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1. Executive Summary

This report forms a summary output of research conducted by DJS Research in conjunction with Chesterfield Royal NHS Foundation Trust (Chesterfield) in the first half of 2018.

The research is designed to examine feedback on the “Team around the Patient” workforce transformation initiative in place at Chesterfield Royal NHS Foundation Trust since 2016, with a view to identifying and sharing key lessons learned.

In line with the national context of increasing pressure on nursing staffing throughout the NHS in England, Chesterfield faced the reality of 90 unfilled vacancies for Registered Nurses (RNs) at its most critical time. Unable to recruit sufficient Nurses to fill positions and increasingly reliant on agency staff, Senior Nursing Management at the Trust, devised and implemented a transformational workforce initiative starting in 2016.

The “Team around the Patient” initiative will result in the transformation of 85 band 5 roles into band 4 roles over a two year period. Already staffing ratios are being maintained on the majority of shifts through internal resourcing, and the use of agency Nurses has fallen from an average fill rate of 46% to 30%.

The work at Chesterfield reveals a series of key learnings:

- The implementation of transformational workforce initiatives should be managed over a number of years through pilot phases and staged delivery
- The transition to new ways of working may be met with a series of obstacles, which can be broadly defined as practical versus perceptive issues
- Practical obstacles include issues relating to time management, staffing and training amongst others and can be overcome by maintaining a flexible approach to implementation that can allow systems and processes to adapt to requirements as they emerge
- Perceptive issues are less tangible and may relate to issues such as misunderstandings, role conflict, anxieties over job security, and working relationships amongst others
- Perceptive issues are often harder to identify and thus manage, but clear and constant communication opportunities and channels appear key to tackling these obstacles, as such communications management throughout a transformation programme (rather than just at the start) is critical to success.
2. Context:

2.1 National Context

In January 2018, NHS Digital published its latest paper on NHS Vacancy Statistics based on the evolution between 2015 and 2017 in the NHS Vacancies survey. The figures revealed that there was, at the time, just over 28,000 FTE vacancies across the NHS in England, and that vacancies in the Nursing and Midwifery staff group accounted for 40% of the shortfall.

In responding to the figures, Janet Davies, General Secretary of the Royal College of Nursing, commented to The Guardian that the report revealed “an NHS desperately short of Nurses”.

The NHS Digital report goes on to reveal that some 33,500 Nurses had left the service in the period 2016-2017, 3,000 more than had joined, and 20% more than in a comparable period 2012-2013.

With increased numbers leaving the service, and difficulties recruiting new talent, reports state across England as a whole, only one in seven empty nursing posts was filled in 2017.

In response, The Department of Health and Social Care has said staffing is now a priority and more money needs to be invested in the frontline, with the then Health Secretary, Jeremy Hunt, promising more training and student places in the future.

NHS Employers has been working to support employers seek and recruit more staff, with Danny Mortimer, Chief Executive of the organisation, highlighting that employers were working “especially hard” to recruit and retain more Nurses.

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3 https://www.bbc.co.uk/news/health-40715955
4 https://www.bbc.co.uk/news/health-40715955
5 https://www.bbc.co.uk/news/health-40715955
2.2 Organisational context

As North Derbyshire’s only acute district General Hospital, Chesterfield Royal NHS Foundation Trust, is responsible for providing care and treatment to more than 400,000 people.

The hospital has 570 beds across 20 wards covering a large variety of care areas, including paediatrics, surgical and 24-hour emergency care.

At present, the hospital has over 3,700 staff in total, but filling Nursing posts remains challenging.

At its most critical, Chesterfield had 90 vacancies for Registered Nurses (RNs)

Where necessary, the hospital like many others, relies on agency and bank Nurses to maintain staffing ratios and also uses Healthcare Assistants to support the wards.

Ultimately unable to fill sufficient band 5, RN posts, a team was put in place at Chesterfield to consider alternative staffing models and moved to the implementation of a workforce transformation initiative: “Team around the Patient” (TAP).
2.3 “Team around the Patient”: brief introduction

Historically, agency and bank nursing staff had been used at Chesterfield Royal to maintain staffing ratios, but the financial impact of this practice had become unviable long-term and led the hospital to consider a more sustainable approach to delivering care on its wards.

In early 2016, Chesterfield Royal embarked on a programme of workforce transformation, known internally as “Team around the Patient.”

The initiative constitutes a change to the skills mix on wards, and aims to re-think staffing by building a team based on the needs of the patient, with the skills required to administer the care they need: “Team around the Patient”.

The initiative sees the established RN staffing principle reinforced by the introduction of new band 4 support roles, namely the Assistant Practitioner and Nursing Associate roles, whilst also integrating the wider registered multi-professional Team eg. Occupational Therapists and Pharmacists. Healthcare Assistants also remain on the wards.

Practically, the aim is to redistribute care activity between job roles, matching tasks to staff skill-sets rather than job titles. The intention is to have skilled staff on wards who can bridge the gap between the RN and the HCA. This means a task that an RN does not necessarily need to carry out, but that a HCA cannot do, can be delegated to an intermediary level member of the Team i.e. an Assistant Practitioner or a Nursing Associate.

Furthermore, ultimately the skills mix would include working with Allied Health Professionals in a similar way, exploring which care tasks can be integrated into their work with patients.

The initiative has been piloted at Chesterfield Royal on 6 adult in-patient wards: 3 Surgical and 3 Medical.

The goal is to transform 85 band 5 (RN) roles into Band 4 roles over a 2-3 year period.

Thus far since March 2016, a total of 58 trainees have embarked on training to become either an Assistant Practitioner (AP) or a Nursing Associate (NA), attending university and studying alongside their work on the wards.
Recognising that a new staffing model would require a cultural, as well as a structural change for the wards involved, the team leading the “Team around the Patient” (TAP) initiative was keen to ensure that all staff were involved in the process from the outset⁶.

Group sessions were held for Ward Matrons initially and information was cascaded down to the wider Team who were encouraged to attend open forum sessions. Figure 2 below provides a brief overview of the initial development and communication of the initiative.

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6 Case study: Using Band 4 roles to build a "Team around the patient. NHS Employers
2.4 Training roles: brief introduction

The “Team around the Patient” initiative is structured around the introduction of new skilled band 4 roles on the wards in the form of either the Assistant Practitioner or the Nursing Associate role.

Starting with the introduction of trainee Assistant Practitioners in 2016, Chesterfield Royal is now employing trainee Nursing Associates, introduced as part of a pilot in 2017.

To date, Chesterfield has put a total of 58 staff into training roles as follows:

- 28 trainee Assistant Practitioners in 2016
- 10 trainee Nursing Associates in 2017
- 20 trainee Nursing Associates in 2018

There are some notable differences between the two roles, indicated below.

<table>
<thead>
<tr>
<th>Assistant Practitioner (AP)</th>
<th>Nursing Associate (NA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In training for 2 years</td>
<td>In training for 2 years</td>
</tr>
<tr>
<td>Become Band 4 upon completion of training</td>
<td>Become Band 4 upon completion of training</td>
</tr>
<tr>
<td>Remain at Band 2 for first 12 months of training</td>
<td>Start training at Band 3</td>
</tr>
<tr>
<td>Not regulated</td>
<td>Regulated by the NMC</td>
</tr>
<tr>
<td>Does not administer medications currently</td>
<td>Administers medications</td>
</tr>
</tbody>
</table>

Figure 3: Table outlining the steps involved in becoming an assistant practitioner or nursing associate
3. Research method

3.1 Research aim

This research has been undertaken by DJS Research in conjunction with Chesterfield Royal NHS Foundation Trust (Chesterfield).

DJS Research (DJS) is an independent market research company and was engaged to provide an:

- Independent evaluation of the “Team around the Patient” workforce transformation initiative at Chesterfield Royal NHS Foundation Trust.

3.2 Research objectives

The research programme was designed to inform the overarching aim and key objectives, from a variety of perspectives.

Specifically, objectives included:

- Understanding motivations for the implementation of the workforce transformation initiative, both at an organisational level, and in terms of perceived purpose from the workforce point of view
- Identifying any fears and anxieties that may exist in relation to the initiative, both before, during and after implementation
- Understanding how the initiative has been implemented
- Exploring to what extent staff have feel engaged in the process
- Identifying any challenges in implementation
- Identifying the impact of the initiative, on staff, on patients, on the delivery of care
- Considering areas for continued improvement during Chesterfield’s ongoing implementation
- Establishing a set of best practice recommendations for the implementation of similar initiative in other NHS organisations
3.3 Research methodology and sample

Methodology
Given the difficulties associated with engaging with patients directly (including permissions, length of stay, illness, data protection), the research focussed on staff at Chesterfield.

A total of 21 tele-depth discussions were conducted with members of staff involved directly or indirectly in the workforce transformation initiative. This included staff from a range of levels, from Band 2 Healthcare Assistants, to Clinical Educators and Senior Nursing staff.

Interviews took place: 19th April – 19th June 2018 and each lasted approximately 30 minutes.

Recruitment and participation
A letter was produced to inform potential participants of the research process and to generate interest in taking part. The letter clearly explained the purpose of the exercise and the practical parameters, including the right to anonymity and data protection.

The sample was drawn from those involved directly or indirectly in the initiative, based on pilot wards where the development has been implemented.

The sample also included a number of non-ward-based potential participants such as Senior Nursing staff and Educators.

A representative of Chesterfield provided a list of interested parties from which a selection was interviewed.

Participants were reassured at the start of each interview with regards the confidential nature of the exercise and how their comments and contributions would be used – anonymously.

Accordingly, quotations used throughout this report are anonymised and redacted in parts where identifying elements may remain.
Sample

A respondent breakdown is provided in Table 1.

<table>
<thead>
<tr>
<th>Job role</th>
<th>Band</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nursing Management</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Educators</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>5/6</td>
<td>5</td>
</tr>
<tr>
<td>Trainee Nursing Associates</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trainee Assistant Practitioners</td>
<td>2/3</td>
<td>1</td>
</tr>
<tr>
<td>Assistant Practitioner (Qualified)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Healthcare Assistants</td>
<td>2/3</td>
<td>3</td>
</tr>
<tr>
<td>Other (Discharge Coordinator)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>21 interviews</strong></td>
</tr>
</tbody>
</table>

Please note:

For the purposes of maintaining anonymity,

- Senior Nursing Management and Clinical Educators are combined and referred to as “Delivery Team” for the purposes of verbatim attribution
- Discharge Coordinator is referred to as HCA for the purposes of verbatim attribution
- Trainee Nursing Associates are referred to as TNA for the purposes of verbatim attribution
- Assistant Practitioners in training and qualified are both referred to as Assistant Practitioners (AP) for the purposes of verbatim attribution
4. Research Findings

The following chapter outlines the research findings drawn from views and opinions of participants included in the research.

4.1 The need to transform the workforce

Understanding the reasons for implementing the “Team around the Patient” initiative at Chesterfield Royal.

Summary: Trust objectives are well defined and Senior Management unified in their vision of the “Team around the Patient” initiative. There is some discrepancy between organisational objectives and objectives as perceived by the wider clinical workforce on the pilot wards, and some (limited) negative interpretation, which may result from miscommunication.

The context for the introduction of the “Team around the Patient” workforce transformation is clearly outlined above, with particular reference to unfilled Nurse vacancies at Chesterfield.

Those involved in the introduction and implementation of the development, at an organisational level, i.e. Senior Nursing Staff and Clinical Educators share a clearly defined and unified vision of the initiative’s purposes and aims:

“Just because they are not a trained practitioner, doesn’t mean that we can’t upskill them…and allow them to augment the nursing workforce and stop the need for having agency staff”

*Delivery Team*

“We knew we wanted to do something around career development for our support staff”

*Delivery Team*

“The motivation was high agency spends, the fact that they haven’t got any Nurses to fill the vacancies and…looking at ways we could provide the most appropriate care that was the driver behind it really”

*Delivery Team*

“It’s about getting people to work as a team, trying to bring staff morale up a bit”

*Delivery Team*
Members of the team leading implementation clearly understand and support the rationale behind the development.

**Their strategic vision centres on:**
- Addressing unfilled RN roles
- Reducing the number of agency staff used
- Improving staff morale
- Improving patient experience
- Providing opportunities and career paths for HCAs

Clinical Educators also place particular emphasis on opportunities for HCAs already employed at the Trust, considering the “TAP” initiative a “win-win” situation; where current staff members can progress professionally, and the Trust can gain from existing knowledge both clinical and familiarity with wards and working practices.

Some of the strategic aims so clearly identified and supported by the Delivery Team, are also recognised by the wider senior staff working on pilot wards, in particular:
- Reducing the use of agency staff
- Providing opportunities for HCAs

There is, on the other hand, little direct reference to the specific need to fill RN vacancies, or any allusion to the difficulty of doing so amongst the wider workforce on pilot wards; the assumption tends more towards the Trust having *decided* not to fill these vacancies with RNs rather than it being practically impossible to do so. This view is particularly prevalent amongst RNs.

It is possible however, that this perception is driven by the previous on-ward experience of having rota that are being filled.
RN staff members are more likely to interpret the TAP initiative as being designed primarily to improve patient experience, particularly in terms of reducing discharge times (not an area specifically highlighted at an organisational level).

Nursing staff also recognise the potential for positive impact on team working and staff morale.

“We’re trying to improve the patient’s experience as well as staff morale”

RN, Band 5

“I had been looking after a patient and he got discharged, he knew my mum and bumped into her and said I was a credit to her. Knowing that I’m doing my job right is great”

AP, Band 3

“It can promote discharge times and people picking up nasty infections because they don’t need to be here”

TNA, Band 3

I hope it’s about the bigger picture and all about providing better patient care, having happy patients and happy staff

RN, Band 5

There is some evidence of less positive interpretation of the Trust’s motivations for implementing the initiative, mainly from RN staff who are the most likely to be negative towards the development initially.

Their main concerns include:

- Believing the initiative is part of a wider scheme to make the RN job role more office-based and less practical. The idea of a more office-based role is unattractive to many.

- Feeling that the development is a way of creating cheap labour and cutting costs by replacing RNs with Band 3/4 staff (less costly to employ) and moving HCAs up a band but still paying them less.

“At some point, the RNs will become less on the ward, doing the bed heads, audits, staffing meetings, the behind the scenes stuff. I like being on the shop floor, it’s why I became a Nurse but if that is taken away, then I will be looking for a new career completely because it’s not something I want”

RN, Band 5

“We basically do everything a staff nurse does and we get paid less. A lot of staff Nurses have been really negative. They started off really positive about it and as time has gone and the role has been adapted to include things like, medication, they’re getting tetchier...We are here to take a bit of stress away from the Nurse. Not take their job but just to fill the gaps because we haven’t got enough nursing staff”

TNA, Band 3
Whilst strong negative perceptions of the initiative’s aims are, in fact, limited, there is the widespread opinion that after initially being introduced and communicated, there has been little ongoing communication or updated information about the initiative.

This apparent lack of ongoing communication may go some way to explaining any apparent disparity between the “organisational” objectives (so clearly defined by the Senior Team) and the objectives as perceived by the wider Clinical Team; HCAs in particular often remain unclear about the stated objectives of the initiative, and therefore some lack of cohesion in terms of vision is revealed.

4.2 Introducing alternative workforce initiatives:

Understanding how “Team around the Patient” (TAP) was presented and received.

Summary: Despite efforts from the Trust to engage staff and proactively “head off” negative perceptions, some barriers to the development exist from the outset. In most cases, these concerns are borne of anxieties over change (“change fatigue”) and personal job security, rather than active disapproval of the initiative itself.

Initial introduction of the TAP initiative

Upon launching the TAP initiative, the Trust organised in-person “Team day” meetings designed to be interactive sessions to encourage engagement with the new way of working across roles and levels. The sessions included activities such as “job role mapping”, identifying all the skills at each level and considering how these could be “mixed” horizontally across roles to maximise the delivery of care, with the patient at the heart of the structure.

The meetings were also designed to provide the opportunities for staff to raise concerns and questions, with the aim of allowing for reassurance over any concerns or preconceptions they may have had.

Staff members at all levels continue to reference these sessions frequently, and found them useful.
As anticipated, a number of concerns and anxieties do emerge amongst staff at the early stage of introduction.

- There was noted scepticism from some more experienced, more senior Nurses who had been at the Trust longer and show signs of “change fatigue”. They struggled to engage with the initiative and were least likely to be positive at the initial stages, believing it was “yet another flash in the pan scheme” making them more resistant to the change and potentially difficult to engage.

- Clinical staff question what the impact on the quality of care will be and some considered the initiative to be the latest in a series of steps taken that are leading to the nursing profession being deskillled.

- Of the different elements of the initiative, the aspect that causes most confusion and reticence is perhaps the inclusion of Allied Health Professionals – this feels like more of a “conceptual stretch” for many who failed to grasp the proposed way of working. Furthermore, there is some reported negativity from the OTs and PTs themselves, who, according to the Nursing workforce, are reluctant to become involved in more generalised care tasks, and unwelcoming of what they perceive to be a change in status from a relatively “independent” worker to being more part of the care Team.
The most significant source of unease at the inception of the TAP initiative comes from the “middle level”; there is palpable **anxiety from RNs** at Band 5 and 6, focussed on a number of different areas:

- Perceived increased workload for RNs resulting from having to conduct their own duties, as well as mentoring / overseeing trainees, and conducting duties that trainees cannot do independently (e.g. administer medications).

- A perception that RN time is in demand from a proliferation of learners seeking opportunities and support including Student Nurses, Trainees, Junior Doctors etc.
  - *For context, Chesterfield did increase its number of student Nurses significantly in September 2017, meaning that there would indeed have been more learners in the working environment.*

- Some RNs recently qualified, consider that the move to a shorter, paid training opportunity to arrive at Band 4, to be a little unfair or even “downgrading” of their own university studies (re. the 3 year nursing degree).

- There is clear evidence of job anxiety at RN level, with a suspicion from some that APs and TNAs are being primed to ultimately take over the job of the RN, which would eventually be phased out.

> **“Our priorities are side-lined. We’re mentoring students more and we’re just side-lined a little bit more from the end goal we’re trying to reach”**  
> **RN, Band 5**

> **“They could just come and get a job in Healthcare and go to university for a year and basically get the same qualification (as a Nurse) which kind of makes a mockery out of everything, as far as I’m concerned, for those of us who have actually gone off and done what they were supposed to do”**  
> **RN, Band 5**

> **“If you’re the Nurse in charge, you don’t generally run your own Team. You attend ward rounds, you speak to social services, you deal with tissue viability, all the referrals and everything else. Now, they’ve got the added pressure of having to oversee an AP, because they want them to do medication. It can become very stressful”**  
> **RN, Band 5**

In implementing the initiative, the Trust recognises the model is “in progress” and that the new ways of working and new roles are emergent. The Leadership Team acknowledges resulting ambiguity and aims to adapt as required to mitigate uncertainties and anxieties.
4.3 Implementing alternative workforces

Understanding how the “Team around the Patient” initiative was put into action and navigated.

Summary: Chesterfield has adopted a flexible, adaptable approach to transforming its Nursing workforce, identifying and resolving obstacles throughout the process with a focus on finding solutions to practical, implementation issues.

How it works: training

The training structure for the trainee Assistant Practitioner (AP) and trainee Nursing Associate (TNA) as part of the “Team around the Patient” initiative broadly operates as follows:

- The trainees attend university 1 day per week which covers theoretical content
- Private study is also conducted in trainees’ own time
- The APs and TNAs undertake a mix of working and learning on their home ward
- Practical experience is gained on the home ward, in placements and from learning opportunities overseen by RNs, Senior Nurses and Clinical Educators
- TNA’s spend 1 day per week in placement (ie, a minimum of 675 hours over 2 years)
- APs and TNAs undertake clinical skills training delivered by the Clinical Educators
- Competencies are assessed by Clinical Educators and ward supervisors

How it works: staffing

Staffing protocol has been adapted on the pilot wards to accommodate the new roles:

- Once initial training is complete and required competencies met, APs and TNAs are rostered to a ward and included in staffing numbers, usually within 6-8 months of commencing their training, but it depends on individuals
- Allied Health Professionals are shared between wards and tasked with incorporating everyday care tasks into their interactions with patients (e.g. taking a patient to the bathroom)
- A further pilot scheme is in place whereby an additional trained AP / TNA is included in numbers on night shifts across two wards that have a similar patient population. In this instance, the member of staff is added to numbers rather than being counted within numbers.
How it works: communications and support

Chesterfield has recognised the importance of communication throughout the change implementation and put in place a structure for knowledge and information sharing.

Senior Matrons are able to feed back to the TAP leads in strategic meetings, and then feed information back to Matrons in Operational meetings. Matrons then conduct ward meetings where it is expected they will inform Ward staff of developments and discuss any issues relating to TAP. There are also regular catch up sessions for those band 3 staff in training and Educators are available for staff to speak to if they have any issues. The university also holds catch up sessions with the trainees.

Newsletters also include information about the initiative and there have been a number of newsletter focussing on TAP.

Figure 5: Diagram showing how information is relayed down to staff on the wards

In practice: overcoming practical obstacles encountered

The “Team around the Patient” initiative has been in progress for over 2 years in various stages of development and Chesterfield continues to consider it a “model in progress”.

Challenges emerge at different stages of deployment, and Chesterfield adapts and develops the initiative where possible to maximise implementation and overcome obstacles.

In practice, a series of practical or functional challenges exist (or have existed), experienced differently according to the stage in the process, or role.
**Practical obstacles and solutions:** The nature of the AP training role

1. A significant problem for most on the wards is the lack of ability of APs to administer medication. Nurses feel their time is disrupted by APs who need a Nurse to administer medication to their patient and APs would also like the ability to administer medications to their own patients. The fact that, when qualified, TNAs will be able to administer medication is a potential cause of tension between the roles and is thought to impact on the way the different trainees are treated and perceived by colleagues.

- Chesterfield has acknowledged this and has negotiated additional training to ensure that all APs complete the same module as TNAs to allow them to be able to administer medication.

2. In a similar way, the difference in the registration status of the qualified AP and NA causes tension, namely the fact that the AP is not a regulated role. RNs feel that they are accountable for the actions of the AP and that any incident caused by an AP would ultimately result in a sanction for the Nurse in Charge, to the extent that they fear losing their PIN. The APs firmly believe that the Nurse in Charge is not accountable for their actions, and there is evidence of this difference in perception having been a source of tension on the wards.

- The Nurse in Charge is, in fact, not accountable for the actions of the AP any more than they are accountable for the actions undertaken by any staff member under their supervision. Chesterfield does not consider there to be a legitimate risk of an RN losing their pin for this reason.

> "Yes, I know some of the Assistant Practitioners start doing their meds training next month I think so, it will be better then. You can spend an hour in the morning doing your own meds without doing somebody else's”

**RN, Band 5**

> "That's why I'm on a register for the accountability of it, but if it comes to the point where they're going to be doing the medications without any kind of supervision, there needs to be that accountability there. They can't just turn around and say that the Nurse in Charge is ultimately responsible because these people aren't registered”

**RN, Band 5**

> "With them not being regulated, it's going to fall to the Nurse. We can't watch them 24/7, we're too busy...If they make a mistake that's quite significant, it's going fall to the Nurse and it's going to be their PIN that's on the line...They might get a slap on the wrist or whatever, but ultimately it will be the Nurses responsibility and they'll be the ones who take the fall”

**RN, Band 5**

> "We take the responsibility and the accountability for that job role, or that specific task. A lot of Nurses feel that they're still accountable for us and they will lose their PIN number if we make a mistake, but that's not the case”

**AP, Band 4**
Practical obstacles and solutions: Trainees

1. Trainees have struggled to achieve learning goals during work time, on shift. There are increasing numbers of learners coming onto wards, all seeking opportunities. Contrary to student Nurses who are not counted in the staffing numbers, most APs / TNAs on wards are working as part of a team, so it can be challenging for them to take the time to observe or practice skills. Historically, Matrons could allow for additional, supernumerary time for APs on a discretionary basis.

2. It is widely acknowledged that it is difficult for trainees to manage time studying, working and attending university; though those on the course are aware of this before commencing. It is felt to be worse at the beginning of the process when trainees are ‘finding their feet’ but tends to ease further into training. It is assumed that the training roles are not appropriate for those with young families for these reasons. Indeed, a number of HCAs declare that they would not take on the training roles due to the perceived pressure and stress on APs and TNAs.

   • The course is indeed an intensive, full-time course, covering 3,000 hours over a 2 year period.
   • There has been speculation in the past as to whether the course could be offered on a part-time basis by the universities, though this has not been progressed at this time.

   “I know my friends have all done it and all been successful but they have all been very stressed with the academic work of it and time management. I am just happy doing my care job”
   
   HCA, Band 3

   “I’d say that it’s a good opportunity to do if you’ve got the time to do it. I’m not at the minute no because I’ve got two young kids both under five, so there’s no time for that”

   HCA, Band 3

Practical obstacles and solutions: Registered Nurses (band 5+):

1. RNs of band 5 or more, feel their workload has increased since “Team around the Patient” was put in place and ultimately feel they spend less time with the patient. They spend more time overseeing their own team and the AP or the TNA – especially for the tasks they cannot do unsupervised (e.g. administering medications). There is a perception that RNs have been asked to take on more responsibility with little acknowledgement.
As part of the introductory sessions on the initiative, Chesterfield demonstrated how skills and tasks could be mixed up horizontally with the aim of each professional being best deployed to undertake a task. Where an RN is required to complete a task for a trainee, the aim is for the trainee to complete a different task, so that all tasks are completed across roles.

2. Registered Nurses sometimes have a **limited understanding** of what tasks TNAs and APs are able to complete as they progress through their training. There is a perception that the acquired competencies evolve quickly and without transparency. This leads to RNs being unconfident in allowing trainees to complete a task.

Chesterfield has provided trainees with a competency pack clearly defining which tasks they can perform. In many instances, the RN will have overseen, or even signed off a trainee’s competency themselves.

As well as practical obstacles encountered, there are also challenges that arise from more perceptive, emotive issues. In particular, Registered Nurses tend to raise concerns of this nature.

**Perceptive obstacles and solutions:**

1. There is evidence of some **role conflict** between trainees and some Registered Nurse colleagues, borne from preconceptions outlined below, including:

   - The perception that they lack the fundamental knowledge base of students and Registered Nurses mainly because they have not studied as long at university. Even though they may have spent a long time on the wards they lack the theoretical knowledge behind the tasks they are performing.

   "I was hoping for a little bit more support on the wards, nobody really understands the role. The course itself has been really interesting and I’ve learnt a lot but most of the challenges have been on the ward with people not understanding what to do with us and how our role works”
   
   **AP, Band 3**

   "I think it needs to be, those doing it know what they’re doing but I don’t know what they’re doing. I don’t know who’s accountable to who, where the book stops at the end of the day, what exactly they can do in terms of experience and gaining experience. It’s all a bit woolly”
   
   **RN, Band 5**

   "Sometimes they can be a little bit aggressive and uptight about what they allocate to you, they’ll say ‘well I’m accountable for you’ but they’re not, we’re accountable to ourselves”
   
   **AP, Band 3**

   "I think education on the difference in the roles and what the nursing practitioners can do would really be of benefit. So, people understand that we are here to take a little bit of stress away from the Nurses, not to take their job but just to fill the gaps because we haven’t got enough nursing staff”
   
   **AP, Band 3**
• The perception that it is ‘deskilling’ and ‘disrespecting’ the nursing workforce to ask those who are “less qualified” to conduct similar tasks to Registered Nurses.

There are examples of band 3 trainees feeling that they were not accepted by their colleagues, especially in the initial stages of implementation.

2. There is the sense that there are now a lot of opportunities for HCAs but **little opportunity and acknowledgement for RNs** who feel they are doing more work for the same pay. This can lead some RNs to feel particularly dissatisfied and disregarded.

3. The RNs describe **continued anxiety and stress** generated by their perceived heightened accountability for the APs. Trainees describe tensions arising from this perception and request more support and understanding from their colleagues.

4. RNs appear to feel **disenfranchised from the process** to the point where some claim to be unclear what the training roles are and unable to explain or barely comment on the “Team around the Patient” initiative.

• Chesterfield has largely relied upon the Matrons to cascade the information down to ward staff, but it appears that this may have been enacted with mixed results.

It should also be noted that there have been few recorded challenges linked to patients directly, and whilst there are one or two examples of patient confusion resulting from the number of different roles, the general consensus is that patients prioritise competent care above all and have been satisfied throughout the process.
4.4 Impact of alternative workforce initiatives

Understanding to what extent “Team around the Patient” has achieved its original aims.

**Summary:** By transforming its workforce, Chesterfield certainly appears to be making progress to resolving its staffing shortages and has established a clear career path for band 2 professionals, and it has done so whilst maintaining quality standards and patient experience. Staff morale at the middle level remains delicately balanced however, with some role conflict and anxiety remaining.

Chesterfield’s primary aim was to improve things for their registered nurses by ensuring there was enough staff on all shifts on the pilot wards, while at the same time reducing the use of costly agency staff. Furthermore, it sought to achieve stability in team structures and provide a career progression route for band 2 staff.

**Positive impact**

Practically speaking, by converting the band 5 roles, Chesterfield has been able to recruit sufficient trainees, and those now qualified at band 4, to cover all shifts on the pilot wards. Indeed, figures provided by the Trust demonstrate that the use of agency staff has reduced significantly in the time period of the pilot. Furthermore, staff turnover has also decreased.

<table>
<thead>
<tr>
<th>Period</th>
<th>Agency fill</th>
<th>Sickness</th>
<th>Turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/16 – 31/03/17</td>
<td>45.7%</td>
<td>4.65%</td>
<td>12.02%</td>
</tr>
<tr>
<td>01/04/17 – 31/03/18</td>
<td>30.4%</td>
<td>4.97%</td>
<td>9.61%</td>
</tr>
</tbody>
</table>

There has been no recorded increase in harms recorded on any of the pilot wards and no perceptible change in quality standards against other measures.

**Staff members themselves now recognise the practical benefits of the TAP initiative, specifically citing:**

- Limited use of agency staff
- Staffing numbers covered on all shifts
- Patient discharge times reduced
Therefore, staff identify additional, less tangible, positive impacts of the initiative, including:

- Improved team working and understanding of each other’s roles
- Examples of TNAs / APs who want to continue to do a full nursing qualification
- Widespread praise and empathy for trainee colleagues, despite initial scepticism

Despite obstacles encountered and the ongoing process to overcome them, it should be noted that individuals now speak very highly of individual trainees. There appears to be admiration for the work that they are doing and recognition of the challenges they also face.

In terms of its stated aims, Chesterfield has been largely successful. However, despite positive feedback and perceived impact, it does appear that there is a vulnerability at the “middle level” with RNs feeling disengaged with the initiative and still harbouring anxieties around personally motivated concerns such as job security.

4.5 Embedding alternative workforces

Considering lessons learned and ideas for continued development of “Team around the Patient” at Chesterfield.

Summary: Chesterfield continues to seek ways to maximise the “Team around the Patient” initiative and having honed practical implementation, can now focus on ensuring continued staff engagement across roles.

As Chesterfield begins to work with the first fully qualified trainees and launches its next round of trainee Nursing Associates, it continues to reflect on lessons learnt and areas for continued improvement as the initiative enters establishment stage.

A number of questions can be posed at this stage:
Perceptive issues, though less tangible and harder to identify, can potentially have long-lasting effects on staff and ultimately damage morale.

➔ How can the focus be shifted from resolving practical implementation challenges (e.g. supernumerary time, staffing) to monitoring and resolving less-tangible issues such as role conflict or job security anxieties?

There is a risk that the RN workforce is becoming disengaged from the initiative, their work and colleagues, and ultimately, patients.

➔ How can Chesterfield dispel dissatisfaction at the RN level and ensure that this core workforce remains engaged with the initiative and their wider work?

There is a risk that incorrect information and “Chinese whispers” circulate amongst staff, which can perpetuate dissatisfaction and anxiety.

➔ How can Chesterfield ensure that communication is maintained throughout the process, and throughout the workforce?

Staff on the wards identify ideas for improving the implementation of the development, and most of these revolve around requests for improved communication:

1. Ensure communication and updates are maintained throughout the process rather than just front-loading engagement, providing regular updates and seeking to gain feedback from staff on the wards as to how the development is working in practice.

2. Ensure communication focuses on RNs who see themselves as most impacted by the new changes to roles on the wards. There is the perception that if RNs are engaged, this will impact staff morale and team building on wards.

“I’m not sure, I’d say it’s more about the staff morale. I think in a way sometimes, it is putting more pressure on Nurses when we’re working with the trainee associates. They have their own patients but we’re still having to do their medication and things, as well taking our own Team”

RN, Band 5

“Hit and miss but again that could be a change for some people, I mean nobody was negative towards the role, that helps but you can see that there were some people not agreeing with it but they didn’t try and block it anyway”

AP, Band 4
3. Ensure engagement specifies *why* the initiative is being implemented - there is a lack of awareness that it is not possible to fill band 5 roles.

4. RNs, HCAs and other staff also struggle to explain what the organisational motivations are behind the development. Therefore outlining this early will help staff to understand the reasons why the changes are necessary and aid transparency between senior staff and staff on the wards.

Indeed, improved, ongoing communications would seem to be a clear route to tackling a number of the residing issues, especially less tangible ones.

The current structure of cascading information about the TAP initiative through Matrons at weekly ward meetings seems insufficient – many staff members claim to have heard nothing about the initiative since the Team Day meetings.

Indeed, the interactive “Team Days” held at the start of the process were very popular, and remembered as a positive exercise by almost all.

Chesterfield should consider how it can maximise communication and a sharing culture on the pilot wards moving forwards, with the aim of dispelling residual concerns.

*For consideration to improve communication:*

- Further full ward “Team Day” sessions positioned as “Reviewing TAP so far”
  - Reiterate processes and structures e.g. what APs and TNAs can and cannot do
  - Work on explaining skills mix working again i.e. if an RN needs to cover a task on an AP / TNA’s Team, then what task can that AP / TNA take from the RN?

- Meetings / sessions just with RNs
  - Focus on unpicking issues around accountability, job anxiety
  - Potentially consider using external / third party facilitators here, to ensure RNs feel able to share information honestly

“No, from that ward meeting I’ve not actually heard anything about the model ward really, so I don’t think it is being expressed very much. It will probably help people out, because patients are in for a while and they are waiting for things, and the staff members are busy so if we could help them out, so it would be a lot easier”

*TNA, Band 3*

“Well, there is the training that happened quite a while ago and I’ve sort of forgotten... I’m not sure about [the motivations behind the model ward] it anymore”

*HCA, Band 2*
• Alternative ways of communicating regular updates (the Ward meeting appears insufficient)
  o Social media e.g. Ward Facebook groups?
  o Text messaging?
  o Clinical Educators visit the ward each week for a 5 minute update?

• Nominating a non-ward based representative for each level of staff to liaise with
  o Ensure that every level of staff has a clear touchpoint

• Include one RN representative for all pilot wards per month at the Operations Meeting?

• Organising further relationship building initiatives
  o Ward employee of the month etc.?

5. Learning from Chesterfield: best practice recommendations for transforming a nursing workforce

Considering how lessons learned at Chesterfield can inform similar programmes.

Summary: The work of Chesterfield Royal highlights a number of requirements and possibilities in the context of implementing a programme of workforce transformation.

Organisations wishing to implement similar models should recognise that this kind of transformational process represents significant change for staff.

The process results in emergent ways of working, and periods of sustained ambiguity that can be difficult for staff to accept, giving rise to genuine, fundamental apprehension around job security and personal situations.

In turn, personal anxieties impact how staff relate to other each other and work, and can ultimately impact the success of implementation.

The work at Chesterfield demonstrates how successful skill mix initiatives can be in overcoming strategic challenges (i.e. staffing, career progression, financial outlay).

Like Chesterfield, organisations must be open and able to show flexibility in their adoption of such models that need to be revised and adapted throughout implementation.
The nature of processes, challenges and revisions required will necessarily be unique to each organisation, but based on the Chesterfield example a series of best practice recommendations can be established.

**Introduction phase**

**Practical recommendations**

**Accept that the process will take time**
- Transformational workforces take time to establish, especially if additional training roles are included. Expect at least a 24-month period for introduction and establishment.

**Select a small initial cohort of trainees**
- Choosing a small cohort with whom to trial training and skills mix initiatives will allow the opportunity for tempered adjustment and refining of the approach.

**Use small number of appropriate pilot wards initially**
- Select just a handful of wards to trial a workforce transformation to ensure that the model is suitable.
- Choose wards with a well-established Team and strong relationships to ensure it is robust enough to trial of new ways of working.
- Choose wards with moderate acuity (as opposed to ICU / CCU) to avoid placing additional pressure on staff and care practice.
- Where possible select wards where Matrons / Sisters are known to be aligned with Hospital Leadership to achieve greater buy in.

**Ensure clarity and support staff on the different training roles**
- Ensure all staff on clear on the similarities and differences between the different training roles.
- Use training roles that match the skills mix requirements / shortages.

**Ensure suitable regulatory status**
- Where possible ensure training results in adequate regulatory status to avoid hierarchical tensions between staff e.g. NMC registration.
Identify suitable training candidates

- For the first cohort, recruit training candidates internally who are well integrated to teams to ensure familiarity with wards and organisational working practices, and acceptance by colleagues.

Communication and management recommendations

Establish a project lead Team

- A project team should be established that has a clear, unified vision on strategic and organisational objectives to ensure a “one voice” approach in communicating the initiative.

Conduct full-ward proactive introductory engagement activity

- Staff engagement in the process is critical to any trial or implementation. Using mixed-role engagement activities with practical activities (e.g. skills mapping) can help to communicate the concept and help staff to feel involved in the design of the initiative.

Ensure clear communication of organisational objectives

- Share strategic context with staff.
- Position transformational workforces as solutions to problems and position initiatives as “trying to find ways to improve things for everyone”.

Ensure practical examples and case studies are used

- Provide real life examples of where skills can be cross mixed between roles e.g. if an RN needs to leave their team to administer meds for another team.

Ensure private communication and feedback channels are established

- Ensure that staff at all levels feel able to raise concerns of a personal nature (e.g. job security anxiety)

Ensure strong leadership – one team, one voice

- Ensure staff maintain a strong unified vision and encourage Senior Matrons to adopt the same view in order to communicate the development well to those working on the wards.
Implementation phase

Practical recommendations

Pilot with a staged approach

- Consider implementing changes over time, focussing on the “easiest” changes first e.g. introduction of trainee Nursing trainees before introduction of Allied Health Professionals

Provide sufficient supernumerary time

- Ensure formal supernumerary time is factored into allow for additional tasks / activities, potentially for both RNs (mentoring, supervising) and trainees (practise, coursework)

Maintain staffing ratio

- Ensure trainees are initially deployed as additional support rather than counted within staffing numbers.

Provide alternative ways of supporting nursing staff with the different learners

- As staff roles are constantly changing and more learners enter wards ensure RNs feel supported in teaching different staff and not overwhelmed and under pressure.

Maintain a similar pace between trainees

- Maintain a similar pace in terms of skills competency to ensure that colleagues are informed of where trainees can and cannot deliver care tasks.

Establish Clinical Educators

- Ensure responsibility for trainees’ progress is given to dedicated staff members.

Communication and management recommendations

Establish communication structure for all levels

- Ensure that all levels of staff have a direct method of communication and information sharing, so they can raise issues and concerns on an ongoing basis.
Continue communications direct from Project Team

- Communications should be delivered periodically and directly from Senior Managers or Project Leads, rather than via other ward staff or via conventional ward communication channels (e.g. Matron via Ward meetings).

Effective, efficient key information updates

- Key succinct information such as competencies achieved by trainees must be easily identifiable and verifiable (e.g. uniform, badges, folders etc.)

Identify and deal with dissatisfaction proactively

- Where dissatisfaction emerges (over a particular issue, at a particular level), explore and identify the source and consider remedial actions.

Engage external support

- Where necessary, consider occasions where external support and facilitation will be more appropriate to deal with issues, i.e. to allow for honest feedback and objective interpretation of issues.

Maintain strong leadership

- Ensure Senior Matrons maintain a strong unified vision and communicate this down to their colleagues.

Establishment phase

Practical recommendations

Introduce further stages of transformation

- Once the pilot phase is complete, begin to add further elements (e.g. Allied Health Professionals)

Pilot further ideas

- Once transformation is in establishment phase, further developments may be trialled and added (e.g. additional AP / TNA across two wards on night shifts)
Assign project roles to first cohort

- Consider how those involved in the pilot phases can become ambassadors for the continued support of the initiative (e.g. for other wards, for staff members)

Communication and management recommendations

Reward those involved in pilot

- Consider how to reward and recognise the work of those across roles involved in pilot initiatives (e.g. interviewed by Senior Nursing staff, invited to presentation meetings, etc.)

Maintain communication channels open for all levels

- Ensure that all levels of staff continue to have a direct method of communication and information sharing, so they can raise issues and concerns on an ongoing basis.

Maintain strong leadership

Ensure staff maintain a strong unified vision and keep communicating the development well to aid understanding and clarity.

Organise review activity

- Engage staff in a proactive review of their own work in piloting the transformation initiative. Consider using similar methods (e.g. Team days) to those used at initial launch

Ultimately, maintaining a flexible and transparent approach at an organisational level is critical to ensuring that the wider workforce responds positively to change.

Organisations should be prepared to adapt and respond creatively to challenges that arise, working with staff to identify the best transformation and, ultimately, most positive outcomes possible.
## 6. Appendices

### Discussion guide used in interviews

<table>
<thead>
<tr>
<th>Project name:</th>
<th>Team Around the Patient (TAP) Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job number:</td>
<td>4933</td>
</tr>
<tr>
<td>Methodology:</td>
<td>Telephone depth interviews</td>
</tr>
<tr>
<td>Version</td>
<td>Version 1</td>
</tr>
</tbody>
</table>

- Depth interviews with those linked to the Team Around the Patient Development at Chesterfield Royal
- Duration: 30 mins
- Incentive: £5 coffee voucher

<table>
<thead>
<tr>
<th>(I) INTRODUCTIONS</th>
<th>3 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief explanation of</strong></td>
<td></td>
</tr>
<tr>
<td><strong>the purpose of</strong></td>
<td></td>
</tr>
<tr>
<td><strong>the research</strong></td>
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</tr>
<tr>
<td><em>First of all, I will just introduce myself and tell you a little bit of background to our study today.</em></td>
<td></td>
</tr>
<tr>
<td>DJS Research is working on behalf of NHS Chesterfield to better understand your experience and perceptions of the ‘Team Around the Patient’ development.</td>
<td></td>
</tr>
<tr>
<td>We thank you for agreeing to take part in this process and are very keen to hear your thoughts and views today. Any feedback you can provide will help us to learn more and improve the development for the future at Chesterfield and at other Trusts.</td>
<td></td>
</tr>
<tr>
<td>- DJS Research complies with the code of conduct established by the Market Research Society. This means that you have the right to participate in this research with complete confidentiality and anonymity.</td>
<td></td>
</tr>
<tr>
<td>- Feedback will be collected confidentially and responses will not be communicated directly with the hospital, the Trust or other parties. You name will not appear in any reports.</td>
<td></td>
</tr>
<tr>
<td>- We will not tell the trust, hospital or other third parties that you personally participated in the research or what you personally said. In our reporting we will ensure that your comments cannot be attributed to you personally, for example, we may say “Band 6 nurses felt that...”.</td>
<td></td>
</tr>
<tr>
<td>- We would like to record the discussion for analysis purposes if possible. This recording remains the property of DJS Research and is not shared with the Trust, the hospital or any other third parties. Is this OK with you? (Moderator, if participant does not agree; take copious notes!)</td>
<td></td>
</tr>
<tr>
<td>- Length of discussion – approx. 30 minutes (telephone)</td>
<td></td>
</tr>
<tr>
<td>- There are no right and wrong answers; we are just interested in your views, opinions and ideas</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Introductions / stage in process</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Could we start off by doing introductions, could you tell me a little about yourself?</em></td>
<td></td>
</tr>
<tr>
<td>- Please tell me your name and a little about yourself</td>
<td></td>
</tr>
</tbody>
</table>
- How many years have you been working in your role?
- What previous work experience do you have leading up to your current role?
- And could you confirm your link to or role in the Team around the Patient or Model Ward (as it was formerly known) development i.e.
  a) **Supervisory** i.e. Director of Nursing / Head of Nursing / Matron / Educator / RN
  b) **Participant who has completed training** i.e. Assistant Practitioner / Trainee Nursing Associate
  c) **Participant currently in training** i.e. Assistant Practitioner
  d) **Potential participant / not involved currently** i.e. HCA

<table>
<thead>
<tr>
<th>(II) INTRODUCTION OF THE DEVELOPMENT</th>
<th>5 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background to working at Chesterfield</strong></td>
<td>I’d like to quickly talk about Chesterfield Royal first to help me understand the context</td>
</tr>
<tr>
<td>- How long have you worked at Chesterfield Royal? Have you had a number of different roles at the Trust / hospital? Have you worked at other hospitals before this?</td>
<td></td>
</tr>
<tr>
<td>- What are your career aspirations? Do you have any goals?</td>
<td></td>
</tr>
<tr>
<td>- Can you tell me a bit about Chesterfield Royal? What kind of patients do you work with?</td>
<td></td>
</tr>
<tr>
<td>- What do you enjoy most about working at the hospital? Why is that so rewarding?</td>
<td></td>
</tr>
<tr>
<td>- What are the biggest challenges facing the hospital at the moment would you say?</td>
<td></td>
</tr>
<tr>
<td><strong>Perceived purpose of the TAP development</strong></td>
<td>I’m now going to talk specifically about the ‘Team Around the Patient’ / ‘Model Ward’ development. Firstly, I’d like to talk to you about the purpose of the development.</td>
</tr>
<tr>
<td>- Can you remember when you first found out about the development being introduced / first discussed the introduction of the development?</td>
<td></td>
</tr>
<tr>
<td>- What was your initial reaction? Why do you say that?</td>
<td></td>
</tr>
<tr>
<td>- As you understand it, what are the main reasons why Chesterfield started the development originally? What was the motivation behind it?</td>
<td></td>
</tr>
<tr>
<td>- What do you think the Trust is trying to achieve in putting the training developments in place? Are there particular issues or challenges that the development is trying to overcome?</td>
<td></td>
</tr>
<tr>
<td>- In terms of staff</td>
<td></td>
</tr>
<tr>
<td>- In terms of the hospital / Trust itself</td>
<td></td>
</tr>
<tr>
<td>- In terms of patients</td>
<td></td>
</tr>
<tr>
<td>- Why are those things so important?</td>
<td></td>
</tr>
<tr>
<td>- Did you receive any feedback from colleagues initially? Who? What did they say?</td>
<td></td>
</tr>
</tbody>
</table>
Initial expectations of the development

- When you first heard about the development and about the training opportunities, how well did you feel that they would respond to the challenges you mentioned at Chesterfield?
  - Is there anything in particular you hoped the development would achieve?
- In comparison, did you have any doubts about the development and its effectiveness before it started from? Why do you say that?

(IV) EVALUATION OF THE DEVELOPMENT PROCESS

I’d now like to reflect on the Team Around the Patient development process so far.

- Thinking about the development now, what would be the first word you would use to describe it to someone else? Why do you say that?
- And taking everything into account, how would you rate the development out of 10?
  - Why do you say that?
- What do you think has been the most positive thing about the development in your opinion?
- Have there been any negatives that have resulted from the development? What are they?
- What has been the most challenging aspect of the development / training from your perspective? Why is that so tricky?
- What has the Trust put in place to try to overcome these challenges?
  - How effective has that been?

Understanding overall perceptions of the development

Appraisal of key elements of the development and suggest improvements

I’d like to learn more about the actual implementation of the development from your point of view; how those processes worked and what if anything can be improved.

- Which part(s) of the development are most enjoyable for trainees/ are you looking forward to most?
- Have there been any part(s) of the development which you been less enjoyable or harder to achieve? What has been difficult about that?
- Taking some of the key aspects of the training, could you tell me your perceptions of them – have they been adequate? Are you satisfied? How could this element be improved?
  - What about the university course / training? What about the resources?
  - What about the skills training / supervision on wards?
    - What opportunities are there to practise key skills you are learning? What sort of practical skills have you learnt?
    - Are there any other skills you have gained from being a part of the development?
  - How have you found the process of managing time between college work / training and work on the ward?
- How supportive has the Trust been of trainees? Why do you say that?
<table>
<thead>
<tr>
<th>(V) PERCEIVED IMPACT OF THE DEVELOPMENT</th>
<th>5 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understanding impact of the development</strong></td>
<td></td>
</tr>
<tr>
<td>Thanks for your answers so far. I’d now like to talk about the impact of the development, both from a practical point of view and from a personal point of view.</td>
<td></td>
</tr>
<tr>
<td>• What impact do you think the Team Around the Patient / Model Ward development has had on wards overall?</td>
<td></td>
</tr>
<tr>
<td>• Have you noticed any improvements...</td>
<td></td>
</tr>
<tr>
<td>o In terms of staffing?</td>
<td></td>
</tr>
<tr>
<td>o Use of agency staff?</td>
<td></td>
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<tr>
<td>o Sickness?</td>
<td></td>
</tr>
<tr>
<td>o In terms of staff morale?</td>
<td></td>
</tr>
<tr>
<td>• Have you received or heard of any feedback from patients directly about their care since the development was introduced? What do you think the impact on patient care has been?</td>
<td></td>
</tr>
<tr>
<td><strong>TRAINEES / POTENTIAL TRAINEES</strong></td>
<td></td>
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<tr>
<td>• And thinking about the impact on you and your career, what impact do you feel the development has / will have?</td>
<td></td>
</tr>
<tr>
<td>• Do you feel as if the development has had an effect on personal confidence and career aspirations?</td>
<td></td>
</tr>
<tr>
<td>o PROBE: Positive/negative?</td>
<td></td>
</tr>
<tr>
<td>• How do you feel your role / job has / will change?</td>
<td></td>
</tr>
<tr>
<td>• Would you agree with this? Up to this point, have you received any patient feedback about the development?</td>
<td></td>
</tr>
<tr>
<td>o PROBE: Has this feedback been positive or negative?</td>
<td></td>
</tr>
<tr>
<td>• In addition to patient feedback, have you so far received any feedback from other staff or your superiors about the development?</td>
<td></td>
</tr>
<tr>
<td>o PROBE: Has this feedback been positive or negative?</td>
<td></td>
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<tr>
<td>Recommendations for the future</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td><strong>(VI) LOOKING BACK/THINKING TO THE FUTURE OF THE DEVELOPMENT</strong> 5 mins</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUPERVISORY</strong></td>
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</tr>
<tr>
<td>- How likely would you be to recommend that other Trusts adopt a similar model? Why do you say that?</td>
<td></td>
</tr>
<tr>
<td>- What do you think you or the Trust would do differently now in terms of adopting this model?</td>
<td></td>
</tr>
<tr>
<td>- Can you think of three key pieces of advice you would give them?</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td><strong>TRAINEES / POTENTIAL TRAINEES</strong></td>
<td></td>
</tr>
<tr>
<td>- How likely would you be to recommend that others take up training as part a similar development? Why is that?</td>
<td></td>
</tr>
<tr>
<td>- To what extent do you feel as if the development / the training has lived up to your own expectations? Is it what you thought it would be like?</td>
<td></td>
</tr>
<tr>
<td>- What recommendations would you make to others hoping to do the training or join a similar development in the future?</td>
<td></td>
</tr>
<tr>
<td>- Can you think of three key pieces of advice you would give them?</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>To finish up, I’d like us to now look back on the development as a whole and think about how others can learn from your experiences</td>
<td></td>
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