluation



## Health and Social Care Evaluations (HASCE)

Commissioned by the Cumbria Learning and Improvement Collaborative (CLIC)

HASCE
Health And Social Care Evaluations

CLIC
Cumbria Learning and Improvement Collaborative

University of Cumbria

# Executive Summary

The Health and Social Care Evaluations team (HASCE), based in the University of Cumbria, was commissioned to evaluate the CLIC Clinical Nursing Skills Programme and its impact on nursing practice. The evaluation team was involved for the duration of the Programme length, ensuring that the impact of this innovative approach to CPD could be captured in a rigorous and robust way. In particular, the evaluation aimed to assess:

- The impact of the Programme on day-to-day practice;
- The extent to which the Programme helped to embed continuous improvement in and across the workplace;
- Whether the Programme was more effective for particular demographics, such as role, age, or locality;
- The distinctiveness of the collaborative approach to training within the Clinical Skills Programme.

The evaluation employed a mixed-methods approach, based around four stages of data collection and analysis:

- A baseline quantitative survey at the start of the evaluation project;
- Two tranches of qualitative data collection and analysis, comprised of:
    - one focus group of clinical educators on the Programme;
    - five semi-structured interviews with Programme participants;
- A second quantitative survey at the end of the evaluation project, drawing together main findings of the three previous stages and testing for representativeness.

The main strength of this evaluation design is that it allows for a broad overview, complemented by in-depth and detailed first-hand accounts of individual experiences and perspectives from practitioners involved in both delivering and learning. As with any evaluation of this size, there are inevitable limitations to the chosen methods and data available. For example, the evaluation report was finalised before all training had concluded; however, participation rates in both the Programme and evaluation surveys provide a more than representative account of its value.

The Clinical Skills Programme was created to meet key challenges facing nursing across Cumbria, including:

- The need to provide consistently high quality care within a challenging economic context;
- The need to embed a culture of continuous improvement within the health and social care section across Cumbria;
- Limited collaboration between health and social care organisations, sometimes resulting in a lack of clarity of roles across boundaries and inefficient use of nursing resources, duplication of commissioning and an inequity of access to funding for training;
- From April 2016, the requirement for nurses to revalidate to maintain their registration necessitated a demonstration of 35 hours of CPD undertaken.

Overall the evaluation study found that the CLIC Clinical Skills Programme has been a great success, achieving its identified aims and generating ideas for further developing and improving this. The findings demonstrate the success of the Clinical Skills Programme in impacting on day-to-day practice, and bringing or maintaining skills as up-to-date.

- The results show a high level of satisfaction with all aspects of the CLIC Programme with regards to continuous improvement of skills and practice; the main benefit was reported as ensuring skills and knowledge are current and up-to-date.

- The analysis suggests that involvement in the CLIC Clinical Skills Programme has encouraged both the participants' educational development, and their motivation to make positive changes to professional practice. Having access to current knowledge was repeatedly noted as a key strength of the Programme.

- The distinctiveness of the Programme was apparent, and was attributed to the enthusiasm and passion that had emerged from the skills training and its collaborative practice. The contribution of the Programme structure to reducing professional isolation and enabling work across professional boundaries was a key driver to facilitating improvements in day-to-day care practices.

- Collaborative learning was a key aspect of the Programme design and the evaluation generally showed clear positive outcomes from using this approach. At

a strategic level, however, some Trainers questioned the commitment from senior clinicians and the Programme steering group.

The report makes five recommendations based on its findings:

1. The evaluative study has identified the support of the follow-up reflective sessions as excellent, and a first-rate way of encouraging knowledge and skills gained into practice. It is recommended that this rapport is strengthened and continues.

2. A more differentiated approach is considered for future Programmes as some areas may need more/less training/encouragement. For example, nursing professionals working in difficult geographical areas or un-sociable shift patterns may need extra support; whilst conversely, those in more established settings, with a well-developed in-house Programme may require less.

3. Future provision to consider the diverse career stages of the Participants, modifying the training into 'basic' and 'more advanced' sessions. A further noteworthy vision which emerged from the data was the prospect of disseminating what was seen as an excellent Programme more widely to include other professional colleagues. This may well occur naturally if the sessions were audience-specific categorised.

4. Irregularity in care provision to be addressed and minimised through the uniformity of care offered by the CLIC Clinical Skills Programme.

5. Mapping patient feedback to specific clinical skills is an area for a future evaluation to attend to.

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# 1 Introduction

## 1.1 Context

The Clinical Skills Programme was created to meet key challenges facing nursing across Cumbria. In particular:

- The need to provide consistently high quality care within a challenging economic context;
- The need to embed a culture of continuous improvement within the health and social care section across Cumbria;
- An increase in community-delivered care across the area;
- Difficulties faced by Cumbria in both recruiting and retaining nursing staff;
- The existing workforce is aging, and a shortfall is predicted in the next five years;
- Limited collaboration between health and social care organisations, sometimes resulting in a lack of clarity of roles across boundaries and inefficient use of nursing resources, duplication of commissioning and an inequity of access to funding for training;
- From April 2016, nurses are required to revalidate in order to maintain their registration. In order to achieve revalidation, nurses must demonstrate 35 hours of Continuing Professional Development (CPD).

The Cumbria 'Alliance' was formed from all the chief and senior executives across health and social care, in order to confront and resolve these challenges together in the interest of patients, the population and the system rather than as individual organisations. Cumbria Learning and Improvement Collaborative (CLIC) has been developed as one aspect of the new 'Alliance' and has been identified as the 'shared vehicle' for driving the new improvement culture, leadership development, education and learning collaboratively across all organisations.

Within this context, CLIC, with support from the Forerunner Fund, established the Clinical Skills Programme as an innovative and distinctive approach to collaborative learning and practice. These strategic developments came alongside the knowledge that clinical skills training must be perceived as relevant and valid to those undertaking the training. Research has identified specific needs for such training from a practitioner perspective: in

a recent study in the Yorkshire and Humber region, examples of these needs included dedicated clinical skills trainers in community settings; clear competency packages; inter-professional learning and official recognition of completion of skills training (see Chappell and Ford, 2014). The Clinical Skills Programme addressed both strategic and operational needs by embedding clinical skills within a culture of shared learning; in this way, the Programme aimed to address these contextual challenges, improve retention rates, and push for the continuous improvement outlined in the Cumbria Clinical Commissioning Group's (CCG) five-year strategic plan.

## 1.2 The Clinical Skills Programme

With the guidance of a Programme Lead (Toni Hall) and a Project Co-ordinator (Claire Watters), six Clinical Skills Tutors (five Band 7, and one Band 8a Programme Lead) posts were created to develop and deliver a high quality clinical skills education and training Programme in association with University of Cumbria (UoC). A competency-based nurse training framework was developed, using Skills for Health competencies, in collaboration with the UoC and nursing leads in the CCG, Cumbria Partnership Foundation Trust (CPFT), Acute Hospitals and Cumbria County Council (CC). This identified the standard skills required in nursing job roles across community settings. The education and training Programme was developed based on organisational Training Need Assessments (TNA), and was aligned to the UoC Practice Development Framework.

The Programme therefore consisted of short courses covering:

- Communications
- Diabetes
- Male/supra pubic catheterisation
- Pain Management and Acute Pain
- Verification of Expected Deaths
- Wound Assessment and Product Selection
- Pressure Ulcer Prevention and Management
- Advanced Wound Care

Overall, 148 training sessions were delivered, to over 800 nurses from across primary care, community and community hospitals, and independent sector (nursing homes). This

provided opportunities for nurses from different organisations to train and learn together, develop new skills and adapt existing skills and knowledge to the changing environment around them. A Clinical Skills Tutor was based in each of Cumbria's geographical localities to ensure improved access and local high quality expertise. These tutors were involved in following up training outside the taught sessions, in order to facilitate and embed the learning within day-to-day practice. Clinicians were therefore encouraged to apply improvement methods routinely to their practice, and, with the support of the Programme, identify opportunities for improvement in their own workplace. As well as supporting staff in cascading and sustaining clinical skills, the Programme also aimed to develop networks or communities of practice to learn and develop collaboratively. In this way, the training was aimed to contribute to cultural change, as well as individual skills development.

The training was predicated on a 'train the trainer' (see Doyle et al., 2008) model. Clinical Skills Tutors identified appropriate clinicians as 'champions' to provide ongoing skills training, support and ensure sustainability within the localities. With the support of the UoC, who provided a development module for preparation of Clinical Skills Tutors and champions, and further supported the development of the 'train the trainer' approach.

## 1.3 The Evaluation Project

The CLIC commissioned the Health and Social Care Evaluations team (HASCE), based in the University of Cumbria, to evaluate the Programme and its impact on nursing practice. The evaluation team were involved for the duration of the Programme length, ensuring that the impact of this innovative approach to CPD could be captured in a rigorous and robust way. In particular, the evaluation aimed to assess:

- The impact of the Programme on day-to-day practice;
- The extent to which the Programme helped to embed continuous improvement in and across the workplace;
- Whether the Programme was more effective for particular demographics, such as role, age, or locality;
- The distinctiveness of the collaborative approach to training within the Clinical Skills Programme.

# 2 Methodology

## 2.1 Overview

The evaluation employed a mixed-methods approach, and was based around four stages of data collection and analysis:

- A baseline quantitative survey was taken at the start of the evaluation project;
- Two tranches of qualitative data collection and analysis, in order to unpack some of the significant aspects of the survey. These comprised of:
    - one focus group of clinical educators on the Programme;
    - five semi-structured interviews with Programme participants;
- A second quantitative survey was taken at the end of the evaluation project, drawing together the main findings of the three previous stages and testing them for representativeness.

In this way, the evaluation sought to capture not only the impact of the training Programme on nursing practice, but remain open to the iterative process that frequently informs the ways in which new programmes are implemented.

The baseline survey was initially opened between May and August, 2015. Respondents were asked to rate their levels of satisfaction and impact of continuing professional development (CPD) training and workplace learning on scale of 1-10 and also invited to provide examples of how their current CPD training and workplace training has affected their day to day practice and reduction in hospital admissions.

The initial set of data from this survey indicated a low level of response, and responses were heavily weighted towards particular localities within Cumbria. Following an initial report of the emergent findings from the baseline survey, a decision was made to re-open the survey from October until the start of December, 2015. This allowed for a greater response rate and a more accurate evaluation of the impact of the training programmes to be gathered.

The qualitative data collection and analysis aimed to gather the more specific and experiential aspects of the Clinical Skills Programme, and in particular to try and articulate

the impact it had on day-to-day practice for nurses across Cumbria. As noted above, this took two forms: a focus group of six Clinical Educators was convened, in order to gather their perspectives on how the Programme had affected the respective local areas that they covered; and individual semi-structured interviews were held with participants regarding the Programme itself. In this way, the evaluation aimed to capture perspectives on the Programme's effectiveness on a broad, quantitative scale; on a local scale through the Clinical Educators; and on an individual scale through the participant interviews.

The focus group was run in November 2015. The use of a focus group for clinical educators allowed the evaluation to gather a sense of the impact of the training, and the mechanisms through which workplace impact was achieved. While initially timetabled for December, due to the severe weather in Cumbria over December, the semi-structured interviews were held in February 2016.

Both the semi-structured interviews and focus groups were organised around six un-biased questions in order to facilitate a full and rich participant response (Willig, 2008). While the content of the questions differed slightly between focus group and interview, for the sake of context, they were designed to cover the same conceptual themes (see below, Appendix One and Appendix Two). The aim of the qualitative data collection was to capture the richness of participants' activities within the Programme, and as such participants were purposively sampled, on the recommendations of Clinical Educators, for their specific involvement in the Programme. Thematic analysis – an extensively used interpretative method of analysing qualitative data enabling the induction of coding and categorisation (Browne and Clarke, 2006; Boyatzis, 1998) – was then applied to the transcripts.

The main findings were then used to inform a second survey, which was opened from February to March 2016, in order to test the representativeness of those key themes identified within the purposive qualitative analysis. This survey asked participants to rate their agreement with statements around the Clinical Skills Programme on a scale of 1-10, with an option for open-box comments. They were also asked to rank the main benefits of their participation in the Programme, as identified by the previous data collection. Data was then analysed according to significant variables, such as comparisons between localities.

## 2.2 Strengths and Limitations

The main strength of this evaluation design is that it allows for a broad overview of the Clinical Skills Programme, and its effects across Cumbria, complimented by in-depth and detailed first-hand accounts of individual experiences and perspectives from practitioners involved in both delivering and learning. This helps to provide a clear picture of how successful the Programme has been in achieving its aims, as well as remaining open to any formative development, learning, or unexpected successes that will often accompany the delivery of a new and ambitious training programme.

As with any evaluation of this size, there are inevitable limitations to the chosen methods and data available. The evaluation report was compiled before all training had taken part, due to the contextual factors affecting the original timetabling of the training sessions (see Appendix One). However, the participation rate in both the Programme and its evaluation surveys provide a more than representative account of its value.

As discussed above in Section 2.1, the initial baseline survey was extended. This meant that some respondents were already participating in the Clinical Skills Programme, and as such this may affect its reliability at recording a clear baseline on *previous* CPD training alone. However, the survey does provide a clear account (supported by the demographic analysis in Chapter 3) of how CPD is perceived and used across distinct variables such as role, age and location. Because the core strength of the Clinical Skills Programme was its emphasis on follow-up visits and extended reflection on skills, the baseline is still valid as a measure of these distinctive and significant longitudinal effects.

On a similar note, it was noted by some participants that one of the key strengths of the Programme was the extent to which improving clinical skills could contribute to long-term health improvements in certain patients. Improving clinical skills in diabetic foot-care, for example, may show an immediate impact in practice; but it is also likely that there will be longer-term benefits for patients with chronic illnesses such as diabetes. The evaluation design was not able to measure longer-term effects of the Programme, but is able to make some informed predictions about these based on the data gathered.

# 3 First Survey Tranche Findings

## 3.1 Introduction

The Baseline Survey was completed by 104 Cumbria based respondents, working across nursing teams, including acute and community hospitals, primary care and community nursing.

Respondents were asked to rate their levels of satisfaction and impact of CPD training and workplace learning on scale of 1-10 and also invited to provide examples of how their current CPD training and workplace training has affected their day to day practice and reduction in hospital admissions.

Analysis of current satisfactory and impact levels of CPD training and workplace training has been completed based upon mean response rates and comparisons of the following criteria:

- Geographical location of work
- Area of working role
- Length of time in current post

While gender of participants was also recorded, comparisons were not made due to insufficient levels between male and female respondents.

## 3.2 Up to Date and Best Practice Skills

Responses regarding the levels of confidence that the current clinical skills used in day-to day practice are up to date and of best practice, showed a good overall, mean level of 7.7. When analysed in terms of geographical location of work (see Figure 1) a good level of confidence was found across areas, the lowest level at 6.8 for Eden and the highest level at 8.8 for Furness. It is important to acknowledge however, that Furness had the lowest number of respondents to the questionnaire with only 9 survey respondents out of the 104 completed which may have skewed the average confidence levels for this particular geographical area.

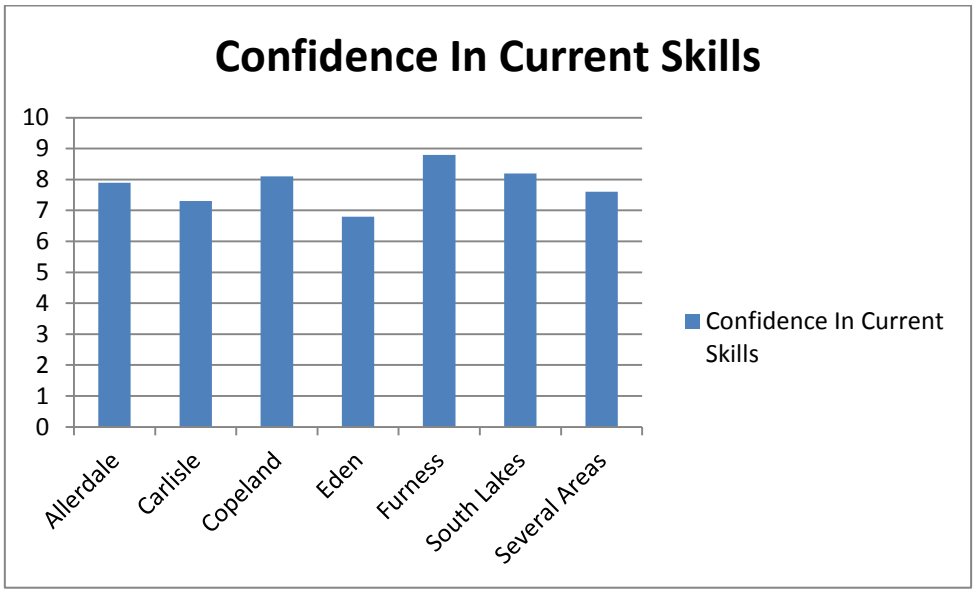


Figure 1: Confidence in current skills based on geographical location

Analysis of confidence levels based upon place of work (see Figure 2) also showed a good, mean level of confidence, with the lowest level at 7.2 for nurses based in care homes and the highest at 8.6 for those working in acute hospitals. Again, acute hospitals had the lowest number of respondents to the questionnaire which accounted for only 5 respondents out of the 104 completed, which may account for the slightly higher than average confidence levels.

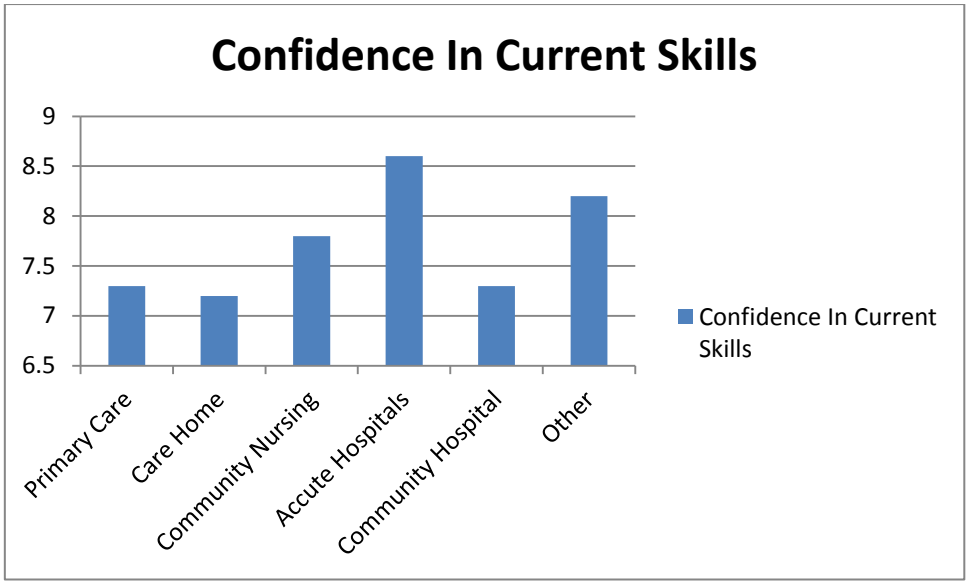


Figure 2: Confidence in current skills based on place of work.

Although on average all respondents reported a good level of confidence regardless of length of time in post, analysis based upon years in post showed an increase in level of confidence in relation to length of time in post, clearly demonstrated in Figure 3 which shows a gradual increase as the time in post increases. The mean level of confidence for individuals in post for 1-2 years was 7.3, which increased to a mean of 8.5 for those in their post for over 20 years.

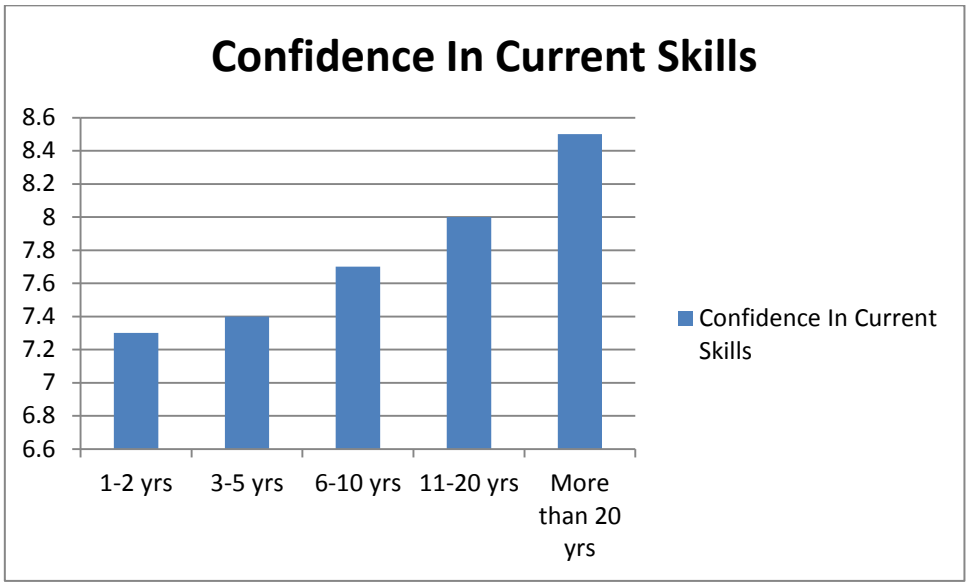


Figure 3: Confidence in current skills based on place of years in post.

## 3.3 Satisfaction Level of Opportunities to Engage with CPD

Individual's level of satisfaction with opportunities for them to access CPD showed a good overall mean of 6.9. Analysis of satisfaction levels based on geographical area showed a similar mean across the areas (see Figure 4) with the lowest mean level of satisfaction at 6 for those who work over two or more different geographical locations and the highest for Furness at 8.1. The lower levels of satisfaction highlighted for individuals working in several areas may highlight a need to ensure that this group's needs in regard opportunities to access CPD are the same as those individuals based in geographical location.

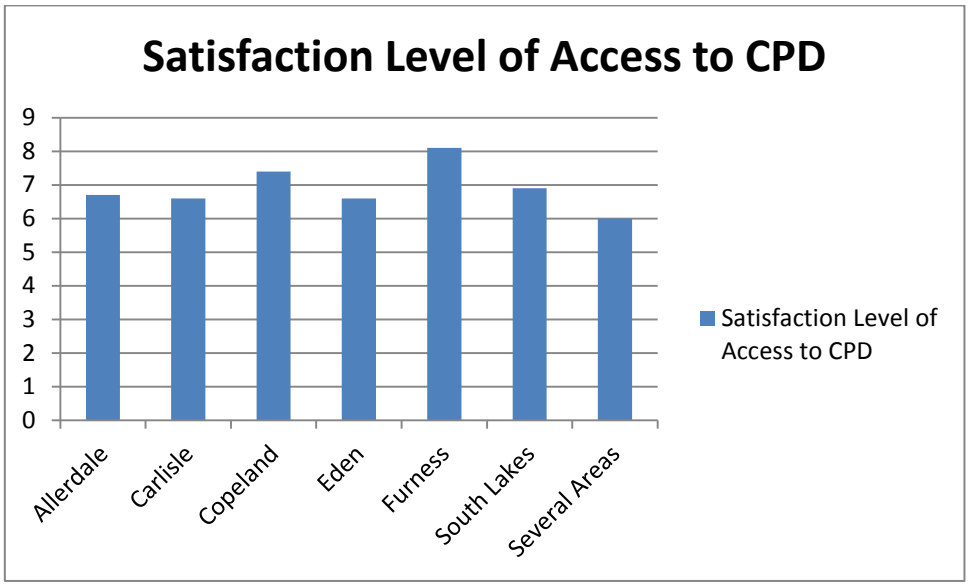


Figure 4: Satisfaction level of access to CPD based on geographical location.

Analysis based on location of work showed a good mean, satisfaction level of 7 or above for community nursing, community hospital and other roles distinct from the set categories. However, slightly lower levels of satisfaction were found for those working in primary care, care homes and acute hospitals with the lowest satisfaction level for those working in care homes at 6.3 (see Figure 5).

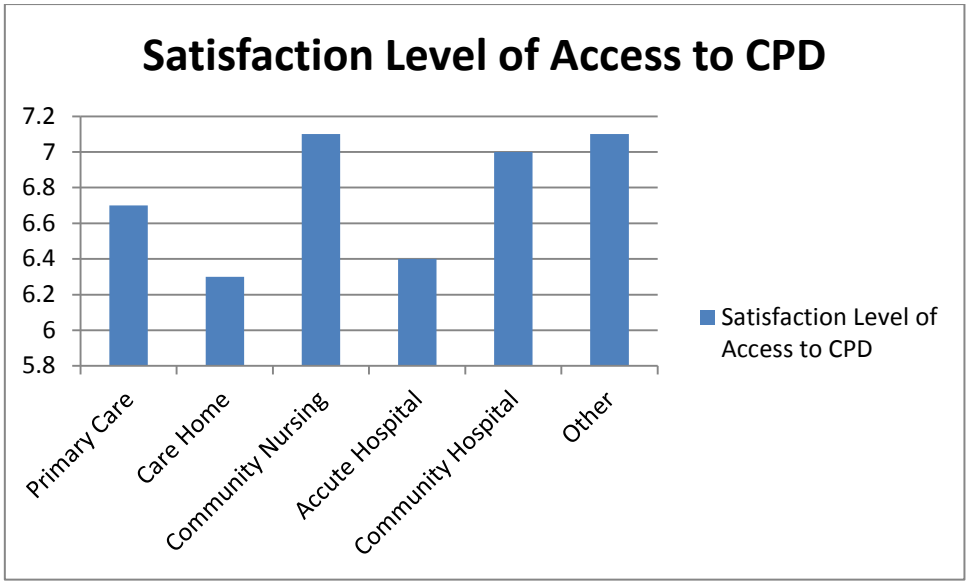


Figure 5: Satisfaction level of access to CPD based on place of work

Analysis of mean satisfaction levels based on years in post (see Figure 6.) showed the stongest level of satisfaction at 8.9 for those in their post between 11-20 years and the lowest at 6 for those in post for 1-2 years. This may indicate a need to increase awareness of CPD opportunities to those new to post.

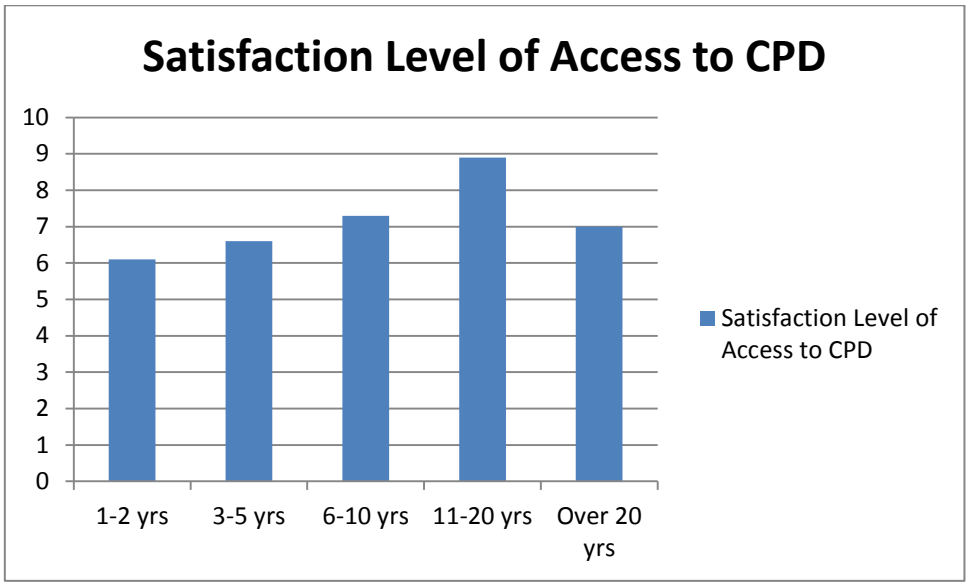


Figure 6: Satisfaction level of access to CPD based on place of work.

## 3.4 Relevance of CPD Training

Regarding satisfaction levels that the CPD training received was directly relevant to professional practice, the overall mean response showed a very good level of satisfaction at 8.4. When analysed based upon geographical areas and area of work (see Figure 7 & 8.) a constant high level of satisfaction is reported across areas.

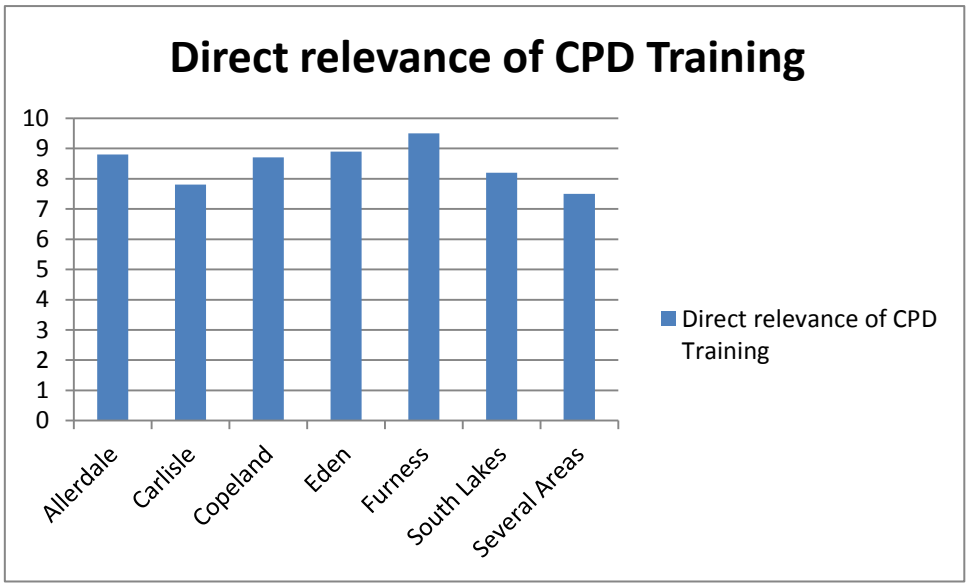


Figure 7: Relevance of CPD training to clinical practice based on geographical location.

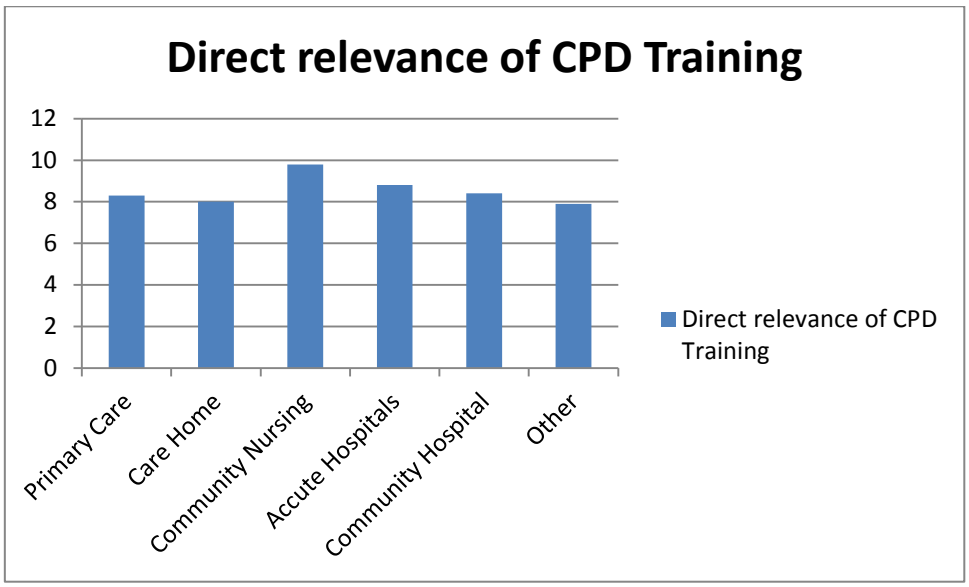


Figure 8: Relevance of CPD training to clinical practice based on area of work

The same high levels of satisfaction were also found when results were analysed based on time in post. However, as shown in Figure 9, those in post between 1-20 years showed a very good mean level of satisfaction, whereas those in post for over 20 years or more report just under average at 7.8.

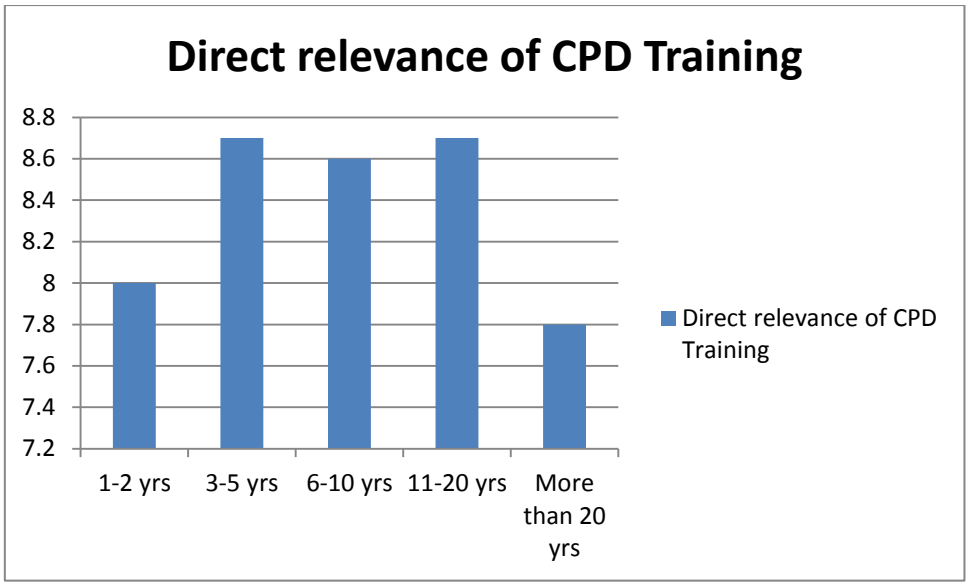


Figure 9: Relevance of CPD training to clinical practice based on time in post.

## 3.5 Direct Impact of CPD Training

Responses regarding the level of impact of CPD training received on day-to-day practice showed a strong level of impact across all geographical areas (see Figure 10) and a high level of impact independent of time in post (see Figure 11).

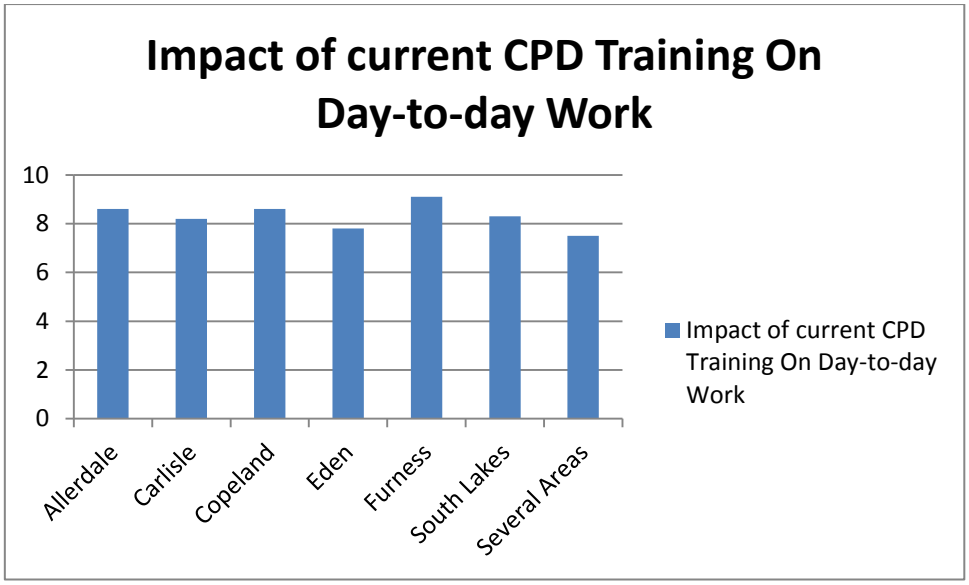


Figure 10: Day-to–day impact of CPD training based on geographical area.

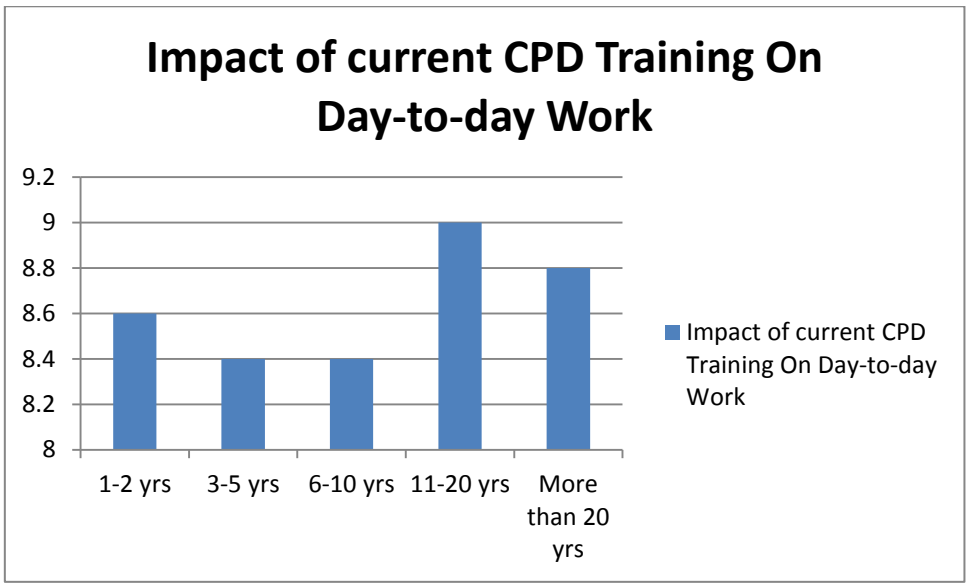


Figure 11: Day-to–day impact of CPD training based on time in post.

When analysed based upon area of work, although a good level of impact was found in all working areas, those working in community hospitals reported on average the highest level of 8.7 whereas those working in acute hospitals and community nursing reported lower levels at 7.8 or below (see Figure 12).

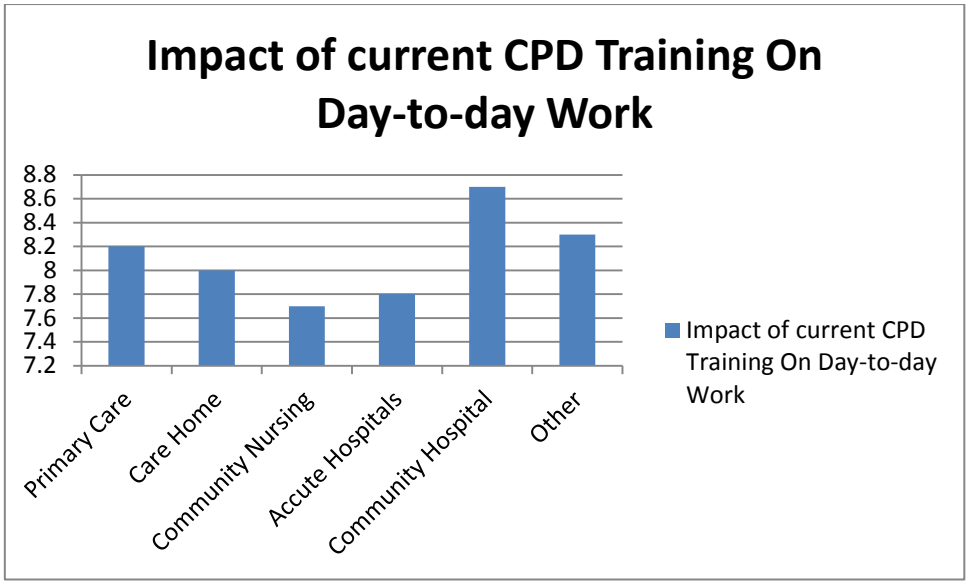


Figure 12: Day-to–day impact of CPD training based on area of work.

Based upon the limited examples provided by respondents, training on diabetes, catheterisation and wound application and treatment were the most prevelant examples of the beneficial ways CPD had impacted practice across all areas of work. Care home examples also cited medicine management and pain management as impacting on current practice. One respondent however, based in South Lakes commented that they would like more opportunities to develop skills. A common Community Nursing response was that they had successfully used theories learned through CPD training to implement change in their setting.

## 3.6 Success levels of CPD in Aiding the Reduction of Hospital Admissions

As shown in Figure 13, the level of impact of CPD training on reducing hospital admissions varied significantly between geographical areas, with Furness reporting the highest success levels at 8.5 and South Lakes reporting the lowest at 4.8 (see Figure 13).

It is important to note however, that the response rate for this particular question was much lower than others answered with only 72 % providing a response, which has led to a possible area bias due to low numbers in particular areas such as Furness which only had 4 responses.

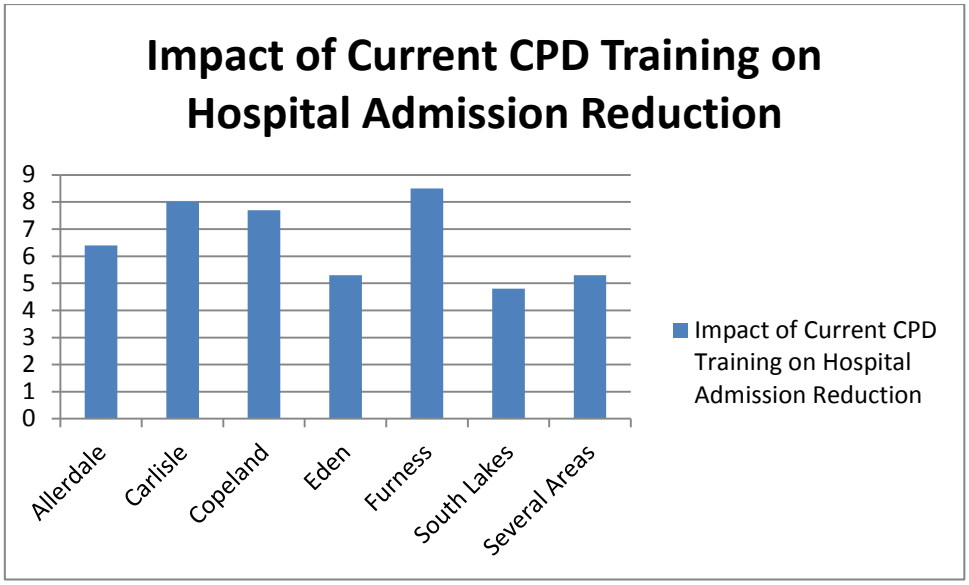


Figure 13: Impact of CPD training on the reduction of hospital admission reduction based on geographical area.

Responses analysed based on area of work and time in post showed a much more even distribution in responses inline with the overall mean reported impact of 6.7 (see Figure 14 & 15).

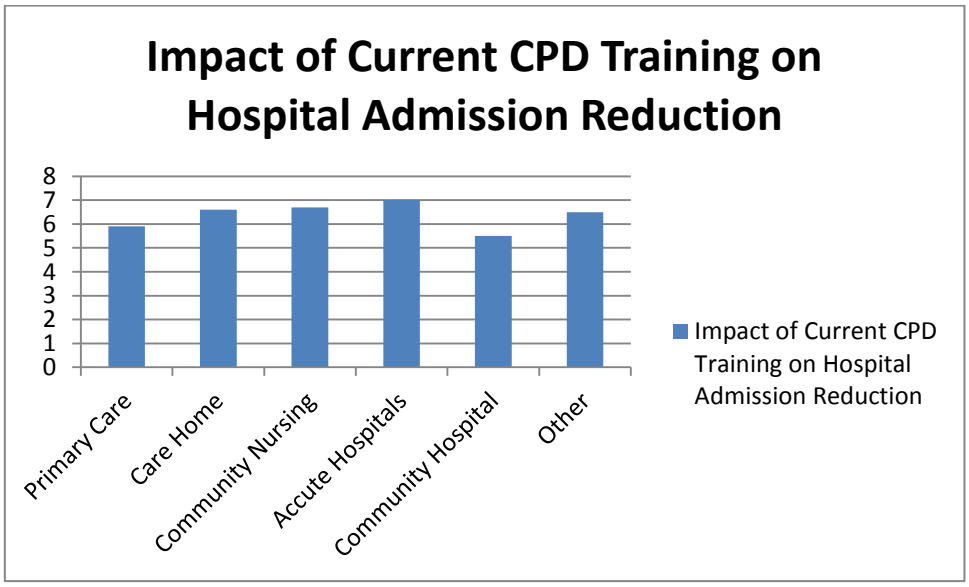


Figure 14: Impact of CPD training on the reduction of hospital admission reduction based on area of work.

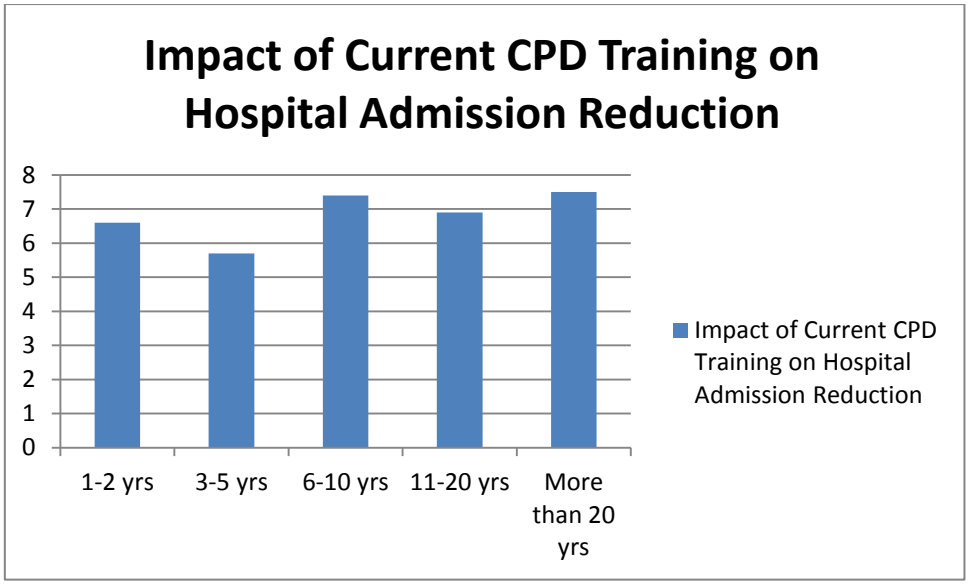


Figure 15: Impact of CPD training on the reduction of hospital admission reduction based on time in post.

Diabetes training was again a prevalent response for primary care and care home workers as beneficial training to reduce hospital admissions. One Care home based response also commented that they had used training to create pro-active care plans to prevent readmissions.

Catheter training and wound treatment and changes training were key responses in community nursing, as well as other technical training such as training of IV application as ways of treating patients in their own home and avoiding hospital admission.

## 3.7 Workplace Training Impact on Day-to-day Work

The responses regarding workplace training and its level of impact on day-to-day work were consistently high throughout the differing geographical areas (see Figure 16).

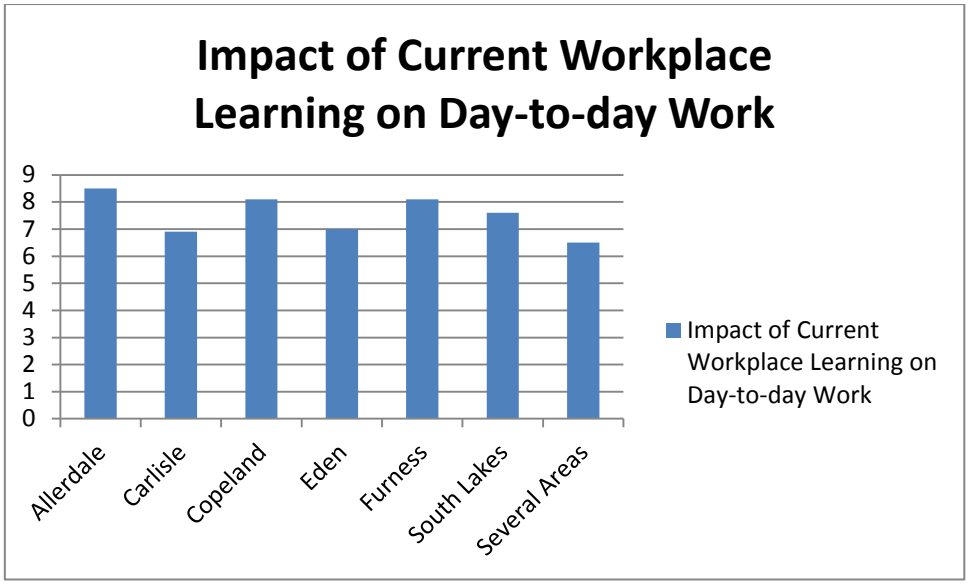


Figure 16: Impact of workplace learning on practice based on geographical areas.

However, when analysed in terms of workplace, primary care, care home and acute hospital reponses were all under the overall average level of 7.3, in contrast to community nursing responses which were above the response average at 7.9 (see Figure 17). Analysis based upon time in post also showed unusual variance around the average rate for this particular question (see Figure 18).

This particular question, again, elicited limited responses leading to the three lower scoring work areas to have very low responses, as did certain year-in-post groups. This again may have resulted in an area bias. Therefore, the examples provided by respondents regarding the impact of workplace learning on practice were analysed further.

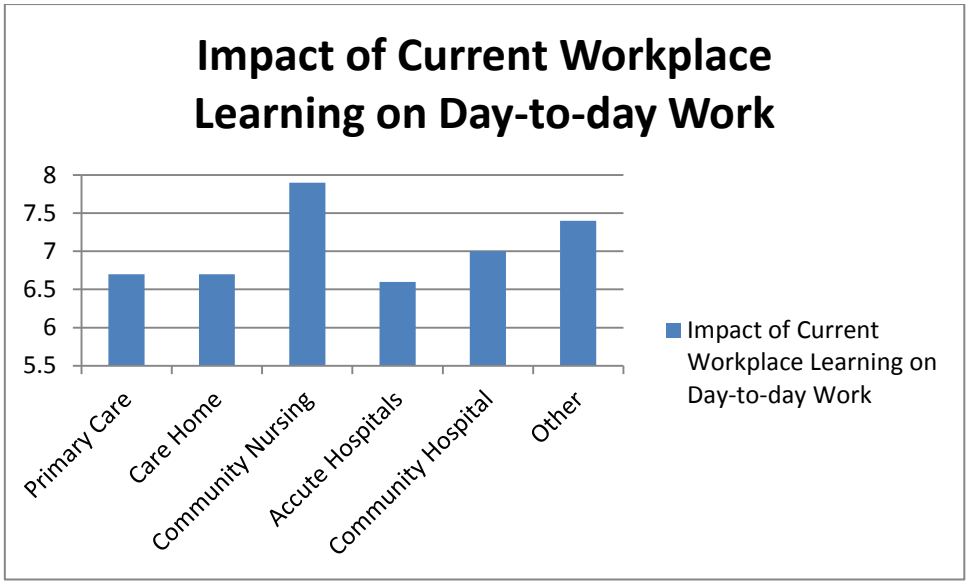


Figure 17: Impact of workplace learning on practice based on area of work.

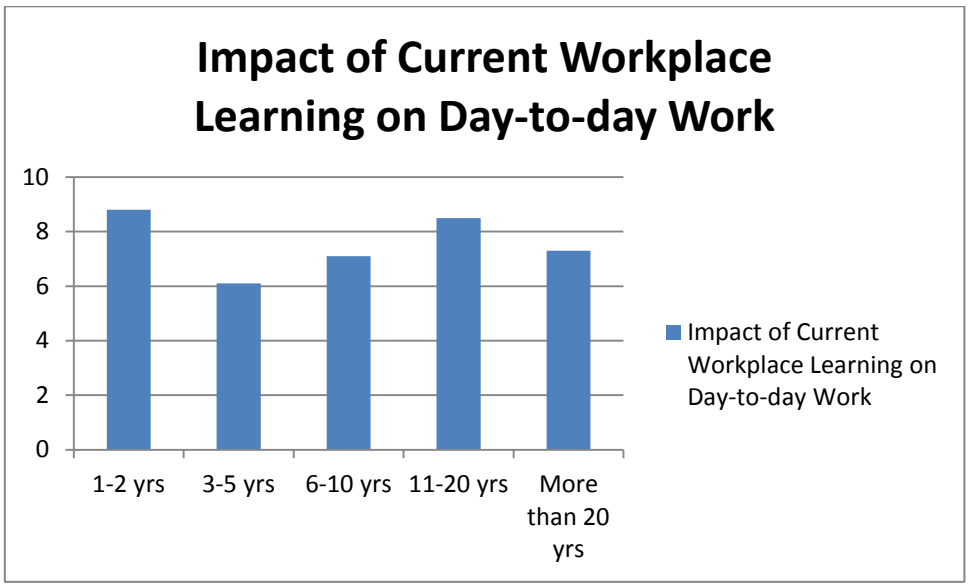


Figure 18: Impact of workplace learning on practice based on time in post.

Responses from respondents based in care homes positively commented on the impact of supervision on the effective treatment of diabetic patients. However, the large proportion of the responses for those working in care homes indicate dissatisfaction due to lack of supervision, often citing work pressures and staff shortage as the cause. The negative responses were not from one isolated geographical area and included Allerdale, Carlisle and Eden.

Community nursing respondents reported the benefits of good supervision and peer support that they have received, this included: encouragement and support when defusing difficult situations, safeguarding and advice on clinical practice.

Acute hospital respondents reported the positive impact of mentorship for students on placement and also setting staff goals and achievements.

## 3.8 Workplace Training Impact on the Reduction of Hospital Admissions

The response rate to the question related to impact of workplace training on hospital admission reduction had a low response rate of 66%. This resulted in an uneven distribution of respondents in geographical area groups, particularly for Furness which consisted of only two respondents which accounts for the results shown in Figure 19, which show the level of impact for respondents based in Barrow at 9.5; much higher than the overall average of 6.4.

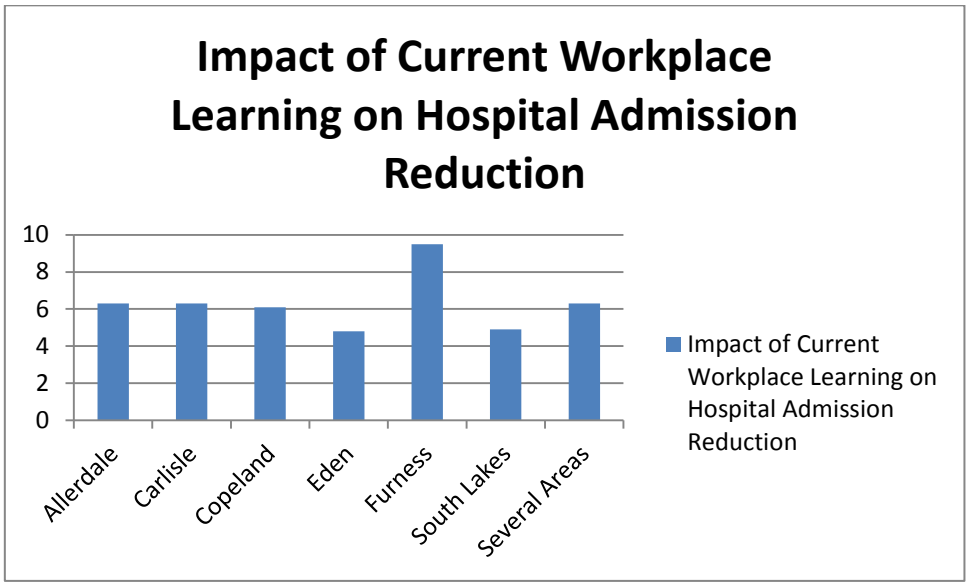


Figure 19: Workplace learning impact on reduction of hospital admission based on geographical area.

Analysis of both work area and time in post showed a steady average between groups for levels of impact of workplace training on the reduction of hospital admissions (see Figure 20 & 21).

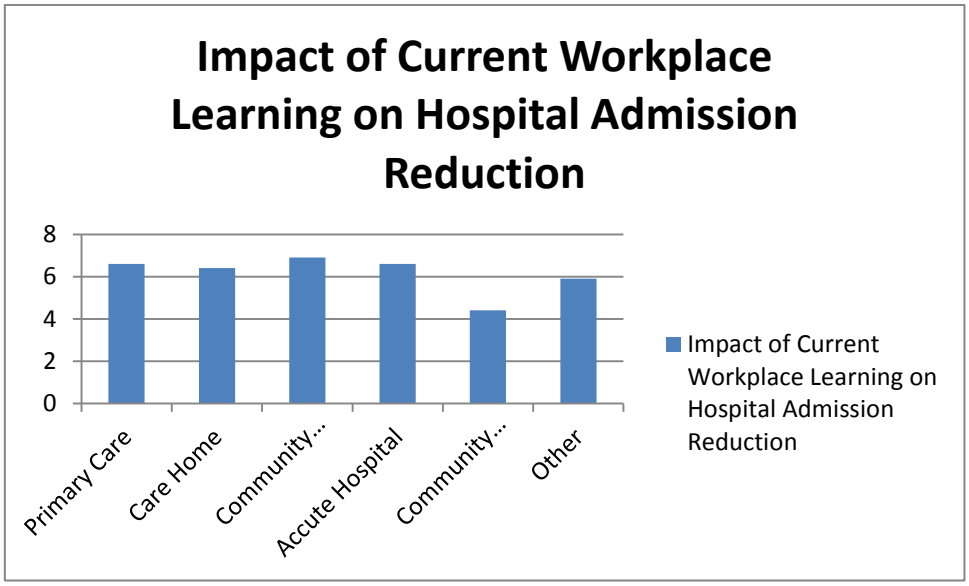


Figure 20: Workplace learning impact on reduction of hospital admission based on area of work.

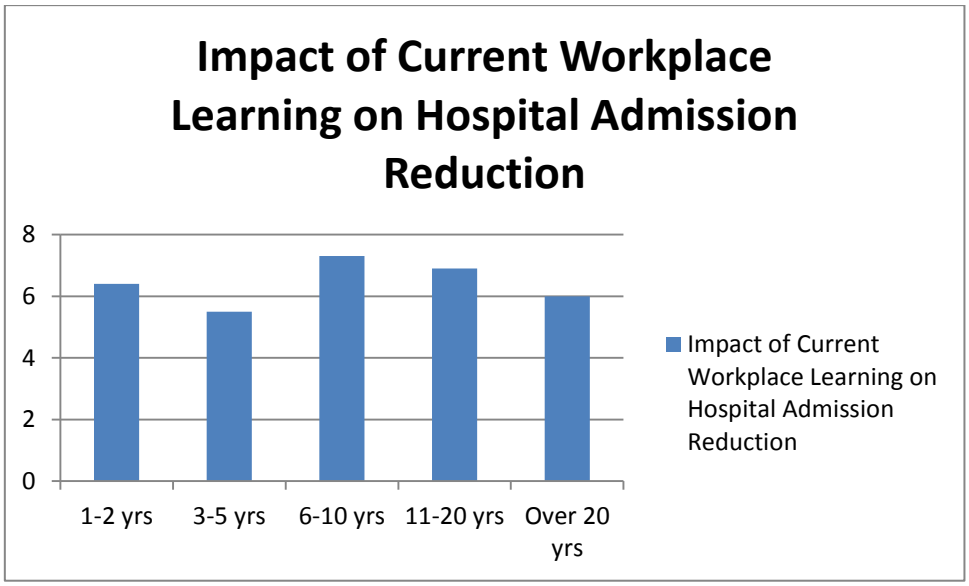


Figure 21: Workplace learning impact on reduction of hospital admission based on time in post.

The further explanation responses were very limited in terms of the way workplace training has helped reduce hospital admission. Primary care and care home respondents flagged supervision and support when treating patients with diabetes and appropriate

dressing application, which reduces the risk of further complications and possible hospital admissions.

Community nursing and community hospital respondents stated that workplace training helps raise awareness of policy/procedural changes and also helps to ensure good, current practice is used at all time, which in turn results in a reduction of readmissions.

## 3.9 Summary of Findings

The findings of the first tranche of surveys can be summarised in the following points:

- Results of survey show that on average there is a good level of confidence in current levels of nursing practice, which is consistent across geographical areas and differing departments. The findings indicate that nursing confidence levels increased the longer they had worked in their current post.

- Findings show a good level of satisfaction regarding access to CPD training. Slightly lower levels of satisfaction were found for those who had been in their job for less than 2 years and for nursing professionals working in acute hospitals and care homes, so it is important to ensure that all departments have full awareness and access to CPD training to ensure departmental consistency and to enable newly recruited professionals to engage with CPD upon commencing post.

- In terms of CPD training relevance to professional practice, the findings showed a very high level of confidence, which was consistent between geographical areas, differing departments and time in post.

- The survey results showed that on average, respondents rated CPD training received as having a high impact on day-to-day practice with catheter, diabetes and wound treatment training indicated as the most common types of training impacting day-to-day practice.

- Respondents rated CPD training as having a good overall level of impact on hospital admission reduction. Although, analysis indicates below average levels of impact for nursing professionals in Eden, South Lakes. Catheter training, diabetes training and wound treatment training were key types of training highlighted particularly by community nursing and care home nursing professionals.

- Impact of workplace learning showed a good average level of impact on day-to-day practice. However, respondents from primary care, care home and acute hospitals showed below average levels of workplace learning impact. Analysis of further responses indicated low levels of satisfaction of supervision provided for nursing professionals working in care homes. In contrast community nursing professionals cited the benefits of the supervision and peer support they had experienced and the positive impact it had on their day-to-day practice.

- The ways in which 'impact' might be articulated, in terms of relating the Programme activities to day-to-day practice, was therefore highlighted as a key area to explore in the qualitative data.

- An average level of satisfactory impact was reported for workplace training effects on hospital admission reduction. However, the low response rate to this question and limited further responses did not allow for a sufficient explanation of this level. It may be that the question was not something participants felt able to accurately identify within the context of the survey.

# 3 Focus Group Findings

## 3.1 Introduction

While the first tranche survey raised some interesting areas for discussion, for a more detailed and rich view of the impact of the training, and the mechanisms through which workplace impact was achieved, qualitative data was gathered.

The evaluation utilised both a focus group and interviews for data collection, with both aiming to encourage spontaneous profound information sharing of personal experiences (Liamputtong & Ezzy, 2005; Willig, 2008). The facilitators employed un-biased questions so as to ensure participant responses would not be influenced (Willig, 2008). Thematic analysis – an extensively used interpretative approach for qualitative data analysis (Braun & Clarke, 2006) which enables coding and categorisation induction (Boyatzis, 1998) – was applied with the aim of extracting individual experiences (Braun & Clarke, 2006).

To facilitate comprehensive data analysis, both the focus group and interviews were, with participant permission, recorded by means of a digital audio recorder. The option for this to be disabled at any time during the focus group was drawn attention to, both prior to signing the Consent Form and the interview commencement (Willig, 2008). Upon interview completion both confidentiality and anonymity were reiterated (Braun & Clarke, 2013). As recommended, interview recordings were subsequently transcribed verbatim, with line numbers being inserted for ease of quotation reporting, in addition to any identifiable information either removed or a pseudonym substituted to ensure anonymity; thus forming the initial data analysis of the information gathered (Braun & Clarke, 2006).

First, a focus group was carried out to evaluate the training Programme from the perspective of six clinical educators involved in its follow up work within practice. This section details a thematic analysis of the focus group data. In some instances, themes were developed in relation to questions posed during the focus group; others were also developed in response to recurrent or particularly notable ideas that emerged during the analysis.

Feedback from focus group participants was overwhelmingly positive. It was felt that there were benefits to those who undertook training both in terms of clinical upskilling, and in psychosocial terms, for example an increased confidence to implement change in clinical practice on both an individual level and at a wider workplace level. Of particular note was the way that teaching collaboratively and providing follow-up visits to trainees was felt to have aided successful embedding of skills in practice.

The following analysis of findings collates the discussion into five major areas. The first examines the *overall impact* of the Programme as a whole (see Figure 22). As noted above (section 3.9), the baseline survey had raised the need to specifically address the notion of 'impact' in more detail, and as such the analysis here specifically discusses some of the key impacts of training highlighted by focus group participants.

Following this, the analysis explores the emergent aspects of the discussion in more depth, in order to thematise some of the reasons suggested to underpin the impacts detailed in Section 3.3. These discussion themes are identified as:

1. Collaborative Learning Beneficial
2. Follow-up Beneficial
3. Collaboration Problematic at Strategic Level
4. Working with University of Cumbria

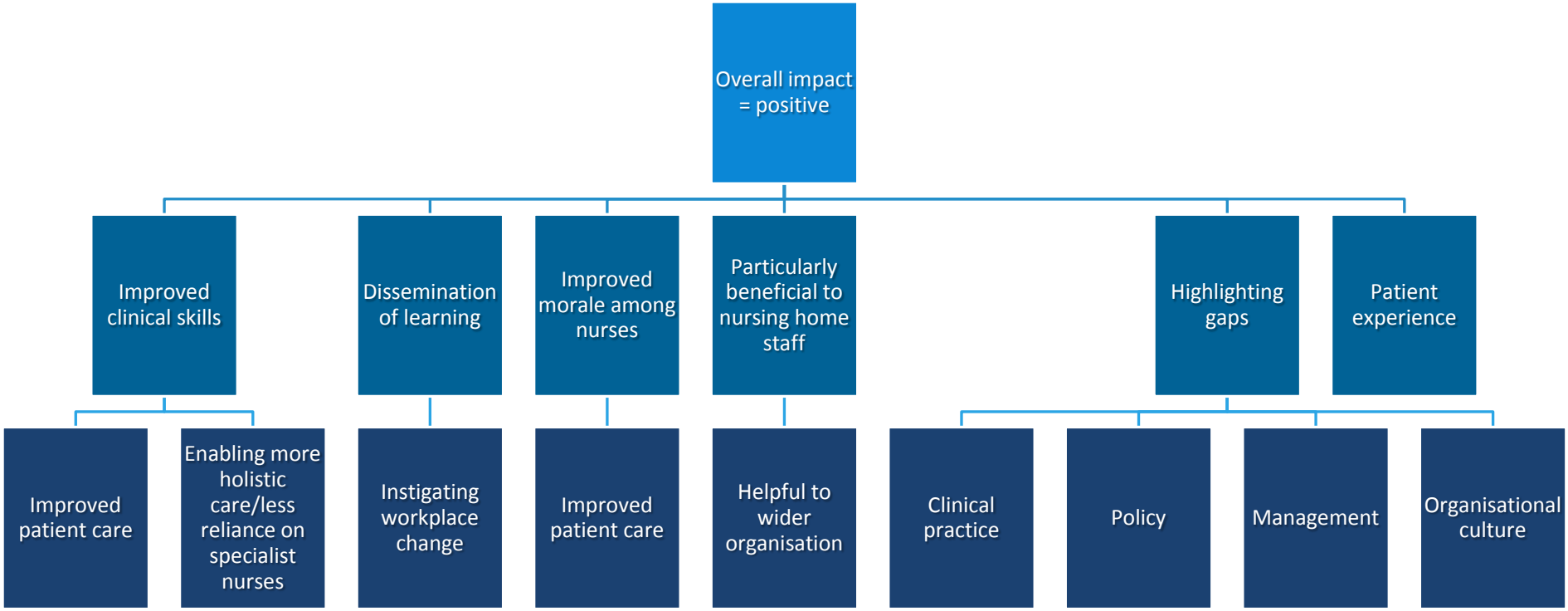


Figure 22: Overall Impact: Thematic Diagram

## 3.2 Overall Impacts

### 3.2.1 Improved clinical skills

The group felt that the workshops had successfully enabled participants to improve their clinical skills. Many people who came on the training were doing so to update pre-existing skills, though for some they were learning a completely new skill. It was suggested that these skills had often previously been developed in practice but that the Programme formalised this training:

> R1 That's a big part of this, some of the skills, there haven't been refreshers, it's relied on people picking it up in practice… some of the skills are new for people but … for many it is the first time they've properly looked at something since they've done their training.

> R4 The feedback from the diabetes stands out particularly; there was some where it was thirty years since they learned.

De-skilling was particularly felt to be an issue among nursing home staff, and consequently the training was seen as particularly beneficial for them:

> R3 [T]hey don't have the turnover of patients like perhaps district nurses or hospitals do and so they become deskilled quite quickly. So that's a real impact because they are very capable but they need that support.

It was also felt that nurses, particularly in nursing homes, wanted to look after patients more holistically, to not have to bring in specialist nurses so frequently. Following training it was suggested that this would be much more possible.

### 3.2.2 Dissemination of learning

Skill acquisition and implementation in practice was often not limited to the individual attending the training:

> R2 They're sharing their learning as well, they're going back and disseminating it within the team. It's not as if they're asked by the manager to do it it's just they've decided they want to share this with colleagues and to improve patient

care. The snowball effect is now these nurses in these workplaces now want to come along to the training.

As such, the training appears to have been very well received by those who undertook it and dissemination is occurring in the workplace and inspiring others to also undertake the training. It therefore appears to be having a positive impact on practitioner morale with enthusiasm for change/upskilling arising as a consequence of the training.

### 3.2.3 Improved morale among nurses

The workshops were felt to have been very positive experiences which aided morale and 'excited' participants' appetites for learning and changing modes of practice:

> R4 [T]hey're really passionate about making those changes and one said to me '*it's reassured me that what I thought is actually right and now I feel confident to actually go and challenge that'.*

'Passion' was not just engendered by the workshop however; it was felt that practitioners had an innate passion to learn and that the workshop enabled them to do that:

> R1 [I]ts coming from them, they're gushing with it, it's not like you've got to prompt…in the majority of cases it's coming from them, it's in them and they want to do it and it's giving them the opportunity. It's almost like we're giving them permission to do what they want to do.

### 3.2.4 Particularly beneficial to nursing home staff

Another impact was on the organisations for which nurses worked. While this was suggested to impact across the range of nursing contexts by some, other focus group members particularly highlighted nursing homes:

> R3 A lot of care homes are actually in special measures and I think there is an impact in that this Programme is helping them get out of special measures.

On a wider organisational level, it was felt that upskilling among nurses would relieve pressure on other services or practitioners

> R3 [I]t's increased [the] ability to deliver complex nursing care in nursing homes and that relieves the pressure in hospitals.

> R4 I think nursing home staff… they've sort of been left out of things and left out of training a lot, and there is that culture of sort of looking down at staff, and it's about bringing them up in value. They're really keen to attend and they've been really innovative in their ideas.

### 3.3.5 Highlighting gaps

Educators also felt that training had served to highlight 'gaps' in nurses' clinical knowledge and practice abilities, in policy – as it related to clinical practice, in management, and in nursing 'culture' more generally:

> R2 At each workshop we say you need to look at your local policy, and when they've done that they've found and highlighted the gaps and they've raised that and the policies have been reviewed and rewritten.

As such, gaps were not only identified but filled. In relation to clinical skills it was felt that nurses had lost breadth in their skillset following an emphasis on specialism during the 1990s. This, it was suggested, meant that many lacked both the confidence and competence to perform certain tasks and were reliant instead on specialist nursing staff in many instances:

> R2 We've lost general nursing background because now nurses don't feel capable to look after [for example] diabetic patients. *'oh I've got to call the specialist nurse'.* Or *'I don't have the knowledge to look after a wound, I have to call the tissue viability nurse.'…* They've lost that power or autonomy to actually feel competent to actually manage a patient themselves.

It was felt that the training had enabled this 'gap' to be filled to a certain extent by upskilling general nurses and allowing them, therefore, to work more autonomously. This was also

suggested to have an economic impact as if nurses had a greater breadth of skills they would not require the assistance of specialist nurses as often.

> R5 [I]t's about having the right care at the right time in the right place, and if you've got the skills in a care home to give the right care so the patient doesn't need to go to hospital that's fine because that hospital bed goes to somebody else who needs that care and that's what it's about.

Gaps were also identified in particular skill/knowledge areas such as safeguarding.

### 3.3.6 Standardisation of training

The group also felt that the training served to standardise practice across a wide variety of nursing sectors within the Cumbria region. In turn this made skills transferrable in a way that they had not been previously.

### 3.3.7 Future impact

The group reported that nurses attending the workshops had found them highly beneficial and had asked when the next workshop would be. Focus group members suggested that a sustainable approach to carrying the Programme forward was needed and that in future the steering group would benefit from working more collaboratively with one another, and from disseminating knowledge of the training Programme to senior nurses. In addition, educators felt that there were training needs among other healthcare professionals including Healthcare Assistants, Pharmacists and Doctors which the Programme could also address, thus widening its scope. Another suggestion was that in certain areas, such as diabetes care, there is potential for courses that would offer an annual update

### 3.3.8 Impact of training on patient experience

Because this was clearly one of the most vitally important aspects of the Programme, this impact is best represented in a separate thematic diagram (see Figure 23).

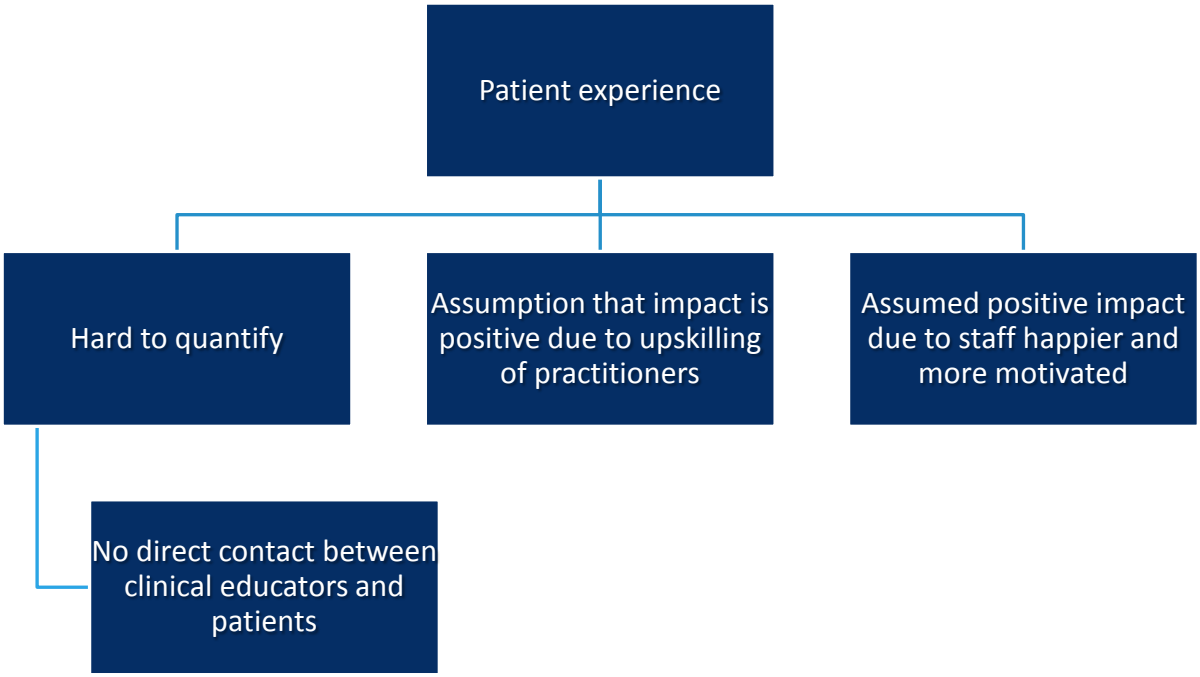


Figure 23: Patient Experience: Thematic Diagram

The impact of training on patient experience was suggested to be very difficult to quantify as clinical educators themselves had no direct contact with patients:

> R3 We'd like to think that it has [had a positive impact] because we know the nurses have made the changes in practice, but it's evidencing that.

In order to overcome the 'evidencing' problem, greater involvement of patients was suggested:

> R3 From my perspective there should have been patient representation, patient involvement from the beginning but there wasn't, and certainly as a collaborative approach that was missing.

There was a general sense that at present impact was difficult to quantify:

R6 [T]hey want numbers and it is impossible to give them to them… There's one question in the survey about admissions avoided and one of the nurses said '*how can I answer that?*' because you can't put a figure on it.

In addition, there were many aspects of patient care that were not easily quantified. For example, training was suggested to impact on patient experience not only in terms of increased skill level among nurses but also in terms of their motivation and wellbeing:

R3 If staff are feeling more motivated and happy then hopefully that will lead to better care as well.

Impact was also discussed in terms of nurses undertaking roles previously carried out by doctors, such as verifying death. The impact here was that doctors would have more time to deal with acutely ill patients. In this way, patient experience is in part a facet of who is carrying out the role.

Changes in practice and their subsequent impact were also felt to happen over time, as skills developed. Having attended a workshop nurses then had a period of time in which they developed their skills, with help from the clinical educator. Again this meant that assessing impact was not straightforward:

R3 Because some of what we're doing isn't having an immediate effect and it takes time to develop a competency.

## 3.3 Discussion Themes

### 3.3.1 Theme One: Collaborative Learning Beneficial

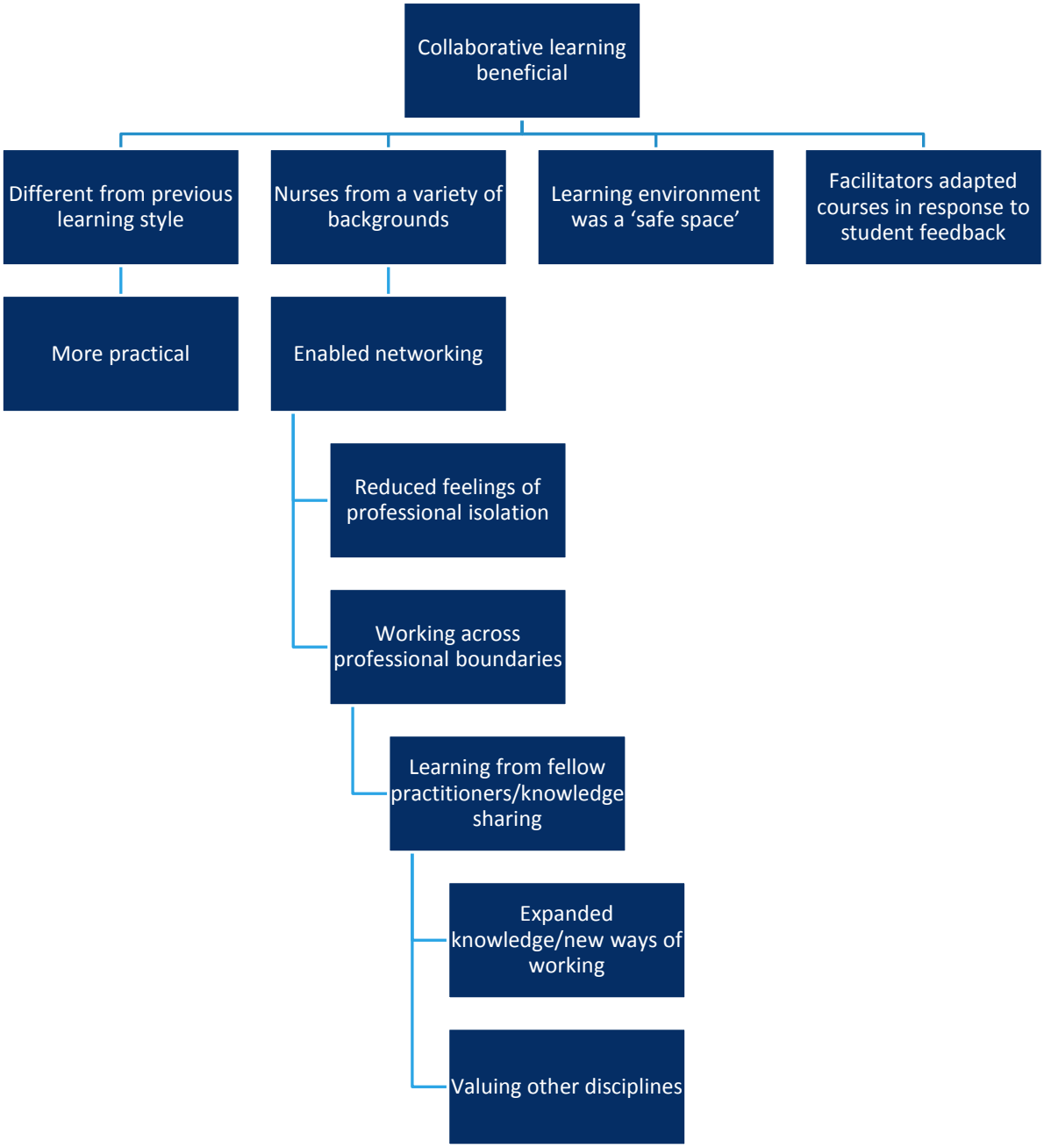


Figure 24: Collaborative Learning Thematic Diagram

The presence of nurses from a diverse range of clinical backgrounds and the collaborative nature of the learning was felt to positively distinguish the Programme from previous training which had tended to limited to particular specialisms.

Bringing nurses together from such diverse practice backgrounds was suggested to have a number of key benefits including reducing a sense of isolation from nurses practicing in different field:

> R1 [I]t's bringing nurses together that can become isolated or only working in an environment for a period of time… it doesn't matter if it's in the acute sector or in a nursing home, you can become very narrow focussed because you only know one way of doing things

Isolation, therefore, was felt to impede sharing of information across specialisms about best/new methods of practice. In particular, working collaboratively was suggested to be more beneficial than e-learning which was stated to be a common learning method:

> R6 The easy option now is e-learning… [most nurses want] to get that e-learning out of the way because of constraints on time, and they lose all that happens in a workshop – the interaction, the shared learning, the experiences… e-learning has its place but I do feel nurses should be attending workshops.

Networking and sharing best practice across disciplines was seen as beneficial to upskilling and improvement in patient care. It was suggested that this was reflective of a wider cultural shift within healthcare of working more collaboratively. In addition, such collaboration and a shared approach to learning allowed trainees to share experiences with one another was felt to foster a sense of mutual respect among the different disciplines

> R2 [I]n a shared environment they're valuing each other more, so the acute is valuing the community nursing more because they're having that opportunity to share stories and then they're '*Oh you have those problems?*' And it's vice versa the staff are realising that they've all got the same problems, similar problems.

This environment of sharing and collaborating also helped to create a 'safe space' in which learners felt comfortable discussing concerns and ideas:

> R2 [A] common theme is the learning environment within the workshop itself; one thing that came out is they feel safe, nurses who have not had the confidence to speak before felt confident to ask questions; they don't feel intimidated.

Sharing and discussion were embedded in the mode of teaching with sessions combining theory and practical activities and group discussion:

> R4 I like the workshops because they're practical and they're combined and so they're not just sitting there having death by PowerPoint. They're there to get involved… they're encouraged to share their experiences and that's how we learn.

Learners seemed to appreciate this and would swap phone numbers and email addresses after the sessions (voluntarily). This shift in training practice was felt to reflect a wider cultural shift within nursing practice and participants noted that while there had been a move toward specialised nursing in the 1990s there was now a shift towards nurses providing more 'holistic' care.

The group also highlighted how facilitators teaching the workshops had been very responsive to feedback from learners, accommodating suggestions for improvement and adapting the courses accordingly. In this way collaborative learning was not confined to those attending the course, but also occurred between attendees and course facilitators.

> R5 [O]ur workshops are continually changing because we respond to their feedback.

### 3.3.2 Theme Two: Follow-up Beneficial

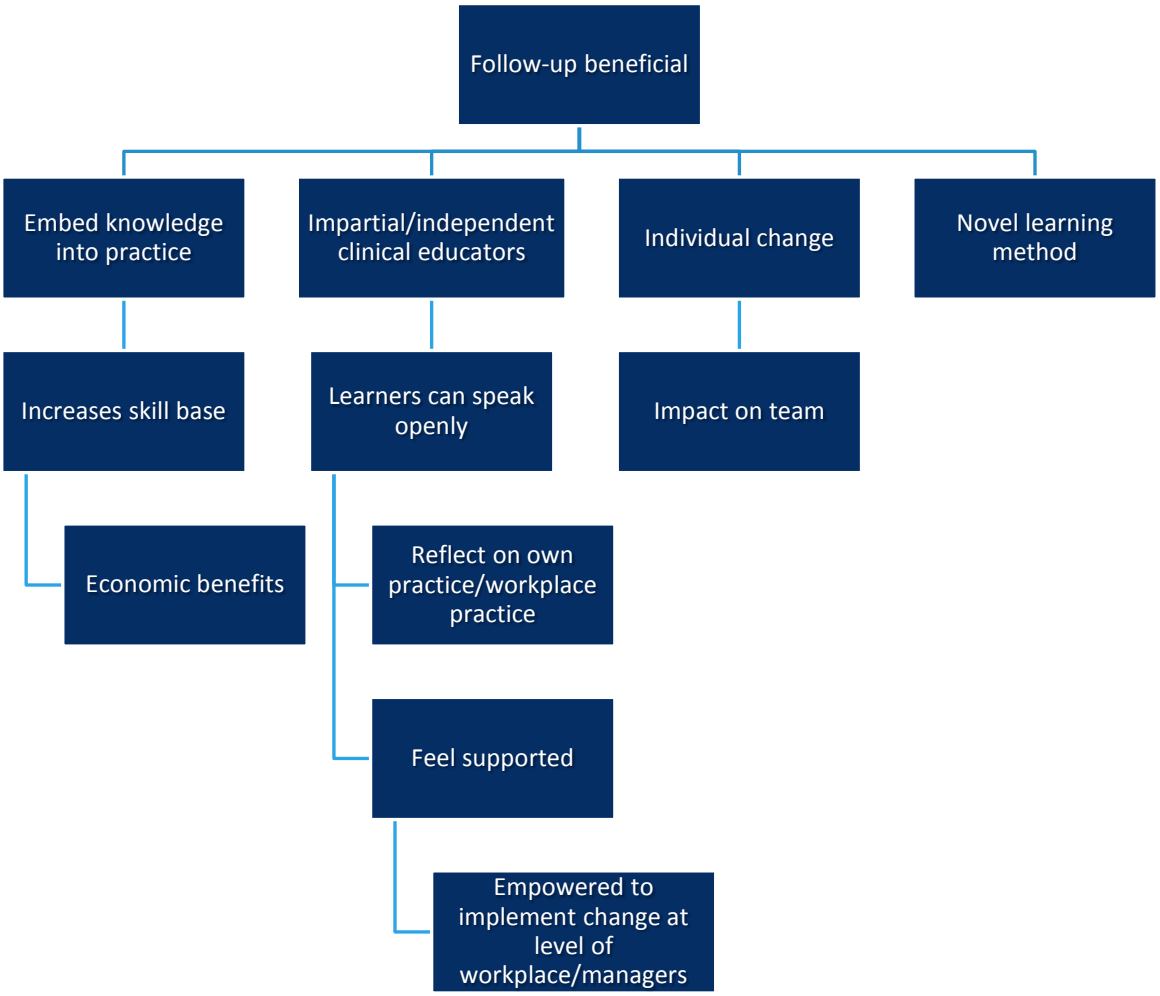


Figure 25: Follow Up Thematic Diagram

Following the initial training workshop all participants received follow-up visits and consultations from a clinical educator. As can be seen in Figure 25, the group highlighted that this was a very novel training method and felt that it had many benefits. The number of follow-up visits was determined by trainee in line with their needs. It allowed the knowledge learned on the course to become embedded in practice as it gave trainees the opportunity to be overseen

implementing/learning to implement the skill in their workplace. As such it ensured that skills taught in the workshop were carried through into practice:

> R3 I think it's having the evidence that people are taking that learning back into practice. My experience of training previously in organisations it's '*how many people have you trained in such a skill?'* It doesn't mean they've actually learned something, they could have done a shopping list at the back and not learned anything you know?

The use of follow-up visits also seemed to be a reflection/recognition that skills take time to develop/perfect and that a one off session is not enough to become competent in a particular skill. In this way it was felt that this mode of training was particularly effective at increasing the skills base of the workforce.

Because follow up helped ensure that learning became embedded in practice, and thus was not 'wasted', the group felt that there was an economic benefit of using this teaching method:

> R5 Ordinarily you would go on a course and no one would check whether you're using that learning and obviously training is a really expensive resource and through this model we see if they're using it or why they're struggling to apply it and [we're] supporting them to make sure that they're able to practice the skill.

This was seen as reflective of wider changes in nursing practice/assessment where, for revalidation purposes, nurses must be able to demonstrate the skill in practice. Attendance at a workshop was no longer sufficient.

The support offered by follow-up visits was also suggested to have social/psychological benefits with group members stating that one-on-one support helped trainees to feel 'empowered':

> R5 [E]mpowerment, that's the main thing, that the staff feel motivated to make the changes that they need to make in their area and that's through the combination of having updated skills and having that little bit of support in the community to share ideas and to have someone to give them that push to go and do it.

In addition, follow-up support gave trainees an opportunity to reflect, with the clinical educator, on both their individual practice and the practice of the team in which they worked. Reflective practice was cited as an important but often previously underutilised practice. The one-on-one

support in combination with the competency framework which allowed learners to assess their own level of competence was felt to aid reflective practice:

> R5 I think one of the by-products of our Programme is we've been able to support a lot of nurses who are not comfortable with reflection to be aware of how reflective practice works.

Crucially, the group suggested that follow-up visits meant that nurses felt supported in taking their new knowledge and implementing it. This enabled them to challenge current practice within their workplace when they felt it was needed and to talk to managers about changes in practice. In this way, the benefits of training were not limited to the individual trainee but impacted on the wider team or organisation in which they worked.

> R3 And some nurses have some really good ideas about improving practice but they become disempowered in their actual workplace so it's giving them that motivation to change practice and how to put that forward to the managers.

One of the most important characteristics that the group cited in terms of clinical educators' ability to empower trainees was that they were independent of the trainees' normal work environment. Trainees therefore felt they could speak openly with their clinical educator about their own practice:

> R5 [B]ecause our role is neutral, and we're not governed by any particular trust, it's interesting in that a lot of nurses feel really well supported and trust speaking to you and airing their concerns.

This neutrality was considered to be an aid to nurturing discussion of issues about the practitioners' work environment:

> R3 You might not talk about catheterisation but how to make a change in the environment that they're in because of the obstacles in their way.

In this way, the ability that staff had to implement new skills was seen as depending as much on creating a supportive work environment, with support from managers to implement change, as it was on clinical skill acquisition.

### 3.3.3 Theme Three: Collaboration Problematic at Strategic Level

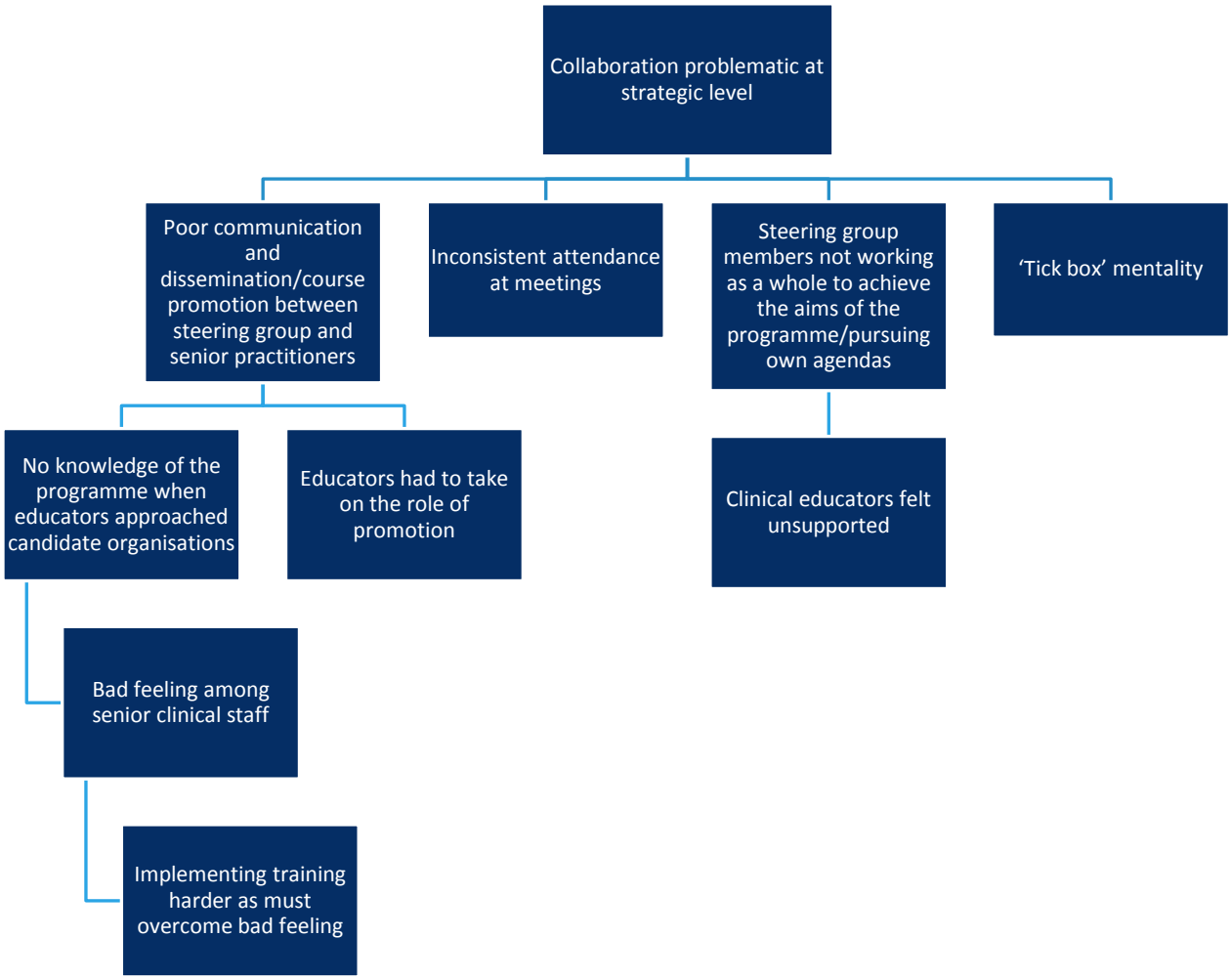


Figure 26: Problematic Collaboration Thematic Diagram

Focus group participants felt that collaboration at the level of strategic leads in the steering group had been problematic and that this had led to a number of difficulties in implementing the programme of training.

There was a feeling among educators that those 'at the top' were 'ticking a box' by attending the relevant meetings but that many had their own individual agendas and did not collaborate well together or in the interests of a unified approach to project delivery. In addition, there had been inconsistent, changeable representation at the steering group, which was suggested to indicate a lack of commitment to the Programme.

R3 When you think about what the steering group have and have not done the project could have potentially fallen apart.

The perception of steering group members as being uncommitted to the Programme led educators to feel unsupported in the delivery of the programme. Educators also reported feeling a lack of support due to a lack of dissemination in terms of promotion and awareness of the project from the 'top down'. They stated that information was not passed from steering group members to senior nursing teams and as such, when educators approached organisations there was no knowledge among staff at any level about the Programme. Educators felt that the majority of the promotion was done by themselves, from the 'bottom up'. While educators were both 'happy and able' to do Programme promotion, it necessitated a significant amount of face-to-face canvassing activity in order to interest staff in the training Programme and to build confidence in the product among staff. This was not what they had anticipated. They had expected awareness of the Programme to have been raised both in person with senior staff and via e-bulletins with wider staff members who might wish to undertake training.

A lack of communication between strategic leads and senior nurses had also led to bad feeling on occasion:

R1 It's not only about feeling respected by your manager, that they haven't been told, but we're a third party coming in and well *'Who do you think you are coming in here?'*... I think there's a lot of work that has had to be done that wasn't necessary really had the right people been involved.

### 3.3.4 Theme Four: Working with University of Cumbria

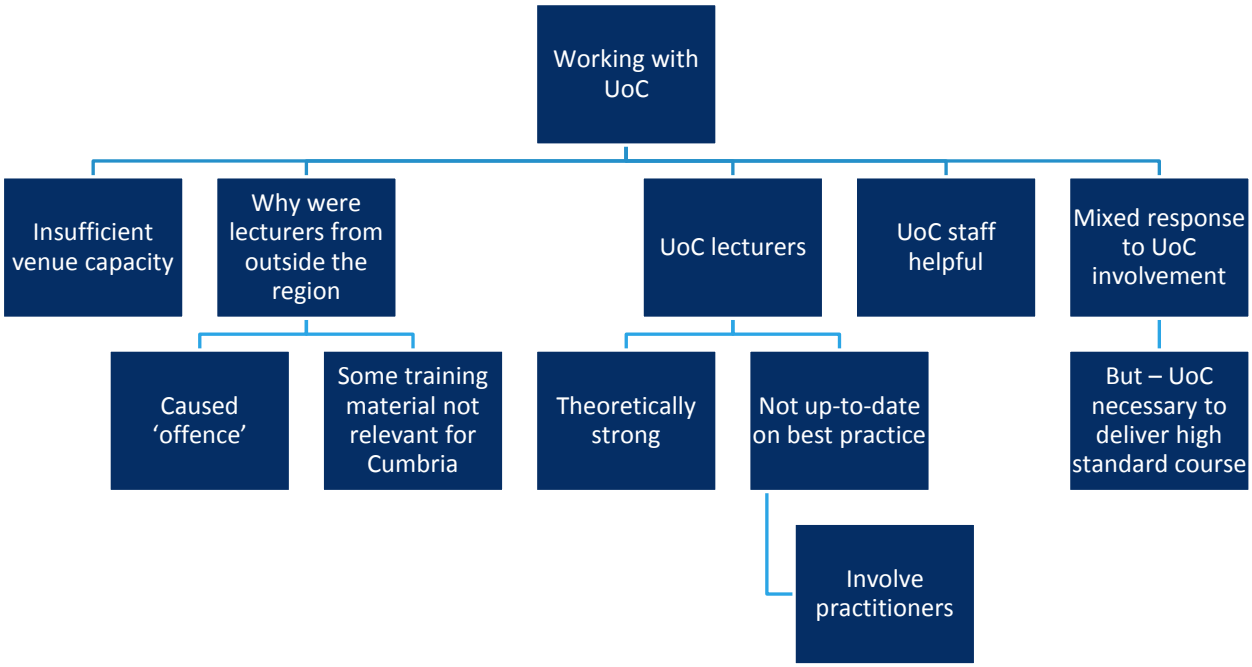


Figure 27: Working with the UoC Thematic Diagram

A number of points were raised about working with the University of Cumbria (UoC). Logistically some problems had arisen after UoC had stated that they were able to provide training rooms but later found they did not have the capacity. This meant that educators then had to look elsewhere for possible training venues.

Educators also commented that lecturers were drawn from outside Cumbria and wondered why specialist nurses from within Cumbria had not been utilised, stating that bringing in trainers from other regions had caused some offence (it is unclear to whom or the prevalence of this). There was a sense that this was a Cumbrian initiative that would have benefitted from being delivered

by local staff. It was mentioned that some nurses had found it hard to relate to the lecturers because the information they were giving was not specific to the local area.

In addition, it was suggested that university lecturers, while having strong theoretical knowledge, were not as up to date as practitioners would have been in terms of knowledge of best practice. As such, it was suggested that greater collaboration between the university and specialist nurses would have benefitted the Programme.

In terms of liaising with UoC staff, the feeling among the group was positive. The key link person from the university had been very helpful, supportive and personable. However, feelings about the involvement of a university – any university – were ambiguous:

> R5 [It] really caused offence for our project 'cause there's nurses in the area who would have liked to be more engaged in the process.

This was not particularly the view of the educators in the focus group however, who felt that without the University's support they would not have had the capacity or resources to deliver the Programme to the level they wanted.

# 4 Semi-Structured Interview Findings

## 4.1 Introduction

The focus group analysis allowed the shared experience of the Programme delivery to be thematised. This allows the evaluation to consider the different mechanisms at work in the Programme, and a variety of contextual factors influencing the impact on practice. To further develop this consideration, individual semi-structured interviews were conducted with practitioners who took part in the training. The question guiding the semi-structured interviews aimed to resonate with those of the focus group, while allowing the individual experiences of the practitioners to come to the fore.

For the semi-structured interviews, participants were purposive-sample selected as a result of being identified as registered nurses who were specifically involved with the CLIC Clinical Skills Programme. As a result, they were able to provide rich, thought-providing data for analysis (Braun & Clarke, 2006). This would then serve as a grounding for the second tranche of quantitative survey, which would allow for a more representative set of findings to emerge.

As encouraged for qualitative study, the small sample size was ideal (Braun & Clarke, 2006; Stith, 2006; Willig, 2008). Five (4 female and 1 male) nurses participated in the study. Two of these (2 females) were registered nurses within a Health Centre setting and two (2 females) were registered nurses in a Care Home setting. The final participant (1 male) was a registered nurse in a Rehabilitation Centre. Whilst most participants had been professionally qualified for a number of years, one participant was newly qualified. All 5 of the participants were employed in registered nurse roles in different areas of the Cumbrian County and represented a geographical dispersal across Carlisle, Cockermouth, Penrith, Ulverston and Whitehaven.

In advance of study commencement, Ethical, Participant Information and Consent Form approval was obtained from the University of Cumbria Ethics Committee (Breakwell, Smith & Wright, 2012; BPS, 2010). A semi-structured interview approach (each lasting approximately 30 minutes) was adopted with all participants and questions (including prompts) started generally, prior to becoming more specific (Willig, 2008). Interviewer and interviewee rapport was established in addition to empathy being demonstrated throughout, which is considered vital for quality comprehensive data attainment (Braun & Clarke, 2006; Willig, 2008).

Individual interviews were performed with all five participants. Interviews, on the whole, took place in an office within the individual health and social care setting, however in the case of where the participant would have otherwise been unavailable, in addition to concern regarding travelling distance due to adverse weather conditions, this was undertaken via a telephone interview. Participants were thanked for agreeing to contribute to the study and read an Information Sheet and given (or emailed) a Consent Form to sign and date prior to the interview commencement (BPS, 2010).

## 4.2 Findings and Discussion

In-depth theme code categorisation was supported through employment of a mind map (see Figure 28) which shows a more exhaustive illustration of the codes and themes and their supporting extracts from the transcript. This resulted in twenty five initial codes being identified: Accessibility, Administration, Session Delivery, Reinforcement, Support, Knowledge, Positive Learning, Disappointing Learning, Rapport, Networking, Experience Sharing, Dissemination, Best Practice, Up to date Information, Relevance, Benefit to Patient, Uniformity of Care, Reflection, Change in Documentation, Change in Provision, Revalidation, Further Training, Modified Training, Training for Others and Training and Patient Experience.

Through further analysis, these initial codes subsequently generated six themes to group these codes within: Programme Qualities, Education, Communication, Influence on Care Provision, Outcomes and Future Vision. The analysis below will discuss each of these in turn.

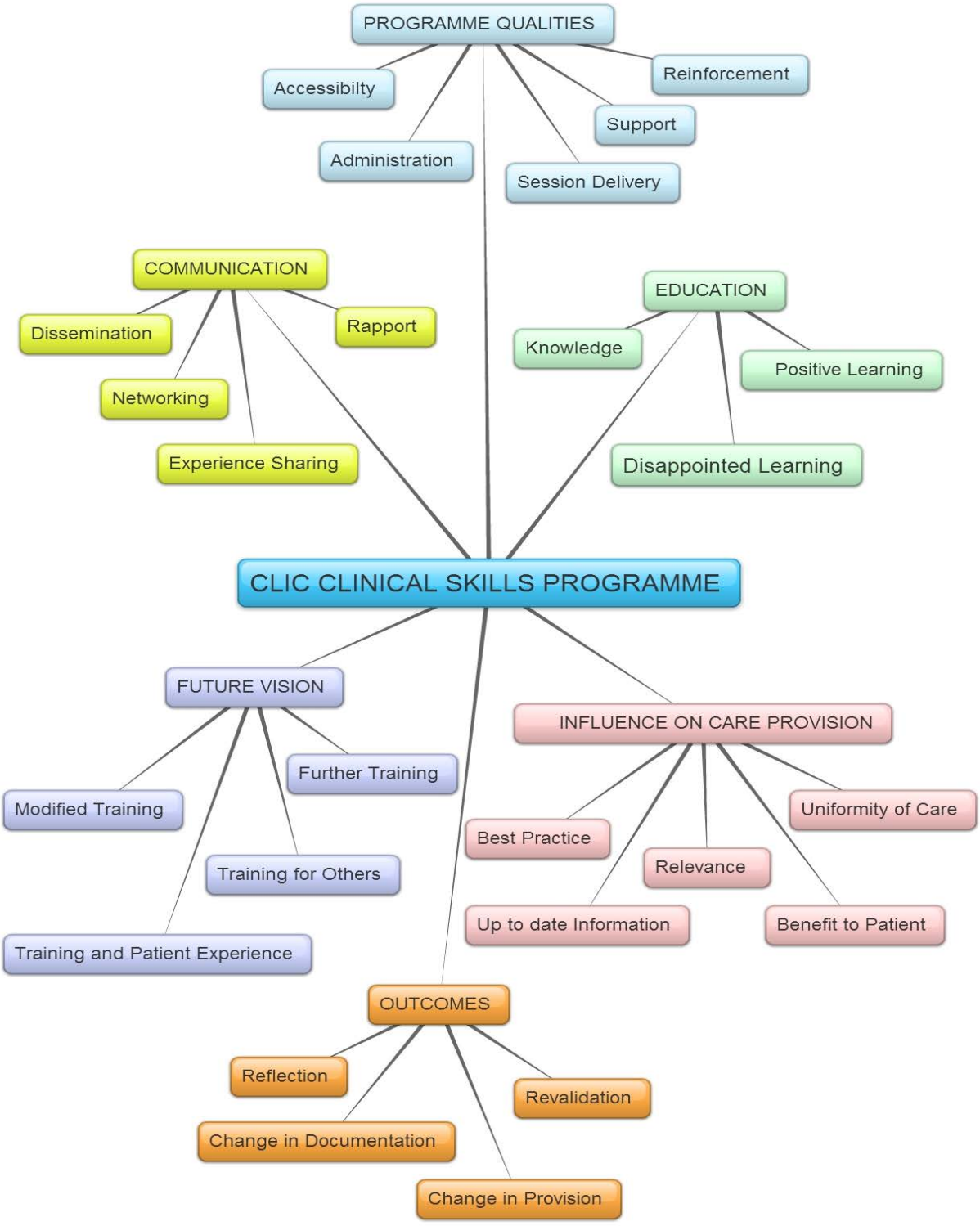


Figure 28: Mind-Map of Interview Analysis Themes

#### 4.2.1 Theme One: Programme Qualities

It was clear from the majority of responses that Participants saw the CLIC Clinical Skills Programme in a positive light. One of the initial qualities expressed was the fact that the initiative was considered to be accessible, especially with regards to booking onto one of the courses which was viewed as being relatively straightforward:

> "It's easy to access" (P1:51)[1]

> "It was accessible [… ] you could book on it quite easily" (P1:57)

Equally, with individuals; not least the nursing contingent; facing increases in the cost of living (Clements, 2015) the fact that the course was free was also seen as an advantage:

> "Because it was free as well [… ] with fees going up and everything else" (P1:54)

> "I think finances for nurses - as anybody is important [… ] it was free" (P1:55-56)

Additionally, a number of Participants referred to the all-encompassing nature of the Programme. This ranged from the suitability for both newly qualified as well as more experienced registered nurses, to the diversity of care settings represented by the audience attending the sessions:

> "Through the sessions that I've attended I have seen a mix of newly qualified or recently qualified [… ] to nurses in their late 40's early 50's who attend and we all bring something to the table" (P1:116-121)

> "Been really good for every level – for both experienced nurses as well as [… ] just qualified" (P2:233-235)

The diversity of settings had undoubtedly come as a surprise to one Participant in particular, although it was recognised that such participation may have been as a result of a registered

[1] For analytical purposes and to enhance anonymity, all participants were given a code for example P.1. In addition, for classification; as recommended by Braun and Clarke (2006); line numbers were then inserted alongside each response within the transcript document. Consequently, responses can be traced back in the transcript document to the participant followed by the line numbers where these answers were presented for example (P1:7-9) would correspond to a response by Participant 1 between lines 7 and 9.

nurse desiring a more intimate environment in which to learn and one which was intimated that the CLIC Clinical Skills Programme was able to provide:

> "We've had hospital nurses who for whatever reason have attended and my inclination would be 'why would they be attending when you have a big corporation like the NHS that do all their own in house training and have somebody to mentor and teach clinical skills pretty much 24/7' [… ] sometimes for personal reasons [… ] lack of confidence in a big working environment [… ] happier in a smaller [… ] more personalised setting which I think CLIC is." (P1:103-113)

This opinion was concurred by one of the other Participants who spoke favourably in respect of the intimate and relatively small groups the Programme embraced:

> "Because these have been a bit more intimate and relatively small groups and things it's been quite good" (P3:497-499)

Ostensibly, the efficient administration of the Programme had contributed to these positive attributes and one Participant specifically highlighted the benefit experienced as a result of the reminders received regarding courses on which they had booked:

> "It's been well organised, that's been a good aspect of it" (P3:503-504)

> "The little reminder things about the study days you've booked are quite useful" (P3:398-399)

Generally, it would appear that the positive experience expressed by the majority of Participants was largely due to the approach of the training session delivery. A number of Participants spoke very highly of those delivering the sessions:

> "They are nurses – they know what they are talking about, they know what we need as much as we know what we need" (P1:185-187)

> "It's been really good. They've been really specific" (P2:232-233)

> "The speakers are good and they're really knowledgeable and that is really helpful" (P3:390-391)

> "They're obviously used to speaking in front of groups" (P3:336-337)

> "The course itself [… ] what we've done has been excellent and we've found very helpful" (P4:687-688)

In addition, Participants acknowledged the confident manner in which the sessions were delivered, specifically where there might be an issue and considered the availability of speakers from diverse sectors, a bonus:

> "They are very good at making sure they get the information across so that everyone understands it well" (P3:337-339)

> "They are very good at answering the questions" (P3:339-340)

> "If there is anything lacking in any of the presentations someone will always ask and I'd like to think as educators that they would adapt to meet needs – and from what I've seen they do" (P1:189–192)

> "The lecturers, tutors [… ] they come from various different places. Some are from the university, some are from the community" (P1:128-131)

One Participant, being so encouraged by the whole experience of the training, summed up the service delivery by sharing that they wanted to attend every session which was available:

> "It sucks you in and before you know it you want to attend all of their training sessions and then we get greedy and we want more" (P1:59-61)

However, this opinion was not expressed by all Participants. Whilst one believed the Programme had endorsed their professionalism, on the contrary, another Participant felt that the sessions were only reinforcing what was already known:

> "Affirms the fact that we are professionals" (P1:24-31)

> "I think it was just really reinforcing what we already [… ] knew and going over things" (P5:709-710)

One area which the majority of Participants recalled as a noteworthy strength of the Programme was the support which they had received from the Programme leaders. This was valued during the actual sessions where they had been made to feel at ease:

"The support from the staff when you get there has been really good – they make you feel welcome" (P3:400-401)

But more importantly, once the training session was complete:

"They support in the workplace as well, they do come out [… ] which again is absolutely brilliant" (P1:211- 214)

"The support afterwards has been good as well with the follow up" (P3:401-402)

"Quite a big thing [… ] normally you go to these study days and that's it, but to have the support and the follow up afterwards I think has been really useful" (P3:402-405)

"With the follow up and the support from the nurses coming to visit in the workplace or wherever to discuss things [… ] that was quite good" (P3:582-585)

"The follow up. You could have an appointment with one of the CLIC Advisors to see how you are going to use it towards revalidation" (P5: 726-728)

Equally, the flexibility in how the support was made available to Participants was expressly emphasised and it appeared that Advisors were prepared to 'go the extra mile' in order to provide support to the registered nurses. Meeting away from the training session or workplace for example in Costa Coffee was highlighted as particularly helpful for those who may find speaking up in a larger group intimidating:

"They are very flexible and I think that gives a bit of a personal touch as well" (P1:217-219)

"For those who don't want to bring anything up that are perhaps a little bit shy [… ] they don't just come to the workplace [… ] a colleague who met one of them in Costa Coffee or somewhere in town" (P1:214-217)

This was specifically supported by a number of Participants who recalled identifiable incidents where they had been given support which they had found especially helpful:

"One of the Clinical Skills Nurses actually helped me follow that up and gave me feedback and we worked together on it so it was very good" (P1:44-47)

"I asked the question and we discussed that briefly and it was suggested to me to contact the pain nurse at Carlisle [… ] people were helpful and supportive" (P3:350-354)

"They were good at signposting me [… ] to the right other people to get the information I needed so that was good" (P3:355-357)

Conversely, however, one Participant did feel that they required more support following training sessions when they went out on their own:

"We need [… ] more [… ] feedback [… ] support, when it's available – when you go out on your own" (P4:693-694).

#### 4.2.2 Theme Two: Education

A second theme to emerge from the data was centred around education. Firstly, Participants believed that having the most current knowledge was as significant as having the practical clinical skills required in their role and this was something all Participants felt had been gained through involvement in the CLIC Clinical Skills Programme:

"We need the knowledge as well as the practical" (P1:151-152)

"The nurses need to be up to date with everything – knowledge and clinical skills" (P1:167-169)

"Making sure my knowledge and skills were current" (P3:372-373)

Further, it was recognised that despite potentially having many years' experience as a registered nurse knowledge evolves and it was important to both acknowledge change and allow previous knowledge to be enhanced:

"No matter how much you think you know and I've been nursing 30 years now, but things change – there are always new ideas come along" (P3:377-379)

"The CLIC Programme has [… ] given me deeper knowledge" (P4:601-602)

Similarly, Participants described aspiring to ensure their knowledge and skills were current so as to ensure they could deliver the best care to their patients and potentially improve practice:

"It's applying that knowledge and information I've got in the workplace and seeing the patients benefit from that" (P3:427-429)

> "It's all about making sure that information and knowledge is current so you can deliver the best care" (P3:486-488)

> "The knowledge that we've gained [… ] has certainly been able to be put into practice" (P4:620-621)

> "People are [… ] going to use that new knowledge to either reinforce what they are already doing or to improve practice" (P5:779-781)

Participants also expressed feeling reassured as a result of attending the sessions as they were aware the knowledge presented was current procedures so even if it was unchanged from their present practice, they were confident that their knowledge was up to date:

> "Even if there isn't anything new that we have learned, it strengthens the knowledge" (P1:11-13)

> "It also lets us know that the knowledge that we have is actually up to date" (P1:13-14)

Secondly, a strong initial code identified (which is appropriate to incorporate into the theme of education) is that of positive learning. It was evident that the majority of Participants found the teaching during the Clinical Skills Programme very beneficial, with one Participant in particular describing it as an experience which had brought confidence through the knowledge imparted:

> "While we are there we learn a lot from what we are actually taught and what's being presented on any given day" (P1:5-6)

> "Because I'm just newly qualified [… ] the course has been really good just to get the fundamental skills under way" (P2:226-228)

> "I was [… ] on the course with 3 of my other colleagues and certainly we talked about them afterwards and felt we'd benefitted" (P4:607-610)

> "We are confident in what we are doing, knowing that we've learned what we've learned" (P4:670-672)

Potentially this positivity may be attributed to the relaxed teaching style, with approachable trainers in addition to the informal format of the sessions:

> "In a way of learning it's just very informal and very easy" (P4:629-630)

> "Very easy to approach the trainers and the staff that are facilitating the learning [… ] from CLIC" (P4:630-631)

Equally important was the unexpected learning which the training session had highlighted for two Participants in confirming learning needs:

> "It has helped me to identify my learning needs. They have been very specific for what I needed to do" (P2:238-240)

> "I thought I was going to be able to do [… ] catheterisation and in actual fact I couldn't [… ]. So really learned from that what we could and what we couldn't do" (P4:614-617)

However, possibly the most important aspect of positive learning to emerge from the data was the impact of the positive learning identified by a number of Participants in respect of the benefit to patient care and practice:

> "Whatever we learn we can bring back and put into practice" (P1:10-11)

> "We actually do feedback questionnaires anyway at work and we always get good feedback from them [… ] which arguably you could relate to what we've learned on these study days" (P3:537-540)

> "Whatever you've learned on that particular course [… ] bring it into practice" (P5:753-754)

At the same time, whilst positive learning was reflected strongly in the data, equally the allusion to disappointing learning cannot be ignored. This was conveyed from an individual perspective where one Participant felt there was nothing new provided by the course and that ideally they would have preferred to have been given more knowledge relating to a specific topic. However, this was also witnessed in connection with other registered nurses attending the course and one Participant expressly felt that involvement in the Programme had ultimately not provided them with significant new knowledge to impart into practice:

> "I've not learned anything new" (P5:818)

> "Personally I would have liked to have seen a bit more in managing chronic long term pain" (P3:346-347)

"Some of the more senior nurses had been advised to go on it and they didn't feel like they'd learned anything, they were the ones who thought it was a waste of time" (P2:320-323)

"It was a full day course and you didn't come away thinking there's lots that I've learned there and I'm going to put that into practice" (P5:800-802)

#### 4.2.3 Theme Three: Communication

One area which was seen as a particular strength of the CLIC Clinical Skills Programme was communication. This was evidenced in a variety of ways. For example, it was apparent that a rapport had been built up between the Programme personnel and the registered nurses both prior to, during and following the training sessions:

"The communication between CLIC and the individual I think is excellent" (P1:57- 58)

"They are very good at answering the questions" (P3:339-340)

"It's the [… ] communication beforehand" (P3:397-398)

Likewise, networking was seen as a valuable opportunity which Participants believed involvement in the Programme had generated for them, especially through encountering registered nurses from different settings which was seen as a bonus:

"Signposting and the networking I think is very important [… ] because it's quite useful that it's not just hospital based staff it's everyone in the health care sector in Cumbria and that's really good" (P3:357-360)

"Seeing people from different areas that you generally wouldn't ever meet much [… ] it's quite good" (P3:492-493)

"Sort of networking and getting to know people" (P3:499-500)

"The networking aspects really good and it [… ] builds almost a bit of a comradery really – you can support each other more" (P3:512-514)

However, this notionally positive experience for Participants was not totally unexpected when the CLIC personnel in addition to the speakers were seen to be leading by example:

> "The people from CLIC and the speakers [… ] they're all very good at chatting and networking [… ] that's been very good" (P3:500-503)

It appears that one of the main reasons networking was highlighted as significant amongst most Participants was attributable to the experience sharing which it invoked. This lead to valuable information being imparted between other professionals on the course and Participants disclosed this was something they found helpful:

> "For me personally and also from talking to colleagues [… ] it opens up discussion on these specific area" (P1: 3-5)

> "We all work differently and you can be a bit isolated in your area sometimes, so to see other people how they work in their areas and pick up little bits of information and help from them [… ] can be very helpful" (P3:361-365)

> "There are lots other people out there who are wanting the same thing and wanting to support and help each other and so it was really good" (P3:514-517)

> "Being able to share with people that have attended the courses with us" (P4:602-603)

> "We've been able to share information and ideas" (P4:603-604)

In comparison, the experience sharing of one of the Participants; having attended what they felt was an exceptionally informative training session; was to their own work colleagues, in an act of encouragement so as to persuade them to also attend the specific training course:

> "The pain management day [… ] I was able to say to my colleagues 'look this is really good – go and do it' " (P3:448-451)

Furthermore, communication can be seen as evidenced through dissemination which could be viewed as an extension to what the Participant referred to above described when sharing their experience from the specific training they had undertaken. Initially this was emphasised by one of the Participants with regards to the dissemination by those actually delivering the lectures, of the most relevant and up to date information:

> "They are obviously having to keep up to date themselves and they will obviously disseminate that through their individual lectures" (P1:199-201)

At the same time, Participants appeared very conscious of their responsibility to communicate information and current practice learned during the training sessions to their colleagues on returning to their specific health and social care setting; regardless of whether this had made an impact on themselves; in order to ensure quality and up to date care was given to patients:

> "Obviously we can disseminate that to those that can't attend so it might just be one person in attendance but it's [… ] the whole home when one of us goes" (P1:15-17)

> "It may not have impacted on me, but the disseminated knowledge to a colleague may have an impact on them" (P1:70-72)

> "I'm picking up new bits of information. So I've been able to take that back to work" (P3:380-382)

> "If we get good information then we can pass that information on to others and hopefully we can help the people we look after to the best of our ability" (P3:435-437)

> "Pass on to work colleagues" (P4:660-661)

> "Talking to colleagues and [… ] cascading any new information down to them" (P5:757-758)

On the other hand, whilst the aforementioned accentuated dissemination may predominantly have been to fellow registered nurses, one Participant also referred to disseminating expertise learned through the CLIC Clinical Skills Programme to other professional colleagues working in their health care setting:

> "We've also managed to liaise with the rehabilitation staff, physios and exercise therapists as well" (P3:452-453)

> "Talking to our Clinical Assistants [… ] we've said 'here you are' and they've said 'that's really good' " (P3:542-552)

More specifically perhaps is the dissemination referred to which is communicated to patients with the sole purpose of providing them with appropriate knowledge and support so as to ensure ultimate best care practice:

> "We are there to educate people to help them and support them" (P3:430-431)

#### 4.2.4 Theme Four: Influence on Care Provision

Reference to best practice can be consistently observed throughout the interview data by all but one Participant and it is clear that Participants were conscious of their accountability regarding the care which they provided:

> "To think about [… ] best practice as well" (P1:31-32)

> "So we are doing best possible practice" (P2:246)

> "The fact that I can make sure that my nursing care is to the highest standard possible – best practice" (P3:409-411)

> "We are showing best practice" (P4:669-670)

Unquestionably, Participants' main agenda was to ensure that they partook of the best training and gained the essential knowledge and skills required to ensure their patients were given the highest quality of care possible and that which was in line with statutory guidance:

> "It was to ensure [… ] I was maintaining [… ] best practice" (P3:371-372)

> "Make sure the knowledge and information and skills I've got are current best practice" (P3:416-417)

> "Knowing that you are giving them the best care that you have been trained, you've been shown. That you can carry out these to the best of your ability" (P4:679-681)

> "That my own practices are in line with NMC and QCQ" (P4:646-647)

By the same token, when contemplating best practice, another fairly strong initial code which was seen represented in the responses of all Participants was the need for up to date information. Participants all acknowledged the importance for a registered nurse to be up to

date with knowledge, skills and best practice in order for the most efficient care to be delivered to their client:

> "The nurses need to be up to date with everything – knowledge and clinical skills" (P1:167-169)

> "It's about making sure your knowledge is current and up to date [… ] never know when you might need it" (P3:474-476)

> "I try to keep myself up to date" (P3:483)

However, concern was raised by one Participant as to the employability of registered nurses whose skills were not up to date, together with the impact for patients if they were in need of care which the registered nurse was not qualified to provide:

> "If you haven't got nurses that have the appropriate skills to look after them then those nurses shouldn't really be employed or we shouldn't be accepting the patient [… ] but to actually keep your skills up to date [… ] to meet the clients that we are having" (P1:143-150)

Nevertheless, it was recognised that up to date information should be acquired through attending training and courses which were pertinent to their role:

> "It's essential we have up to date training and courses" (P2:262-263)

Taking this into consideration, the CLIC Clinical Skills Programme was accentuated by most of the Participants as providing a means for both updating the required skills and knowledge, but also providing peace of mind for the registered nurses through corroborating that such information was up to date:

> "Let's us know that the knowledge that we have is actually up to date" (P1:13-14)

> "It's all up to date [… ] it's all up to date evidence [… ] current evidence" (P2:243-245)

> "Basically [… ] keeping you up to date on how things are being done [… ] the right way of doing things" (P4:664-666)

In fact, one Participant expressed appreciation that this provision was freely available which was perceived an advantage which they felt might not be available in the private sector:

> "Those [… ] in the private sector that might perhaps not receive free up to date training on core clinical skills" (P1:100-102)

Further, those Participants who had potentially been qualified for a longer period of time also acknowledged the value and significance of the Programme in potentially highlighting more recent research which may advocate alternate ways of doing things or change practice which could ultimately influence care provision:

> "Even if you have been qualified for years and you have experience there's always new ways and new evidence and new products that need to be introduced rather than just being set in the way you have always done it" (P2:288-292)

> "A lot of it is [… ] a refresher, updating [… ] but things change, new information comes along, new research comes along" (P3:483-486)

Conversely, however this overall opinion was not shared by all Participants as it was pointed out in one response that the Programme was only reinforcing what the registered nurse should both already be up to date with, not to mention already practicing:

> "At the end of the day that was reinforcing what we should already be up to date with [… ] according to [… ] guidelines and [… ] medications and that sort of thing" (P5:719-722)

> "So it should have a positive effect because you are showing evidence that you are keeping up to date with practice. But you should be doing that anyway" (P5:743-745)

In contrast, the relevance of the specific 'core nursing skills' focus of the Programme was discussed by all Participants, with a divergence of opinions. For example, whilst most Participants commended the choice of topics:

> "Absolutely relevant" (P1:140)

> "All the courses have been relevant to all of us" (P2:284-285)

> "It was really good [… ]. Very useful" (P3: 516-517)

> "Oh, more, more relevant" (P4:677)

One Participant conversely considered the sessions to be superfluous due to 'in-house' training which they were already involved in and knowledge which they felt they had already acquired,

coupled with the fact that they could not perceive how it was possible to link the sessions to the NMC Code of Practice:

> "We have a lot of PLT days as well [… ] once a month [… ] we attend training sessions any way" (P5:784-786)

> "They've gone over what I already knew really" (P5:803)

> "I haven't seen how to actually link it in with the NMC Code of Practice" (P5:811-812)

On the other hand; as it was pointed out by one Participant; 'relevance' may well be interrelated to the specific setting of each registered nurse. However, the importance of accessing relevant and up to date information, whether it appeared currently relevant or not, was nevertheless emphasised as, as the Participant highlights; no-one knows when an emergency demands the information which appeared irrelevant in order to provide quality care provision to a patient:

> "I only work nights [… ] arguably I don't have as much impact as [… ] some of my colleagues on days or in other areas that have attended the courses" (P3:415-422)

> "We don't tend to change catheters much any way and on nights in particular, unless it was an urgent thing [… ] it's highly unlikely we'd do it so there's little bits like that for me [… ] but information is still important" (P3:465-474)

> "Even the things that are slightly less relevant are important because [… ] I need to know exactly what's what these days to make sure that in an emergency I can do things the right way without causing any problems" (P3:525-529)

Equally, as another Participant alluded, whilst some material may be more relevant than others, there was always, in reality, the potential to pass on information learned during the teaching sessions, which, although may be considered not relevant for that particular Nurse at that time, may in actual fact be relevant for another colleague:

> "Some things will be more relevant [… ] others not quite as relevant" (P3:521-522)

> "We've been passing on bits of information that we thought might be relevant to them" (P3:550-551)

Although this may be true, what is of utmost importance is the actual benefit to the patient being cared for as a result of utilising the skills and knowledge learned. This was something which a number of Participants remarked upon:

> "Whatever we learn we can bring back and put into practice" (P1:10-11)

> "I would like to think [… ] it's beneficial because a lot of my colleagues as well as myself have been to several of these study days and we've all found them very useful" (P3:534-537)

> "You should [… ] see an improvement in practice because you should be able to use the skills" (P5:751-752)

Correspondingly, Participants were keen to describe ways in which they considered the training had provided opportunities for them to bring benefit to patient care:

> "Looking inwards – what can I do to change my practice [… ] there might be subtle things that I could do" (P1:75-77)

> "It's given me more confidence" (P2:266)

> "Make sure that my client's patients get the best benefit" (P3:411-412)

> "We are doing things appropriate [… ] that are [… ] right. Right way of doing things" (P4:642-644)

Nevertheless, it was noted by one Participant that registered nurses should in fact already have been offering a level of care which was beneficial to the patients in their care:

> "I like to think that I was pretty good at making sure the patients got a high standard of care any way" (P3:418:419)

Conversely it was drawn attention to in one response that in reality it was difficult to correlate benefit to patient with a specific course attended as, dependent on the training, for example the session surrounding diabetic care, it may be a number of months later when the patient is seen and so it would be difficult to say whether any improvements for the patient had been as a direct result of the explicit training the registered nurse had received or not:

> "The diabetic one – the results that you see from that you see [… ] 3, 4, 6 or 12 months down the line so it's difficult to say if it's been the influence of the course or not" (P5:716-719)

In contrast, in respect of the same training, another Participant credited the session with particularly highlighting how it would be possible to use the knowledge and skills learned to benefit a particular patient in their care:

> "The diabetes day that I attended – with diabetic foot care [… ] it really for me highlighted that with one of the clients that we had" (P1:35-39)

> "Diabetic foot care [… ] the patient is obviously going to respond i.e. get their foot check or [… ] better pressure area prevention and wound management" (P1:82-89)

As a matter of fact, this Participant even went as far as to say that they felt the information gained from the training course could be expanded upon in practice in order to bring benefit to the patient in their care:

> "Going back to diabetic foot care actually using that information to take it forward [… ] utilise a resource or basically 'kick butt' on a resource that's out there people have forgotten about and [… ] better deliverance of patient care" (P1:82-87)

As Participants frequently drew attention to, if a patient is being accepted for into a care setting then it is up to the registered nurse to be able to provide care which is of benefit to the patient:

> "With rules and regulations if you are accepting a patient you have to be able to provide and deliver care to them" (P1:141-143)

Furthermore, it would appear that as a consequence of the all-encompassing nature of the CLIC Clinical Skills Programme; by virtue of it being made available to all registered nurses employed in health care settings within the Cumbrian County; inconsistency in care practice would potentially be minimised. Ultimately, according to a number of responses, uniformity of care was something that Participants welcomed and believed would ensure; in theory; that all patients in whichever setting would receive the same level of care:

> "Everybody's singing from the same hymn sheet so [… ] there's a certain level and an expectation that patients receive similar care so if you have the same training in theory everybody will be provided with the same care" (P2:304-308)

> "It's participants from all over Cumbria [… ] making sure that you are all working the same [… ] that there's not a difference in practice." (P5:702-705)

Equally from the registered nurse perspective, this was also seen optimistically as a means of ensuring staff were exposed to identical training to ensure up to date knowledge and core skills were equivalent, regardless of whether the individual was, for example, a newly qualified or more experienced member of staff or a practice or district nurse:

> "I can do the same tasks as everybody else in the team [… ] it doesn't [… ] single people out who can only perform particular tasks" (P2:273-275)

> "It shouldn't be any different whether you are a practice nurse or a district nurse [… ] whatever you pick up on that day should be the same across the board" (P5:774-779)

#### 4.2.5 Theme Five: Outcomes

The penultimate theme to emerge from the data was concentrated on outcomes. Firstly, it was apparent from all of the responses that Participants had taken time for reflection following their interaction with the CLIC Clinical Skills Programme. Whilst these deliberations were somewhat diverse in nature, initial reflections revealed what one Participant referred to as the uniqueness of the collaboration in that it was not an initiative which they were aware of happening elsewhere in the country:

> "I've not heard of anything else like it anywhere round the country [… ] when I first came across it I thought [… ] this is a really good idea" (P3:506-510)

Likewise, echoing this positivity, another Participant reflected on the response they had observed surrounding the Programme:

> "I think it is doing very well. I've not heard any negative comments about it at all – the delivery – the site – for Carlisle [… ] I haven't been to any of the other ones has been brilliant" (P1:202-206)

In the same vein three Participants focused their reflections around the success of the CLIC Clinical Skills Programme which they all viewed positively:

> "Was this successful? Absolutely, yeah" (P1:137)

> "Has it been successful? Yes I would say so – yes" (P2: 299)

> "Has it been successful? Yes" (P4:674)

This was also corroborated by the response from a fourth Participant who believed there was nothing currently which they felt could be improved:

> "At the moment I don't think there is anything more they could yeah" (P1:219-220)

Interestingly, further contemplations were based around how to manage the Participant's reflections and whether this in fact would lead to change within their practice. Ultimately they deduced that such changes had the potential to have a significant impact and lead to a change in policy within a health and social care environment.

> "Am I reflective when I come away and what do I do with that reflection [… ] does it make me think that I can change something" (P1: 65-68)

> "As a big picture it could change policy within a home or working environment" (P1:78)

Conversely the reflections of one of the other Participants were not quite as positive. The Participant felt that the diabetic session had not taught them anything new; this was attributed to the session mixing individuals with no experience of diabetic care to those who attended to diabetic patients on a regular basis:

> "From the first one, the diabetic one, we felt on the whole that it wasn't actually [… ] we didn't learn anything new from it" (P5:794-796)

> "There were people there with experience who deal with diabetics and there was people there who didn't have any experience really with diabetics so they had to cover the full range" (P5:797-800)

On the other hand, this negativity may potentially also be due to the Participant not fully engaging with the Programme for a number of reasons:

> "The diabetes – I should have sat down probably and reflected on that" (P5:739-740)

> "I think the follow up. You could have an appointment with one of the CLIC Advisors to see how you are going to use that towards revalidation which I haven't had time to do at the moment, but they have been in touch with me" (P5: 726-729)

From an alternative perspective a number of Participants commented on the reflective sessions connected to the courses which they all spoke encouragingly about:

> "They do come out and they do reflective sessions with us which again is absolutely brilliant" (P1:212-214)

> "We do the reflections [… ] afterwards" (P2:229-230)

In particular Participants made reference to the on-going training and development following the training session completion. This was something they felt reinforced teaching and facilitated their continual reflection of what they had learned on the course and thus encouraged new knowledge and skills to be put into practice rather than just attending the training session and forgetting about it. Additionally, by encouraging reflective discussions with other Participants this encouraged the networking and experience sharing spoken of earlier:

> "There's been questions and you have to do reflection so it continues after the course" (P2:251-253)

> "The little work booklets [… ] it makes sure that you are still thinking about things and putting them into practice. Rather than just attending the study day and taking all the bits of paper home with you and shoving them in a drawer" (P3:584-589)

> "We're taking it back and we've got little assessments – we can have little reflective discussions with each other. It's making sure it's not just a paper exercise" (P3:589-591)

Secondly, two Participants referred specifically to change in documentation which had been considered as a direct result of their involvement in the CLIC Clinical Skills Programme. For one Participant this could be seen as CPD as they had taken the lead on this:

> "There has to be change [… ] for the better [… ] better documentation [… ] change in policy" (P1:92-94)

> "Pain management again in particular we've re-looked at [… ] documentation [… ] that we have surrounding pain management [… ] I've been leading that at work" (P3:382-386)

Thirdly a change in provision which had occurred for patients as an outcome of the Programme was highlighted by two Participants. One was in connection with annual diabetic foot care checks which had resulted in identifying a person to organise this, whilst the other was in respect of a health education session for pain management which was organised in corroboration with the rehabilitation staff physios and exercise therapists:

> "Did follow up and we found that there was a little bit of a grey area in the care home section as to who actually [… ] does the annual diabetic foot checks. So that was something that we could carry forward and we've managed to get that sorted" (P1: 39-44)

> "There has to be change [… ] for the better [… ] better practice [… ] better resources" (P1:92-94)

> "Also managed to liaise with the rehabilitation staff physios and exercise therapists and we've re-looked at the health education session we do on pain management" (P3:452-453)

The final outcome identified was revalidation which Participants shared mixed feelings about. On the one hand it was seen in a positive light, as an aid to accomplishing revalidation.

> "It all counts to revalidation as well" (P2:228-229)

Whereas, on the other hand, one Participant spoke of it more as a burden where they considered the CLIC Clinical Skills Programme to have been developed purely in order for the registered nurses to be able to complete revalidation. Additionally, they felt that it was something they had no choice over and which had generated additional work which potentially could have been avoided as the courses they already attended would count towards revalidation:

> "The CLIC courses [… ] been brought about because of revalidation" (P5: 733-734)

> "We've got to use any evidence in order to revalidate" (P5:735-736)

> "If it's something we've got to do for revalidation then [… ] we haven't got a choice have we, we've got to do this supposedly to revalidate" (P5:765-767)

"We have a lot of PLT days as well [… ] whether it's CLIC or not [… ] we can use the information towards our revalidation" (P5:784-789)

"It sounds like there's a lot of hard work" (P5:815-816)

#### 4.2.6 Theme Six: Future Vision

Finally, future vision was a key theme which emerged from the data, with all Participants keen to share how they saw the collaboration developing in the future. Primarily, further training was considered as a strong response area although, there was a differing of opinion as to how this would materialise. In the first instance one Participant suggested that they would appreciate any further training which was relevant to the registered nurse role:

"Any further training which is relevant to our role would be welcomed" (P4:684-685)

This was corroborated by another Participant who, whilst also wanting to attend all of the training sessions, described being so drawn into the sessions that they were craving more:

"It sucks you in and before you know it you want to attend all of their training sessions and then we get greedy and we want more" (P1:59-61)

Equally another Participant proposed more generalised further training which was more applicable to conditions people were facing nowadays such as those relating to heart disease or obesity for example:

"Whether there could be some more generalised sessions [… ] that are perhaps relevant today like managing obesity, managing coronary heart disease, OPD" (P3:562-567)

In like manner a further Participant spoke of more specialised training they felt would be beneficial due to the type of care which was presently being required on a more regular basis. For example, being able to care for a patient requiring PEG-feeds would potentially enable that individual to be cared for in a residential rather than hospitalised setting. However again, any relevant further training was advocated as being valuable:

"We're seeing more and more elderly patients with PEG-feeds [… ] so PEG care is another good one which we hoped they would do" (P1:158-161)

> "Talking to colleagues [… ] it's PEG – PEG training [… ] and anything else that we can think of basically" (P1:181-183)

Additionally, further training in the context of follow on courses was alluded to by one Participant. They perceived these to be in stages where stage 1 for example would provide basic relevant information whereas stage 2 would then go on to provide more advanced training for those perhaps dealing with this situation on a regular basis:

> "A follow up course from it [… ] so you could have [… ] step 1 is this course in diabetes, step 2 for [… ] a practitioner that has more involvement" (P5:833-836)

> "Follow on training sessions that were more directed at certain practitioners, depending on what level you are at" (P5:837-839)

In contrast, three of the Participants considered the range of sessions currently available to be adequate for their current needs and did not anticipate further training to become a necessity:

> "At this stage I wouldn't [… ] because I'm newly qualified" (P2:311-314)

> "We've covered quite a good range really" (P3:561-562)

> "I think really what they've done already is probably appropriate" (P3:597-598)

> "The course itself [… ] what we've done has been excellent and we've found very helpful. I don't know where it could be improved really" (P4:687-689)

Conversely, one of these Participants expressed concern about developing the training further as they were anxious that this would lead to further assessments and regular tests for the registered nurses:

> "I'm not sure if it needs improving from what there is already because there's a danger then of going into re-assessments [… ] let's all do a test every year" (P3:593-596)

Secondly, future vision was deliberated from the perspective of modified training. The concept referred to by Participants was around adapting the current Programme in order to cater for differing needs. For example, one Participant suggested expanding the topics currently available, although they recognised that there may be a restriction on this due to the original remit of the CLIC Clinical Skills Programme:

> "Diversifying in topic but obviously not too much because it's got to be on the core skills because that was their aim so they would obviously have to change their aim for that but I think there is a slightly bigger 'core' to the skills – you could add a few more" (P1:207-211)

Similarly, another Participant suggested retaining the current topics but expanding these so as to produce more advanced or in-depth training which they suspected may be more appropriate for those registered nurses who are more experienced and essentially could theoretically retain their attentiveness for longer:

> "I'd imagine that people that have more experience might want more advanced [… ] same subjects but more advanced – more depth" (P2:311-316)

> "If the course had been more adapted to more experienced nurses then they might have got more out of it" (P2:324-325)

Alternatively, it was further suggested by one Participant that they would benefit from having updates to the courses attended rather than these being 'one-offs'. This could potentially link to the earlier proposition of more in-depth learning:

> "I think it would be good to have updates rather than just doing it once and then that's it" (P2:330-331)

Furthermore, it was recognised that the registered nurses participating in the Programme were all at different levels and stages of their career. Therefore, bearing this in mind and in support of the earlier suggestion regarding further training, it was suggested by one Participant that having staged training sessions which were more clearly identified to the professionals prior to their attending a specific course, may avoid individuals being frustrated as a result of feeling the sessions were not appropriate to the learning they felt they needed:

> "Such a variety of people on the course [… ] if they gave [… ] more information on – this course would be suitable for somebody that's [… ] just starting in dealing with diabetic patients or this would be for somebody who is dealing with clinics [… ] a little bit more information about the course [… ] and what's involved" (P5:821-827)

In spite of the above comments, it was clear that the vast majority of the Participants had hugely benefited from being part of the CLIC Clinical Skills Programme, so much so in fact, that training for others was something they felt deserved consideration:

> "Some of our Clinical Assistants [… ] have said [… ] it might be quite useful [… ] for some of the things to go and attend" (P3:545-547)

> "Talking to our Clinical Assistants [… ] we've said "here you are" and they've said "that's really good" perhaps it might be good if we could go to things" (P3:542-552)

Finally training and patient experience transpired as an initial code. It was apparent that Participants were not conscious of patients being aware that they were attending the CLIC Clinical Skills Programme. However, they did believe that regardless of this, patients would have an expectation that they would receive a certain quality of care:

> "That would be for you to ask them but they would obviously not be aware that we are attending these training sessions" (P1:163-165)

> "Ones what have capacity, if asked, there would be an expectation that they would get good care" (P1:165-167)

Although this may be true, and undeniably patients should be receiving the highest quality of care, perhaps the only way to completely understand the impact of the CLIC Clinical Skills Programme on the quality of patient care is to consult the patients themselves:

> "We've not looked at any kind of feedback from patients really related to what we've done on the study days" (P3:532-534)

## 4.3 Summary of Findings

The findings of the Semi-Structured Interviews can be summarised in the following points:

- Programme Qualities were identified as fundamental to the success of the programme. These included: the all-encompassing nature of the Programme; its accessible nature in terms of ease of booking onto courses, free cost and the efficient administration of the Programme. A particular strength of the Programme was the support received from the Programme leader together with flexibility in how this support was provided.

- Education, defined as having the most current knowledge as well as role-specific practical clinical skills, had been gained through involvement in the CLIC Clinical Skills Programme. Arguably, the most important aspect of positive learning to emerge from the data was the impact of the positive learning in respect of the benefit to patient care and practice.

- Communication was seen as a particular strength of the CLIC Clinical Skills Programme. This included rapport between Programme personnel and registered nurses; networking, skill-sharing and dissemination between Practitioners; and in communication with patients with the purpose of providing appropriate knowledge and support, ultimately to ensure best care practice.

- Participants' main concern was the influence of training on Care Provision, which they identified as the need to gain the essential knowledge and skills to ensure patients were given the highest quality of care possible, in line with statutory guidance. The CLIC Clinical Skills Programme was provided a means for both updating the required skills and knowledge, and ensuring that such information was up to date. A consequence of the all-encompassing nature of the CLIC Clinical Skills Programme was that inconsistency in care practice would potentially be minimised, allowing uniformity of care for all patients, whatever the setting.

- Reflection enabled Participants to identify a number of positive outcomes following interaction with the CLIC Clinical Skills Programme. This included acknowledging the uniqueness of the collaboration. The on-going training and development following training sessions reinforced teaching and facilitated continual reflection of course-based

learning and encouraged new knowledge and skills to be put into practice. Additionally, reflective discussions between Participants encouraged the networking and experience sharing.

- A clear future vision emerged with Participants keen to share ideas for how the collaboration could develop. Further training, both generic (to meet general health needs) and specific (contextualised to settings) was identified as needed, with the suggestion that this could be tailored to reflect different levels and stages of career. This included offering staged training sessions, clearly identified to professionals prior to attending a specific course, to avoid individuals being frustrated as a result of feeling the sessions were not appropriate to their role.

# 5 Second Survey Tranche Findings

## 5.1 Introduction

The second survey was completed by 120 Cumbria and North Lancashire based respondents, working across nursing teams, including acute and community hospitals, primary care and community nursing.

Respondents were asked to rate their levels of satisfaction and impact of the training they had received to date and invited to provide further information regarding the benefits of the training received or any personal issues or recommendations for improvement going forward.

Analysis of current satisfactory and impact levels of the training workshops have been analysed based upon mean response rates and comparisons of the following criteria:

- Geographical location of work
- Area of working role

(*Comparisons were not made based on length of time in current post and years since qualified, as there were no significant differences of findings based on these factors*).

## 5.2 Up to Date & Best Practice Skills

Following participation in the Clinical Skills Programme, responses regarding the levels of confidence that the current clinical skills used in day-to-day practice are both up to date and of best practice, showed a high overall, mean level of 8.7. This was an increase from the previous baseline survey which showed an overall, mean level of 7.7.

### 5.2.1 Confidence That Clinical Skills Are Up To Date and Of Best Practice

When analysed in terms of geographical location of work (see Figure 29) a high level of confidence was found across all areas, the lowest level at 8 for Eden and the highest level at 10 for North Lancashire. It is important to acknowledge however, that North Lancashire had the lowest number of respondents to the questionnaire with only one survey respondent which

means the results for this area are not entirely representative and skews the average confidence levels for this particular geographical area.

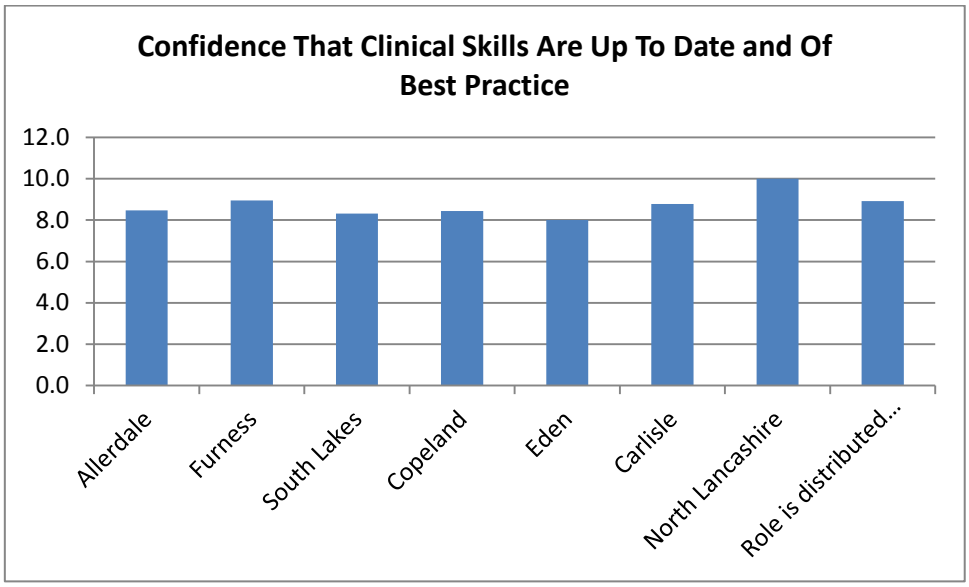


Figure 29: Confidence in Current Skills Based on Location

Analysis of confidence levels based upon place of work (see Figure 30) also showed a high, mean level of confidence across the different settings. The lowest mean level was reported at 8.4 by nursing professionals working both in community nursing and by those who came under 'other' for place of work (generally bank nurses). The highest mean level was reported by nursing professionals based in community hospitals at 9.

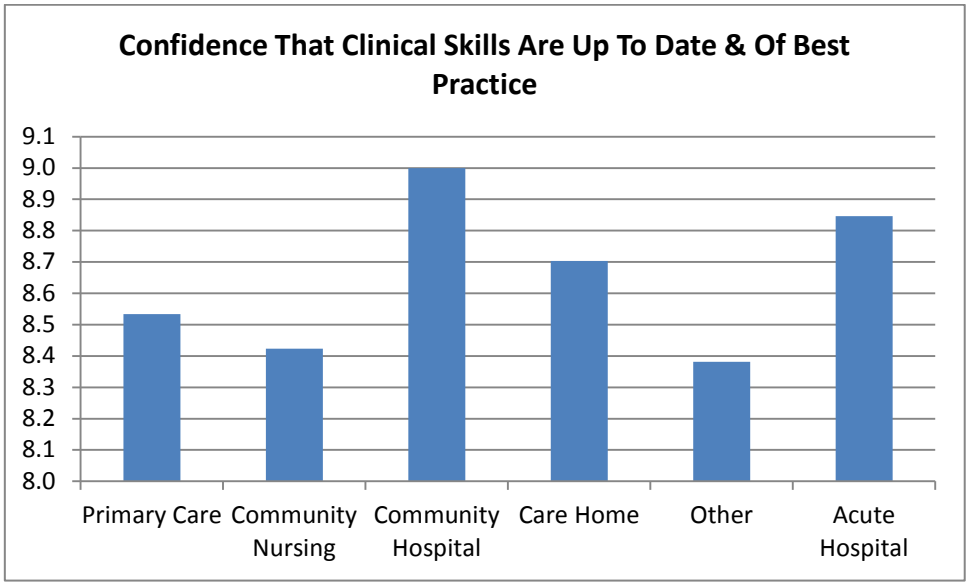

Figure 30: Confidence in current skills based on place of work

### 5.2.2 New Skills Learned & Skill Development

Responses regarding levels of satisfaction post training of new skills learned or developed which made a noticeable contribution to improving provision of care for patients showed a high overall mean level of 8.5. Upon analysis of levels based upon geographical area (see Figure 31), the lowest mean level was reported by those based in Allerdale at 7.5 and the highest again for the one respondent based at North Lancashire at 10. The second highest reported mean was reported by nursing professionals based in Furness with a mean level of 9.

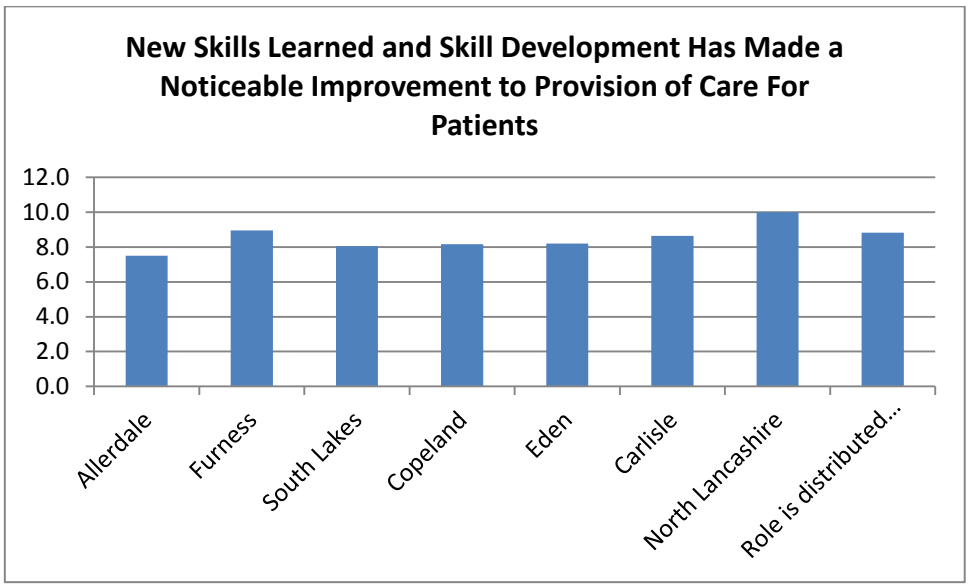


Figure 31: Skills Learned & Skill Development Based on Location

When satisfaction levels were analysed based upon place of work, the lowest levels were reported by those who came under the band of 'other' at 7.7 and those based in community hospitals at 7.8. The highest level of satisfaction levels was reported by those based in acute hospitals at a mean level of 9 (see Figure 32).

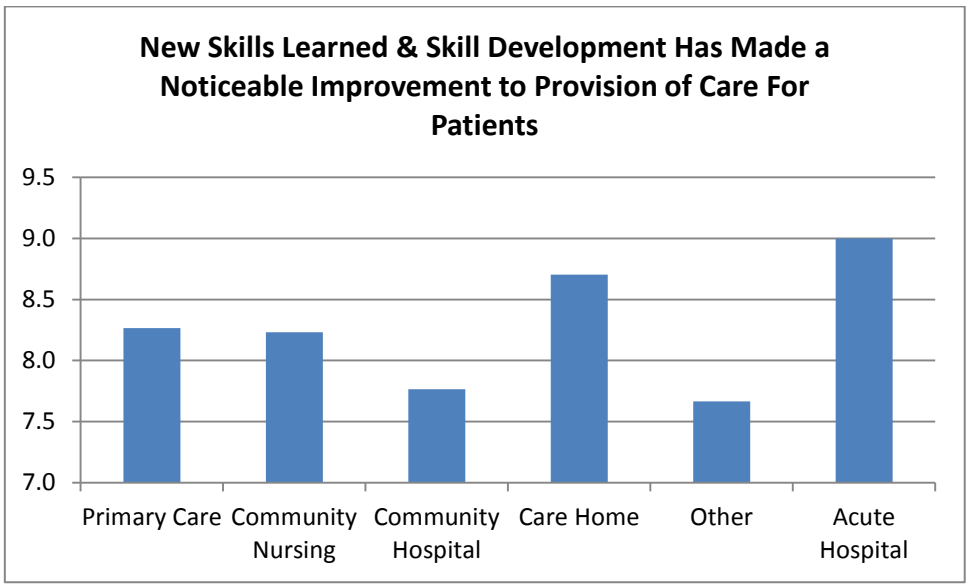


Figure 32: Skills Learned & Skill Development Based on Area of Work

Further information provided by participants indicated that the training provided was successful in consolidating existing skills and improving standards in patient care, as well as increasing confidence levels. There was an emphasis on benefits of the effective interactive methods of teaching used which incorporated both practical and theoretical elements.

The following skills learned were specified by respondents as particularly useful:

- Changes and developments regarding medication
- Enhancement of knowledge regarding pain scales, particularly for nursing professionals treating dementia patients

Respondents who had provided further information regarding low satisfaction levels with acquired skills and skill development based on the training they had received had mainly commented that they had not yet had the chance to apply their new skills as of yet. However, one respondent did comment that they had hoped to learn more about the new drugs used in diabetic treatment but felt they had not been covered in the training they had received.

### 5.2.3 Support From Clinical Skills Nurse Educators

Levels of satisfaction regarding the follow-up support from clinical skills nurse educators showed a good overall mean level of 7.8. Upon analysis of responses based upon geographical areas (see Figure 33), the majority of areas showed a good average level of satisfaction with the highest

level of satisfaction from North Lancashire with a mean satisfaction of 10 and the next highest satisfaction of 8.3 from respondents situated in Carlisle. However, Eden showed a marked lower overall satisfaction mean level of 5.7.

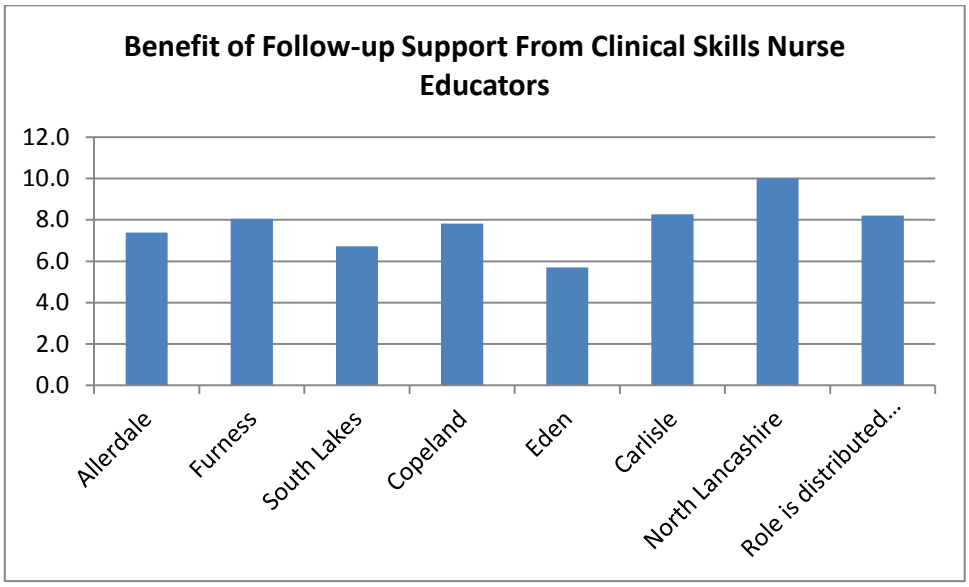


Figure 33: Satisfaction Levels of Support From Clinical Skills Nurse Educators Based on Geographical Area

Response analysis based upon place of work however, showed a consistent good level of satisfaction with the support they had received with the highest level of satisfaction reported by nursing professionals working in primary care settings at 7.7 and the lowest level at 7 for those classed as 'other' eg bank nurses (see Figure 34).

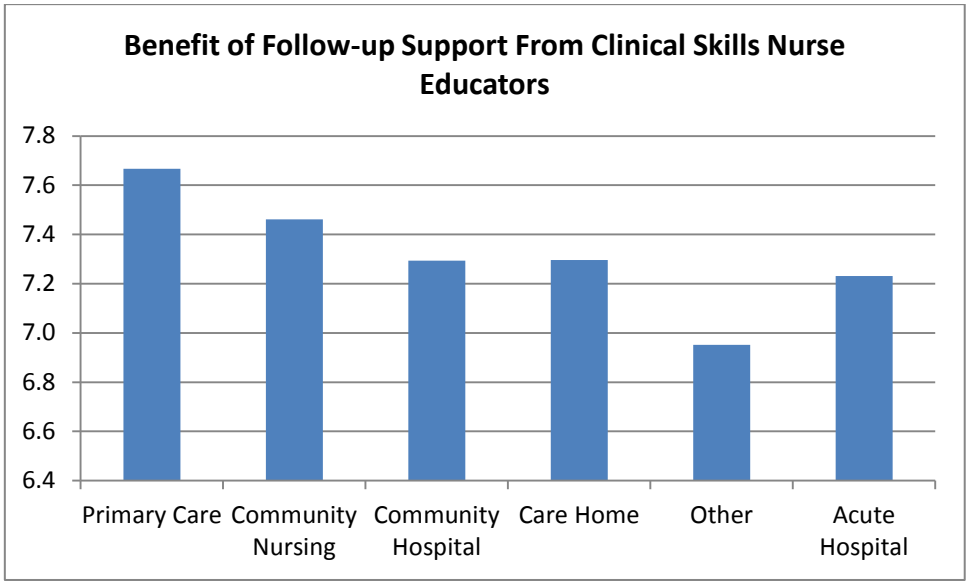


Figure 34: Satisfaction Levels of Support From Clinical Skills Nurse Educators Based on Area of Work

Further information provided by respondents comments were highly positive regarding the useful and supportive nature of having follow-up support from their clinical skills nurse educators, in particular the one-to-one nature of the support which allowed nursing professionals to specify points of concern and areas for further support.

Respondents who had provided further information as to why they had rated lower levels of satisfaction mainly had done so because they had not yet had their follow up meeting. However, the following areas of concern were raised:

- Nursing professionals working nightshifts or in difficult locations had found it difficult to have their one-to-one meetings with their clinical skills nursing educator due to a lack of communication
- Some nursing professionals were yet to receive their feedback despite attempts to contact the appropriate person responsible

Due to the limited number of respondents who provided further comments, the lower levels of satisfaction found in by nursing professionals working in Eden were not supported with sufficient information to accertain why levels were lower for that area. The respondents who had raised points of concern ranged across several geographical areas, which would indicate that there although there is a good average level of satisfaction with the support received, there are still measures to be taken to ensure that all nursing professionals receive follow-up, one-to-one meetings, particularly those with difficult shift patterns or difficult localities and also that the appropriate communication between clinical skills nursing educators and nursing professionals are maintained.

### 5.2.4 Shared Learning & Networking

Respondents reported a high overall mean level of satisfaction of 8.4 regarding the shared learning and networking they had experienced during their training and its impact upon their professional practice.

Responses based on geographical areas (see Figure 35) showed that the strongest level of satisfaction was reported by the respondent from North Lancashire and the second highest level from respondents situated in Furness with a high mean level of 9. The lowest level of satisfaction was reported by respondents from South Lakes at 6.9.

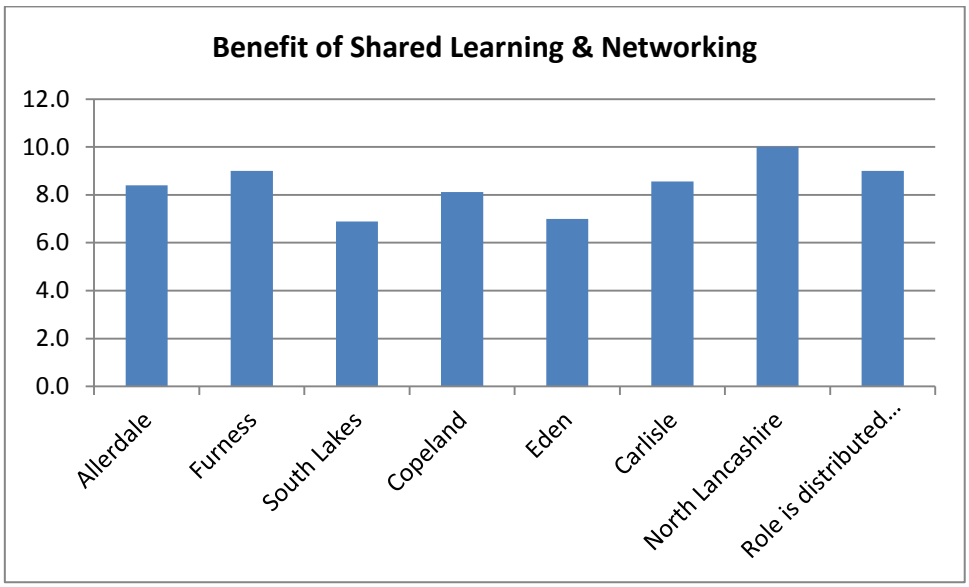


Figure 35: Benefit of Shared Learning and Networking on Professional Practice Based on Geographical Area

The overall level of satisfaction, when analysed in terms of workplace setting, showed a consistent, strong level of satisfaction (see Figure 36). The highest level of satisfaction was reported by nursing professionals working in community hospitals at 9.1 and the lowest level was reported by nursing professionals working in acute hospitals at 7.5.

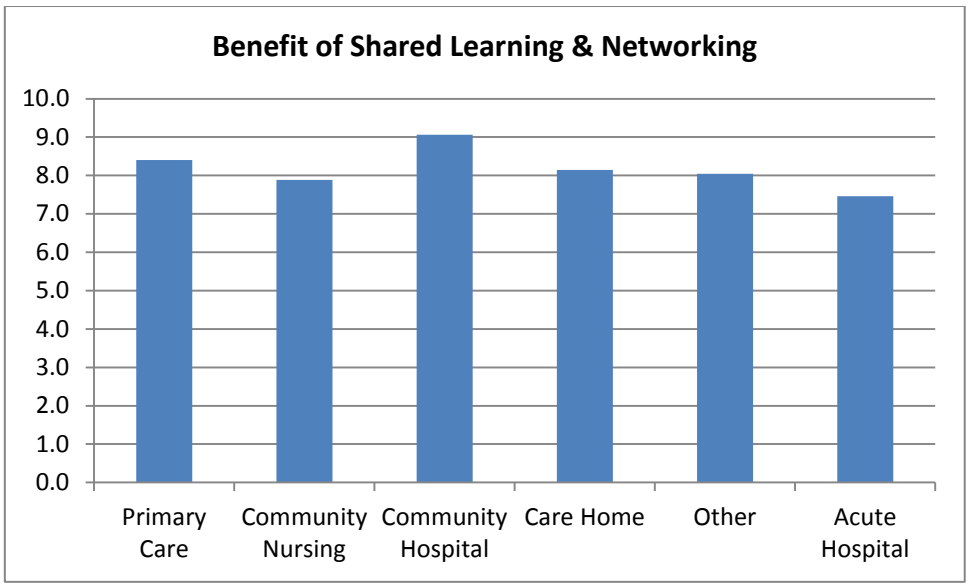


Figure 36: Benefit of Shared Learning and Networking on Professional Practice Based on Area of Work

Further information provided by respondents regarding the benefits of the shared learning and networking they had experienced through training and the positive impact on their professional practice included the following:

- Sharing tips and experiences with other nursing professionals
- Exchanging ideas and thoughts regarding professional practice and procedures with other nursing professionals
- Sharing experiences of difficulties and struggles provided a feeling of support between nursing professionals and also encouraged them to me more attuned to offering support in future to other colleagues
- The ability to learn about each others' professional roles
- Building networks with other nursing professionals

### 5.2.5 Dissemination of Good Practice in the Workplace

Participants reported a high mean level of confidence in their ability to disseminate good practice in the workplace due to the training they had received, with the overall mean level of 8.5.

When responses were analysed in terms of both geographical areas (see Figure 37) and areas of work (see Figure 38) a strong level of confidence was reported across all areas.

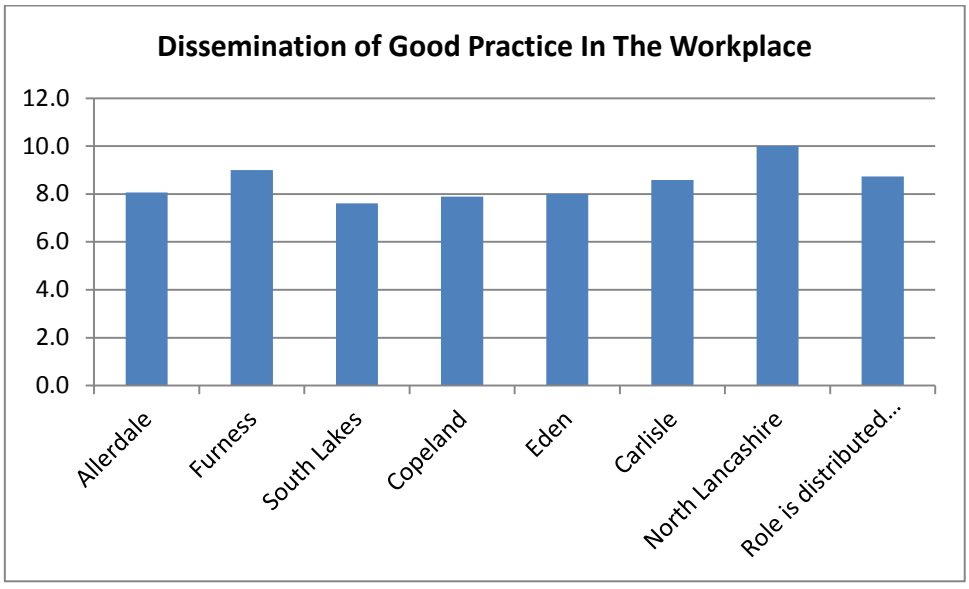


Figure 37: Confidence in Dissemination of Good Practice Following Training Based on Geographical Area

The highest level of confidence was reported again by the respondent in North Lancashire at 10, with the second highest level of confidence reported by nursing professionals working in Furness with a mean level of 9.

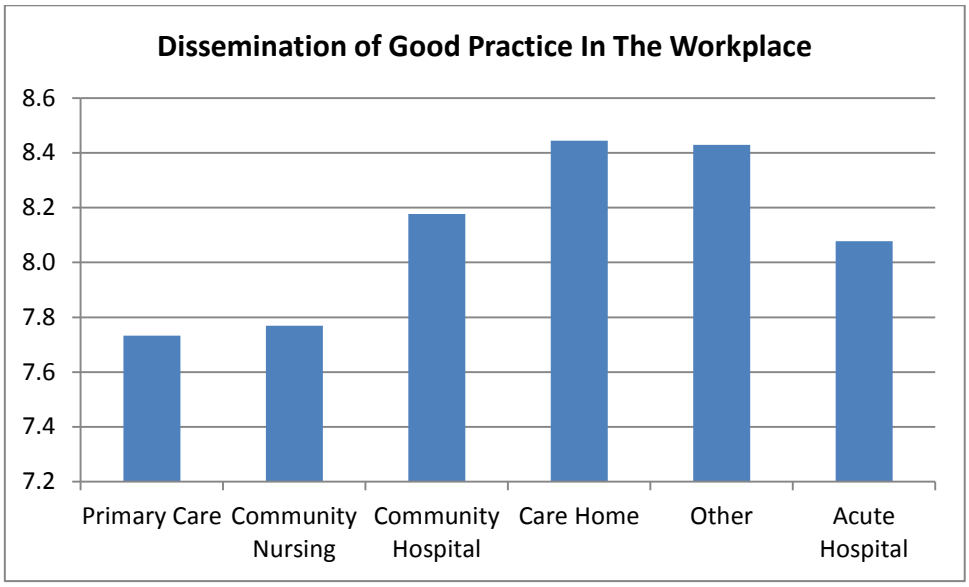


Figure 38: Confidence in Dissemination of Good Practice Following Training Based on Area of Work

The highest level of confidence based on area of work was reported at 8.4 by nursing professionals working in care homes and those classified as other. The lowest level of confidence was reported by nursing professionals working in primary care at 7.7.

Further information provided by respondents provided the following ways in which the training they had received enabled them to disseminate good practice in the workplace:

- Providing useful feedback and information to other nursing professionals on team feedback days
- Helping student nurses with updates on policy
- Enabled nursing professionals within a care home setting to update care support workers
- Enabled nursing professionals to ask the correct questions and provide the correct answers to others

Further responses provided by repondents who had reported low levels of confidence had largely done so as they had not yet had the opportunity to disseminate good practice in the workplace as they had only recently received their training. However, one respondent based in South Lakes who had reported a low level of confidence, stated that they felt there was an opposition to re-learning in their workplace. This may be an area of concern regarding workplace culture, although it is important to note that this was only one respondent and caution should be taken due to the low level of further responses.

## 5.3 Main Benefits of Participation in Training Programme

Respondents were asked to rate what they felt was the main benefit they had experienced from the training they had received. Respondents were asked to rank the following areas between 1-9, where 1 was the most important benefit and 9 the least:

- Ensuring skills and knowledge are current and up-to-date
- Assisting with forthcoming revalidation
- Providing space for reflective discussions on learning and practice
- Follow-up support to develop competence in practice
- Opportunity to share experiences and learning with others
- Motivation to make positive changes to professional practice
- Sharing learning from workshops with colleagues
- Contributing to more holistic care provisions for patients
- Establishing a competency framework to support development


**Figure 39: Benefits of Participation in Training**

- Figure 39 shows the average response to each benefit. In this case, the lower the average score, the more beneficial the statement is ranked by respondents. It was noted by several participants that all were considered benefits, and ranking was a difficult task. This is perhaps reflected in the mean distribution of the rankings, which were very balanced, and did not show many significant trends towards particular benefits.

- Unsurprisingly, given that respondents reported high levels of confidence in the skills and knowledge learned through training previously in the survey, this was rated overall the most important to the participating nursing professionals, and was ranked on average as most important to all nurses regardless of area of work.

- The benefit of the training received on impact of forthcoming revalidation was ranked on average as one of the two most important benefits for nursing professionals under classification of 'other' (mainly bank nursing).

- Based upon responses and information provided earlier in the survey when respondents were questioned regarding satisfaction levels with clinical nurse educators the high satisfaction levels and information provided indicated that the respondents overall had experienced good level of support. This helped develop their competence in practice and gained space for reflective discussions on learning and practice. The motivation to make positive changes to practice was positioned as a strong benefit.

- Based upon responses and information provided earlier in the survey the high levels confidence levels reported regarding dissemination of knowledge and information from the workshops, the training received enabled nursing professionals to share experiences and learning with others. This was reflective in the ranking in which this element of their training was rated as the most benefit to nursing professionals in community nursing and acute hospital settings.

- Contributing to a more holistic care provision for patients was rated as the most beneficial element of the training for nursing professionals working in community hospitals.

- The development of a competency framework to support the nursing professional's development was ranked the lowest on average. This is not to suggest that the framework would be considered unimportant; rather, that there were perceived benefits that spoke more immediately to those participating in the programme.

## 5.4 Summary of Findings

The findings of the second tranche of surveys can be summarised in the following points:

- Improved levels of confidence that current clinical skills used in day-to day practice are both up to date and of best practice due to training. Original baseline survey showed an overall mean confidence level of 7.7, which has increased to a high mean level of 8.7 since training.

- High satisfaction levels were reported regarding new skills learned and skill development on workshops. High levels were consistent both overall and regardless of geographical location or areas of work.
- Training on the newest drugs used in diabetic treatment would be beneficial to incorporate into the relevant workshops provided
- Overall satisfaction levels regarding support from clinical skills nurse educators showed a good overall mean level. Strong levels of satisfaction were found over the majority of geographical areas apart from respondents based in Eden who reported considerably lower levels of satisfaction.
- Appropriate follow-up procedures must be adhered to for support from clinical skills nurse educators to ensure that nursing professionals working in difficult geographical areas or un-sociable shift patterns are not missed
- Strong levels of satisfaction were found for shared learning and networking during training with numerous benefits to nursing professionals' levels of confidence and impact on their professional practice
- A high, overall level of satisfaction was found regarding dissemination of good practice in the workplace
- The main benefit of training for respondents was to ensure the currency of skills and knowledge.

# 6 Conclusion

## 6.1 Introduction

The main aims of this evaluation of the CLIC Clinical Skills Programme were to assess:

- The impact of the Programme on day-to-day practice;
- The extent to which the Programme helped to embed continuous improvement in and across the workplace;
- Whether the Programme was more effective for particular demographics, such as role, age, or locality;
- The distinctiveness of the collaborative approach to training within the Clinical Skills Programme.

In this section, we will present the conclusions of the data analysis in response to these general aims.

## 6.2 Impact

- The qualitative findings express a huge sense of the success of the Clinical Skills Programme in impacting on day-to-day practice, and bringing or maintaining skills as up-to-date.

- The second survey confirmed the qualitative findings, quantifying the improved levels of confidence that clinical skills are up to date and of best practice, with an increase in overall mean from 7.7 to 8.7; a significant improvement, statistically. Overall there were high satisfaction levels with training and support, and with the opportunities for networking, shared-learning and dissemination provided by the Programme. The survey also highlighted the need to ensure that adequate support is provided for professionals working in difficult geographical areas, or working unsociable shift patterns.

- The baseline from the first survey showed that respondents from primary care, care home and acute hospitals showed below average levels of workplace learning impact

(Figure 17, p20). In comparison, the second survey shows all areas have a noticeable improvement to provision of care for patients (deemed to be a priority impact for workplace learning) as a result of participating in the Clinical Skills Programme (Figure 32, p77). Of particular significance, respondents from primary care, care home and acute hospitals show a positive impact, with respondents from community hospitals showing the lowest level.

- The qualitative analysis suggests that involvement in the CLIC Clinical Skills Programme has encouraged participants' educational development. Having access to current knowledge either as a newly qualified or through enhancement of previous learning in respect of the more experienced registered nurse, was repeatedly noted as a key strength of the Programme. Participants noted the link between acquiring the most current knowledge and skills and increasing their confidence in putting these into practice; consequently, ensuring the best care possible was provided for their clients. This is confirmed by the findings from the second survey, which not only reported improved levels of confidence that current clinical skills used in day-to day practice are both up to date and of best practice due to training, but also positioned this as the primary benefit to participating on the Programme itself.

    - Whilst reference to positive learning is obviously reflected strongly within the data, some disappointment was also noted. Ostensibly this seems in the main to be in respect of more experienced Nursing Practitioners who reputed gaining new knowledge to convey into practice. In some ways, this echoes the findings of the baseline survey, which demonstrated that nursing confidence levels increased the longer they had worked in their current post.
    - Again, this was confirmed by the second survey which generated suggestions on how the Programme may be adapted to take account of this.

- It was also apparent from the interview data that generally participants considered the benefit to the patient of paramount importance. In particular, they spoke of spending time deliberating how to put the knowledge and skills learned into practice in order to improve patient care.

- One participant deemed equating training session participation with improved benefit of care to a patient difficult to measure due to the gap in time between attending the course and potentially actually seeing a patient. As the focus group noted, some roles, such as nursing home staff, would encounter patients in markedly different contexts to those in, for example, acute care.
- This difference in regularity of care within context was reflected in the findings from the second survey as, whilst all areas reported a noticeable improvement in provision of care, the most marked improvements were in acute care and care home, where there was likely to be the least gap in time between training and practice.

- The focus group noted how the delivery of training involved highlighting specific gaps in policies, and enabling these to be challenged and filled. Comparing this to findings from the second survey, there was a high, overall level of satisfaction regarding dissemination of good practice in the workplace. Further, the motivation make positive changes to professional practice figured highly as an overall benefit of participation on the Programme, signalling how this training has the potential to inform and contribute to policy development.

- The potential for uniformity of care as a result of the CLIC Clinical Skills Programme being available to registered nurses across Cumbria, was welcomed, with the belief that as a result, any irregularity in care provision had the potential to be minimised.

## 6.3 Continuous Improvement

- The second survey results show a high level of satisfaction with all aspects of the CLIC Programme with regards to continuous improvement of skills and practice; indeed, the main benefit of participating in training for respondents was the ability to build a competency framework to support their development.

- All participants in the semi-structured interviews recognised the need for their knowledge and skills to be up to date and for them to utilise relevant training courses in

order to do this. To this end, the majority of participants acknowledged the CLIC Clinical Skills Programme both as a medium for updating these skills; regardless of number of years' experience; in addition to providing reassurance and instilling confidence in what was being taught was current.

- In spite of this, one Participant still believed the sessions were only reinforcing what the registered nurse should in fact already be up to date with and already putting into practice. This sentiment is not echoed, however, in the findings from the second survey, where the importance of skills ranked highest lowest in the benefits of participation in training (Figure 39, p89).

- The Programme was noted both by interview participants and by respondents to the second survey to be a key tool for achieving revalidation.

- Within the semi-structured interviews, all but one participant felt the topics chosen for the 'core nursing skills' emphasis of the Programme to be totally relevant to their registered nurse role.

    - One participant found them to be nonessential, potentially as a result of being involved in 'in-house' training within their own care setting.
    - Conceivably 'relevance' however may be attributed to the specific care setting in which a registered nurse finds themselves, for example working nights and in that instance, it is recognised that some training may be more relevant than others.

## 6.4 Collaboration

- Collaborative learning was a key aspect of the Programme design. Collaboration is described by Lai (2011, p.2) as a "joint commitment of members in a synchronised attempt to solve an issue reciprocally" or as Dillenbourg (1999, p.1) suggests "circumstances where two or more individuals study or endeavour to learn something jointly". Through a shared 'vision' and development of a 'relationship', it is possible for 'results' to be generated and consequently benefits to be realised (Aaim, 2016). The evaluation

generally showed clear positives to collaborative learning. The qualitative findings showed that participants largely viewed the collaborative aspects of the Clinical Skills Programme optimistically, and considered positive qualities such as its accessibility, the all-inclusive nature for both newly trained in addition to more experienced nurses, alongside the ability to incorporate an audience from a diversity of care settings.

  - Participants noted specifically the more intimate and relatively small group approach offered, together with the efficient administration; especially in respect of pre-course reminders.

- This positive ambience appeared to be predominantly attributable to the high level of course delivery, both in respect of the confident and knowledgeable manner in which the sessions were imparted by UoC staff and Clinical Tutors, but also as a result of the multiplicity and approachability of the speakers. This had resulted in one participant wanting to attend every session available.

- At a strategic level, however, a number of issues were raised by Trainers around the commitment from senior clinicians and the Programme steering group.

- Collaboration in terms of sharing experiences and learning with colleagues and patients, and contributing to a more holistic care provision were identified by survey respondents as major benefits of participating in training. Indeed, contributing to a more holistic care provision for patients was rated as the most beneficial element of the training for nursing professionals working in community hospitals.

- Opportunities for reflective discussions, shared learning and networking during training, dissemination of good practice within the workplace and follow-up support were all identified by survey respondents as positive outcomes of collaboration. In particular, sharing experiences of difficulties and struggles provided a feeling of support between nursing professionals, enabling them to learn more about each other's professional roles.

- Communication was highlighted by the majority of participants as being a noteworthy strength of the Programme. The rapport developed prior, during and on completion of the training sessions was described as excellent and was clearly instrumental in creating

the positive experience described earlier. Likewise, the focus group highlighted how important it was for participants to speak openly, and to feel supported in both bringing their skills up to date (and, if necessary, challenging current practice in their workplace).

- Similarly, the Programme was considered an ideal opportunity for networking, both with the speakers and Programme leaders, but additionally with other nurses from diverse health care settings; enabling valuable experience sharing to be undertaken. Experience sharing was also witnessed 'in-house' through one Participant networking within their own work environment in order to motivate colleagues to attend what they considered a particularly enlightening training session.

- Dissemination of the current knowledge and skills gained through the training sessions was identified in both interviews and focus groups as essential in order to ensure both quality and up to date care provision was made available to patients. Whilst for the most part this dissemination was to fellow nurses, the interviews also identified transference to other professional colleagues, but more importantly in some instances, to patients themselves in order to educate and support them in their care.

## 6.5 Distinctiveness

- A feature that emerged strongly from the interview responses was the appreciation of the level of support the Programme leaders had afforded to them both during the training sessions and more unusually, once the training sessions were complete. Indeed, one or two Participants were keen to share examples of specific support they had received. In particular, the flexibility surrounding the follow up sessions from taking place in the workplace to, for example, a local coffee shop appeared to make the Programme more accessible; especially for those nurses who may be less self-assured.

- Across both sets of qualitative data analysed, the enthusiasm and passion that had emerged from the skills training and its collaborative practice was clearly visible. The contribution of the Programme structure to reducing professional isolation and enabling work across professional boundaries was a key driver to facilitating improvements in day-to-day care practices.

- A key aspect contributing to the uniqueness of the Programme that arose from the interviews was reflection. The reflective sessions provided through the Programme were viewed positively and were considered both an excellent way of reinforcing the learning provided by the training sessions but more importantly, an encouragement in aiding participants to follow through to practice the knowledge and skills gained.

- Both the focus group and interviews suggested that participation in the Programme had initiated both a change in workplace documentation and care provision within health care settings. In this sense, the Programme clearly fulfilled its ambitions of embedding cultural change, at least in some contexts.

## 6.6 Recommendations

Overall the CLIC Clinical Skills Programme has been a great success, achieving its identified aims and generating ideas for further development. The evaluative study has identified the support of the follow-up reflective sessions as excellent, and a first-rate way of encouraging knowledge and skills gained into practice. It is recommended that this rapport is strengthened and continues.

It is difficult to confidently state the extent to which role and locality play a role in delivery, other than to suggest that some areas may find more training or encouragement beneficial. For example, nursing professionals working in difficult geographical areas or un-sociable shift patterns may need extra support; whilst, conversely, those in more established settings, with a well-developed in-house Programme, may require less.

Future provision may consider the diverse career stages of the Participants, modifying the training into 'basic' and 'more advanced' sessions was advocated. A further noteworthy vision which emerged from the data was the prospect of disseminating what was seen as an excellent Programme more widely to include other professional colleagues. This may well occur naturally if the sessions were audience-specific categorised.

At the same time, the potential for uniformity of care the Programme offered was found to be welcomed by Participants, and felt to be a way in which irregularity in care provision could be minimised.

The evaluation project was not able to assess the impact of training on patient experience. Trainers suggested that good practice by nurses would lead to better patient care; but within the interviews, participants were not generally aware of whether their patients were familiar with the fact that they were interacting with the CLIC Clinical Skills Programme and as such. Mapping patient feedback to specific clinical skills would be an area for future evaluation to attend to.

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# Appendix One: Cohort Attendance

| Cohort | Date | Venue | Locality | Course Capacity | Numbers booked on | % of capacity | Number attending | % of capacity | % of those booked actually attending |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 12/01/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 28 | 140% | 23 | 115% | 82% |
| 2 | 22/01/2015 | St, Michael Church, Workington | Allerdale | 20 | 17 | 85% | 16 | 80% | 94% |
| 3 | 02/02/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 26 | 130% | 19 | 95% | 73% |
| 5 | 09/03/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 24 | 120% | 24 | 120% | 100% |
| 6 | 18/03/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 28 | 140% | 15 | 75% | 54% |
| 7 | 13/04/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 24 | 120% | 23 | 115% | 96% |
| 8 | 29/04/2015 | St, Michael Church, Workington | Allerdale | 20 | 35 | 175% | 27 | 135% | 77% |
| 9 | 12/05/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 14 | 70% | 21 | 105% | 150% |
| 10 | 21/05/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 16 | 80% | 14 | 70% | 88% |
| 11 | 05/06/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 25 | 125% | 13 | 65% | 52% |
| 12 | 17/06/2015 | Cumberland Infirmary, Carlisle | Carlisle | 20 | 12 | 60% | 5 | 25% | 42% |
| 1 | 22/06/2015 | Whitehaven Hospital | Allerdale | 20 | 8 | 40% | 7 | 35% | 88% |
| 1 | 26/06/2015 | CLIC Office, Carlisle | Carlisle | 16 | 17 | 106% | 14 | 88% | 82% |
| 2 | 26/06/2015 | CLIC Office, Carlisle | Carlisle | 16 | 13 | 81% | 12 | 75% | 92% |
| 3 | 29/06/2015 | Energus, Workington | Copeland | 16 | 8 | 50% | 6 | 38% | 75% |
| 4 | 29/06/2015 | Energus, Workington | Copeland | 16 | 9 | 56% | 9 | 56% | 100% |
| 3 | 01/07/2015 | CLIC Office, Kendal | South Lakes | 16 | 6 | 38% | 5 | 31% | 83% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 4 | 01/07/2015 | CLIC Office, Kendal | South Lakes | 16 | 13 | 81% | 10 | 63% | 77% |
| 6 | 10/07/2015 | Millom | Furness | 16 | 9 | 56% | 9 | 56% | 100% |
| 7 | 13/07/2015 | Alston Hospital | Eden | 16 | 5 | 31% | 4 | 25% | 80% |
| 1 | 15/07/2015 | St Mary's, Ulverston | South Lakes | 25 | 25 | 100% | 22 | 88% | 88% |
| 3 | 27/07/2015 | Cockermouth Hospital | Allerdale | 25 | 15 | 60% | 8 | 32% | 53% |
| 5 | 27/07/2015 | CLIC Office, Carlisle | Carlisle | 16 | 16 | 100% | 12 | 75% | 75% |
| 6 | 27/07/2015 | CLIC Office, Carlisle | Carlisle | 16 | 11 | 69% | 8 | 50% | 73% |
| 10 | 31/07/2015 | Whitehaven Hospital | Allerdale | 25 | 5 | 20% | 2 | 8% | 40% |
| 13 | 18/06/2015 | Barrow | Carlisle | 20 | 21 | 105% | 12 | 60% | 57% |
| 9 | 02/10/2015 | Workington Hospital | Allerdale | 16 | 17 | 106% | 10 | 63% | 59% |
| 10 | 02/10/2015 | Workington Hospital | Allerdale | 16 | 16 | 100% | 8 | 50% | 50% |
| 18 | 10/08/2015 | Carlisle UoC | Carlisle | 25 | 15 | 60% | 12 | 48% | 80% |
| 12 | 14/08/2015 | Barrow, Furness General | Furness | 25 | 7 | 28% | 5 | 20% | 71% |
| 7 | 21/08/2015 | WCH, Whitehaven | Copeland | 16 | 7 | 44% | 5 | 31% | 71% |
| 8 | 21/08/2015 | WCH, Whitehaven | Copeland | 16 | 11 | 69% | 4 | 25% | 36% |
| 13 | 24/08/2015 | Newton Rigg, Penrith | Eden | 25 | 16 | 64% | 14 | 56% | 88% |
| 9 | 24/08/2015 | Cockermouth Hospital | Allerdale | 16 | 10 | 63% | 3 | 19% | 30% |
| 10 | 24/08/2015 | Cockermouth Hospital | Allerdale | 16 | 12 | 75% | 8 | 50% | 67% |
| 14 | 07/08/2015 | West Cumberland Hospital, Whitehaven | Copeland | 15 | 13 | 87% | 12 | 80% | 92% |
| 15 | 07/09/2015 | Grange Over Sands | South Lakes | 25 | 25 | 100% | 11 | 44% | 44% |
| 11 | 16/10/2015 | CLIC, Kendal | South Lakes | 16 | 16 | 100% | 15 | 94% | 94% |
| 12 | 16/10/2015 | CLIC, Kendal | South Lakes | 16 | 16 | 100% | 11 | 69% | 69% |

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|---|---|---|---|---|---|---|---|---|---|
| 19 | 21/09/2015 | Furness General, Barrow | Furness | 25 | 12 | 48% | 8 | 32% | 67% |
| 7 | 24/09/2015 | Newton Rigg, Penrith | Eden | 25 | 22 | 88% | 15 | 60% | 68% |
| 1 | 25/09/2015 | WCH, Whitehaven | Copeland | 20 | 15 | 75% | 7 | 35% | 47% |
| 2 | 25/09/2015 | WCH, Whitehaven | Copeland | 20 | 10 | 50% | 8 | 40% | 80% |
| 6 | 28/09/2015 | Kendal | South Lakes | 25 | 24 | 96% | 15 | 60% | 63% |
| 13 | 19/10/2015 | Keswick Hospital | Allerdale | 16 | 7 | 44% | 5 | 31% | 71% |
| 14 | 19/10/2015 | Keswick Hospital | Allerdale | 16 | 8 | 50% | 5 | 31% | 63% |
| 3 | 02/10/2015 | Hindpool Community Centre, Barrow | Furness | 20 | 19 | 95% | 15 | 75% | 79% |
| 4 | 02/10/2015 | Hindpool Community Centre, Barrow | Furness | 20 | 18 | 90% | 14 | 70% | 78% |
| 7 | 05/10/2015 | St Mary's, Ulverston | South Lakes | 25 | 27 | 108% | 16 | 64% | 59% |
| 2 | 06/10/2015 | CLIC Office, Carlisle | Carlisle | 25 | 27 | 108% | 8 | 32% | 30% |
| 21 | 12/10/2015 | WCH, Whitehaven | Copeland | 25 | 26 | 104% | 12 | 48% | 46% |
| 5 | 13/10/2015 | CLIC Office, Carlisle | Carlisle | 20 | 11 | 55% | 8 | 40% | 73% |
| 6 | 20/10/2015 | Jubilee House, Penrith | Eden | 20 | Cancelled | 0% | Cancelled | | |
| 15 | 03/09/2015 | West Cumberland Hospital, Whitehaven | Allerdale | 20 | 24 | 120% | 17 | 85% | 71% |
| 15 | 14/12/2015 | CLIC Office, Carlisle | Carlisle | 16 | 19 | 119% | 13 | 81% | 68% |
| 16 | 14/12/2015 | CLIC Office, Carlisle | Carlisle | 16 | 19 | 119% | 9 | 56% | 47% |
| 13 | 16/10/2015 | WCH, Whitehaven | Copeland | 25 | 11 | 44% | 5 | 20% | 45% |
| 8 | 19/10/2015 | CLIC Office, Carlisle | Carlisle | 25 | 28 | 112% | 16 | 64% | 57% |
| 17 | 07/08/2015 | Risedale, Barrow | Furness | 16 | 18 | 113% | 12 | 75% | 67% |
| 18 | 07/08/2015 | Risedale, Barrow | Furness | 16 | 11 | 69% | 10 | 63% | 91% |
| 7 | 20/10/2015 | Jubilee House, Penrith | Eden | 20 | 14 | 70% | 14 | 70% | 100% |
| 8 | 10/11/2015 | Furness General, Barrow | Furness | 20 | 26 | 130% | 21 | 105% | 81% |
| 15 | 22/10/2015 | Health Centre, Grange | South | 25 | 19 | 76% | 17 | 68% | 89% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Lakes | | | | | | |
| 19 | 18/09/2015 | WCH, Whitehaven | Copeland | 16 | 11 | 69% | 8 | 50% | 73% |
| 20 | 18/09/2015 | WCH, Whitehaven | Copeland | 16 | 10 | 63% | 7 | 44% | 70% |
| 16 | 15/10/2015 | WCH, Whitehaven | Allerdale | 20 | 23 | 115% | 14 | 70% | 61% |
| 10 | 02/11/2015 | Gillinggate Centre, Kendal | South Lakes | 25 | 26 | 104% | 19 | 76% | 73% |
| 1 | 03/11/2015 | Botcherby Community Centre, Carlisle | Carlisle | 20 | 14 | 70% | 11 | 55% | 79% |
| 2 | 03/11/2015 | Botcherby Community Centre, Carlisle | Carlisle | 20 | 17 | 85% | 10 | 50% | 59% |
| 3 | 04/11/2015 | Jubilee House, Penrith | Eden | 20 | 9 | 45% | 5 | 25% | 56% |
| 4 | 04/11/2015 | Jubilee House, Penrith | Eden | 20 | 3 | 15% | 2 | 10% | 67% |
| 17 | 09/11/2015 | WCH, Whitehaven | Copeland | 20 | 23 | 115% | 15 | 75% | 65% |
| 11 | 09/11/2015 | Cockermouth - Kirkgate | Allerdale | 25 | 37 | 148% | 25 | 100% | 68% |
| 14.1 | 09/11/2015 | Jubilee House, Penrith | Eden | 25 | 22 | 88% | 18 | 72% | 82% |
| 16 | 10/11/2015 | Energus, Workington | Allerdale | 25 | 17 | 68% | 3 | 12% | 18% |
| 9 | 10/11/2015 | Furness General, Barrow | Furness | 20 | 25 | 125% | 22 | 110% | 88% |
| 10 | 01/12/2015 | CLIC Office, Carlisle | Carlisle | 20 | 23 | 115% | 16 | 80% | 70% |
| 5 | 11/11/2015 | Thursby Parish Hall | Allerdale | 20 | 5 | 25% | 3 | 15% | 60% |
| 6 | 11/11/2015 | Thursby Parish Hall | Allerdale | 20 | 9 | 45% | 6 | 30% | 67% |
| 21 | 13/11/2015 | Newton Rigg, Penrith | Eden | 16 | 18 | 113% | 14 | 88% | 78% |
| 22 | 13/11/2015 | Newton Rigg, Penrith | Eden | 16 | 13 | 81% | 9 | 56% | 69% |
| 12 | 16/11/2015 | WCH, Whitehaven | Copeland | 25 | 21 | 84% | 14 | 56% | 67% |
| 23 | 16/11/2015 | Cleator Moor Health Centre | Copeland | 16 | 12 | 75% | 5 | 31% | 42% |
| 24 | 16/11/2015 | Cleator Moor Health Centre | Copeland | 16 | 7 | 44% | 6 | 38% | 86% |
| 11 | 20/11/2015 | Risedale, Barrow | Furness | 16 | 9 | 56% | 4 | 25% | 44% |
| 12 | 20/11/2015 | Risedale, Barrow | Furness | 16 | 10 | 63% | 8 | 50% | 80% |

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|---|---|---|---|---|---|---|---|---|---|
| 14 | 23/11/2015 | Newton Rigg, Penrith | Eden | 25 | 18 | 72% | 13 | 52% | 72% |
| 3 | 24/11/2015 | Wigton Hospital | Allerdale | 25 | 23 | 92% | 15 | 60% | 65% |
| 13 | 27/11/2015 | Newton Rigg, Penrith | Eden | 16 | 25 | 156% | 20 | 125% | 80% |
| 14 | 27/11/2015 | Newton Rigg, Penrith | Eden | 16 | 24 | 150% | 14 | 88% | 58% |
| 22 | 30/11/2015 | St Mary's, Ulverston | South Lakes | 25 | 24 | 96% | 15 | 60% | 63% |
| 11 | 01/12/2015 | CLIC Office, Carlisle | Carlisle | 20 | 24 | 120% | 17 | 85% | 71% |
| 23 | 13/10/2015 | CLIC Office, Carlisle | Carlisle | 20 | 7 | 35% | 5 | 25% | 71% |
| 18 | 03/12/2015 | WCH, Whitehaven | Copeland | 20 | 25 | 125% | 14 | 70% | 56% |
| 4 | 03/12/2015 | Sedbergh Medical Centre | South Lakes | 25 | 10 | 40% | 6 | 24% | 60% |
| 20 | 07/12/2015 | Risedale, Barrow | Furness | Cancelled due to floods | | | Cancelled due to floods | | |
| 17 | 07/12/2015 | CLIC Office, Carlisle | Carlisle | | | | Cancelled due to floods | | |
| 25 | 30/10/2015 | Furness General, Barrow | Furness | 16 | 8 | 50% | 6 | 38% | 75% |
| 26 | 30/10/2015 | Furness General, Barrow | Furness | | Cancelled | | Cancelled | | |
| 5 | 14/12/2015 | Gillinggate Centre, Kendal | South Lakes | 25 | 32 | 128% | 17 | 68% | 53% |
| 7 | 15/12/2015 | Jubilee House, Penrith | Eden | 20 | 10 | 50% | 3 | 15% | 30% |
| 8 | 15/12/2015 | Jubilee House, Penrith | Eden | 20 | 14 | 70% | 6 | 30% | 43% |
| 23 | 11/01/2016 | Energus, Workington | Allerdale | 25 | 25 | 100% | 17 | 68% | 68% |
| 19 | 13/01/2016 | WCH, Whitehaven | Copeland | 20 | 22 | 110% | 18 | 90% | 82% |
| 1 | 13/01/2016 | CLIC Office, Carlisle | Carlisle | 20 | 15 | 75% | 9 | 45% | 60% |
| 2 | 13/01/2016 | CLIC Office, Carlisle | Carlisle | 20 | 22 | 110% | 13 | 65% | 59% |
| 9 | 14/01/2016 | Risedale, Barrow | Furness | 20 | 15 | 75% | 11 | 55% | 73% |
| 10 | 14/01/2016 | Risedale, Barrow | Furness | 20 | 25 | 125% | 17 | 85% | 68% |
| 24 | 18/01/2016 | CLIC Office, Carlisle | Carlisle | 25 | 38 | 152% | 28 | 112% | 74% |

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|---|---|---|---|---|---|---|---|---|---|
| 8 | 19/01/2016 | Risedale, Barrow | Furness | 25 | 35 | 140% | 21 | 84% | 60% |
| 3 | 20/01/2016 | Whitehaven Golf Club | Copeland | 20 | 17 | 85% | 10 | 50% | 59% |
| 4 | 20/01/2016 | Whitehaven Golf Club | Copeland | 20 | Cancelled | 0% | cancelled | | |
| 12 | 25/01/2016 | WCH, Whitehaven | Copeland | 20 | 20 | 100% | 11 | 55% | 55% |
| 13 | 25/01/2016 | WCH, Whitehaven | Copeland | 20 | 18 | 90% | 11 | 55% | 61% |
| 25 | 01/02/2016 | Cockermouth Community Hospital | Allerdale | 25 | 23 | 92% | 11 | 44% | 0.47826087 |
| 26 | 08/02/2016 | Gillinggate Centre, kendal | South Lakes | 25 | 17 | 68% | 13 | 52% | 0.764705882 |
| 27 | 08/02/2016 | CLIC Office, Carlisle | Carlisle | 16 | 19 | 119% | 17 | 106% | 0.894736842 |
| 28 | 08/02/2016 | CLIC Office, Carlisle | Carlisle | 16 | 16 | 100% | 14 | 88% | |
| 11 | 09/02/2016 | Whitehaven Golf Club | Copeland | 20 | 20 | 100% | 9 | 45% | 45% |
| 12 | 09/02/2016 | Whitehaven Golf Club | Copeland | 20 | 7 | 35% | 3 | 15% | 43% |
| 13 | 10/02/2016 | Risedale, Barrow | Furness | 20 | 22 | 110% | 19 | 95% | 86% |
| 14 | 10/02/2016 | Risedale, Barrow | Furness | 20 | 11 | 55% | 7 | 35% | 64% |
| 9 | 11/02/2016 | Cockermouth Hospital | Allerdale | 25 | 32 | 128% | 18 | 72% | 56% |
| 5 | 15/02/2016 | Furness General, Barrow | Furness | 20 | 18 | 90% | 11 | 55% | 61% |
| 6 | 15/02/2016 | Furness General, Barrow | Furness | 20 | 24 | 120% | 16 | 80% | 67% |
| 14 | 18/02/2016 | Newton Rigg, Penrith | Eden | 20 | 27 | 135% | 25 | 125% | 93% |
| 15 | 18/02/2016 | Newton Rigg, Penrith | Eden | 20 | 26 | 130% | 17 | 85% | 65% |
| 15 | 22/02/2016 | Newton Rigg, Penrith | Eden | 16 | 16 | 100% | 12 | 75% | 75% |
| 16 | 22/02/2016 | Newton Rigg, Penrith | Eden | 16 | Cancelled | 0% | cancelled | | |
| 27 | 23/02/2016 | Risedale, Barrow | Furness | 25 | 28 | 112% | 21 | 84% | 75% |
| 7 | 24/02/2016 | Newton Rigg, Penrith | Eden | 20 | 23 | 115% | 13 | 65% | 57% |
| 8 | 24/02/2016 | Newton Rigg, Penrith | Eden | 20 | 10 | 50% | 8 | 40% | 80% |
| 6 | 25/02/2016 | WCH, Whitehaven | Copeland | 25 | 26 | 104% | 12 | 48% | 46% |
| 17 | 25/02/2016 | CLIC Office, Carlisle | Carlisle | 16 | 16 | 100% | 9 | 56% | 56% |
| 18 | 25/02/2016 | CLIC Office, Carlisle | Carlisle | 16 | 8 | 50% | 8 | 50% | 100% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 19 | 26/02/2016 | St Mary's, Ulverston | South Lakes | 16 | 11 | 69% | 4 | 25% | 36% |
| 20 | 26/02/2016 | St Mary's, Ulverston | South Lakes | 16 | Cancelled | 0% | cancelled | | |
| 9 | 29/02/2016 | Thursby Parish Hall | Allerdale | 20 | 8 | 40% | 4 | 20% | 50% |
| 10 | 29/02/2016 | Thursby Parish Hall | Allerdale | 20 | 12 | 60% | 8 | 40% | 67% |
| 15 | 01/03/2016 | Energus, Workington | Allerdale | 20 | 22 | 110% | 9 | 45% | 41% |
| 16 | 01/03/2016 | Energus, Workington | Allerdale | 20 | 31 | 155% | 11 | 55% | 35% |
| 1 | 03/03/2016 | CLIC Office, Carlisle | Carlisle | 20 | 24 | 120% | 20 | 100% | 83% |
| 29 | 04/03/2016 | Newton Rigg, Penrith | Eden | 16 | 17 | 106% | 11 | 69% | 65% |
| 30 | 04/03/2016 | Newton Rigg, Penrith | Eden | 16 | 15 | 94% | 11 | 69% | 73% |
| 31 | 07/03/2016 | Risedale, Barrow | Furness | 16 | 18 | 113% | | 0% | 0% |
| 32 | 07/03/2016 | Risedale, Barrow | Furness | 16 | 16 | 100% | | 0% | 0% |
| 2 | 08/03/2016 | Newton Rigg, Penrith | Eden | 20 | 7 | 35% | 7 | 35% | 100% |
| 3 | 15/03/2016 | WCH, Whitehaven | Copeland | 20 | 14 | 70% | | | |
| 1 | 15/03/2016 | Quaker Tapestry, Kendal | South Lakes | 60 | 39 | 65% | | | |
| 28 | 21/03/2016 | Newton Rigg, Penrith | Eden | 25 | 30 | 120% | | | |
| 2 | 21/03/2016 | CREA, Penrith | Eden | 60 | 42 | 70% | | | |
| 18 | 23/03/2016 | CLIC Office, Carlisle | Carlisle | 25 | 30 | 120% | | | |
| 4 | 24/03/2016 | St Mary's, Ulverston | South Lakes | 20 | 10 | 50% | | | |
| 29 | 11/04/2016 | St Mary's, Ulverston | South Lakes | 25 | 25 | 100% | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | **3092** | **2646** | 86% | **1637** | 53% | 62% |

# Appendix Two: Focus Group Schedule

**Verbal Introduction**

The CLIC Clinical Skills Programme represents a different approach to education and training by working collaboratively and co-operatively with partners across health and social care in Cumbria and the University of Cumbria to build trust and communication across nursing teams, improve networks and opportunities for learning, develop common core nursing skills and improve the quality of patient care.

For this focus group, we are interested in how the Programme has had an effect on practice in the short- and intermediate- term following the training courses themselves. We are looking to hear about your own experiences of seeing the effects and impacts of the training on practitioners.

**Questions**

1. In what ways have you found this Programme to be new, different or distinctive from previous clinical skills training, or similar initiatives?

2. Based on your experience so far, what would you say are the main strengths of the programme?
    - Are any specific strengths of the Programme agreed by participants?
    - Are there any points of disagreement, based on individual's experiences?
    - How has this affected patient experience, do you think?

3. Much of the delivery of the Programme aims for positive impacts on working practices. What, for you, counts as 'impact', in this context?
    - What does the 'impact' of training look like? How do you recognise it in a practitioner's work?

4. Thinking about impacts on practice: would you say that the Programme has had more effect on particular groups of practitioners that others?
    - E.g. length of time nurses have been qualified, type of practice, etc.

5. What do you think the effect of the collaborative aspect of the Programme has been?
    - Was this successful?
    - Has the focus on 'core nursing skills' made the training more, or less, relevant to practitioners?
    - How has this aspect affected patient experience?

6. What areas of the Programme would you like to see further developed or improved?
    - E.g. content of training
    - E.g. structure of training (in terms of how it is carried forward beyond the initial training sessions)

# Appendix Three: Semi-Structured Interview Schedule

**Verbal Introduction**

The CLIC Clinical Skills Programme represents a different approach to education and training by working collaboratively and co-operatively with partners across health and social care in Cumbria and the University of Cumbria to build trust and communication across nursing teams, improve networks and opportunities for learning, develop common core nursing skills and improve the quality of patient care.

For this interview, we are interested in how the Programme has had an effect on practice in the short- and intermediate- term following the training courses themselves. We are looking to hear about your own experiences of seeing the effects and impacts of the training on your practice.

**Questions**

1. Based on your experience so far, what would you say are the main strengths of the Programme?
    - General strengths (across many participants)?
    - Specific strengths (for the individual practitioner)?
    - Have these strengths affected or related improved patient experience, do you think?

2. In what ways have you found this Programme to be new, different or distinctive from previous clinical skills training, or similar initiatives?

3. Much of the delivery of the Programme aims for positive impacts on working practices. What, for you, counts as 'impact', in this context?
    - What does the 'impact' of training look like?
    - How do you recognise it in your own work?
    - How do you think other's might see the impact of the training in your work?

4. Thinking about impacts on practice more generally: would you say that the Programme is likely to have more effect on particular groups of practitioners that others?
    - E.g. length of time nurses have been qualified, type of practice, etc.

5. What do you think the effect of the collaborative aspect of the Programme has been?
    - Was this successful?
    - Has the focus on 'core nursing skills' made the training more, or less, relevant to you as a practitioner?
    - How has this aspect affected patient experience?

6. What areas of the Programme would you like to see further developed or improved?
    - E.g. content of training
    - E.g. structure of training (in terms of how it is carried forward beyond the initial training sessions)