Capturing impact

A practical toolkit for nurse consultants

Kate Gerrish, Ann McDonnell, Fiona Kennedy

Capturing impact
A practical toolkit for nurse consultants

Developed by

Kate Gerrish
Ann McDonnell
Fiona Kennedy

Sheffield Hallam University
July 2011

The authors

Kate Gerrish
PhD, MSc, B.Nurs, RN

Kate holds a joint appointment as Professor of Nursing at the University of Sheffield and Sheffield Teaching Hospitals NHS Foundation Trust. She has led a number of commissioned research projects examining innovative approaches to nursing organisation and the implementation and evaluation of new role developments. Kate was Principal Investigator for the research study examining the impact of nurse consultants which led to the development of this toolkit. (kate.gerrish@sheffield.ac.uk)

Ann McDonnell
PhD, MSc, BSc, RN

Ann is a Reader in the Centre for Health and Social Care Research at Sheffield Hallam University. She has a longstanding research interest in new role developments in nursing and the allied health professions and the evaluation of services which involve nurses working in advanced roles. (A.McDonnell@shu.ac.uk)

Fiona Kennedy
PhD, MSc, BSc

Fiona works as a Research Fellow in the Centre for Health and Social Care Research (CHSCR) at Sheffield Hallam University. With a background in health psychology Fiona's research interests centre on applied, patient-led research and research that is beneficial to both patients and health professionals. (F.Kennedy@shu.ac.uk)

CONTENTS

Introduction to the toolkit

This toolkit has been designed to help nurse consultants assess the impact they have on patients, the staff that they work with, their organisation, and the contribution they make outside their organisation. It was developed as part of a research project commissioned by the Burdett Trust for Nursing which examined approaches to measuring the impact of nurse consultants. We interviewed several nurse consultants together with the key stakeholders to their post (e.g. colleagues, managers and patients) about the impact that the nurse consultants had. We then worked with each nurse consultant to identify ways whereby they could demonstrate their impact. Throughout this toolkit quotes from these interviews are used to illustrate important issues and many of the examples we provide are based on the nurse consultants' experiences.

How will this toolkit help me?

This toolkit is not an exhaustive guide to capturing every possible impact that might relate to your role as a nurse consultant - this would be an unwieldy resource given the wide variation between different nurse consultant posts. Rather, the toolkit is designed to provide you with practical assistance to:

- Identify the key areas of impact relevant to your post
- Assess barriers and facilitators to capturing impact
- Consider different approaches that you could use to demonstrate your impact

This is achieved through presenting information and giving you the opportunity to work through a number of reflective activities. We also provide examples of tools that have been piloted by nurse consultants to assess their impact and guidance on how these may be adapted for different nurse consultant posts. Where possible, we refer you to helpful books, resources and published examples.

The toolkit has been reviewed by several nurse consultants and other stakeholders who have provided very positive feedback regarding its potential usefulness for nurse consultants. We would value any feedback from nurse consultants who use the toolkit - please visit our website to tell us what you think: http://research.shu.ac.uk/hwb/ncimpact/ . Individual copies of the tools and activities that are presented in this toolkit are available as Word documents on our website, where an electronic copy of the entire toolkit can also be found.

> *If new to post I'd find the toolkit very useful but also it's useful for existing nurse consultants to reflect on their practice and provide evidence to support and improve practice.*
>
> *I could see it forming part of performance review and my own portfolio/record of progress.*
>
> *I liked the structure - it's logical and tells the story. The tools are practical and usable and examples help to illustrate the points.*

Who might find this toolkit useful?

This toolkit is intended primarily to be used by nurse consultants. If you are new in post it might help you to develop your role, whereas if your role is more established it should help you to monitor your impact on an on-going basis. The toolkit may also be useful to the following other groups.

- Line managers of nurse consultants – it can be used as a tool for managers to support the development of their nurse consultants, especially where nurse consultants are new in post. Some of the tools might also be useful in annual reviews.
- Other advanced practice nurses (e.g. clinical nurse specialists, nurse practitioners) who may face similar challenges in terms of capturing their impact.
- Multi-disciplinary teams – the toolkit offers generic guidance and advice on capturing impact that may be applicable to a whole team.
- Allied health professionals in consultant roles - who have similar core elements to nurse consultants so the ideas within this toolkit could be adapted accordingly.

How to use this toolkit

This toolkit can be used as a resource that you can dip in and out of as necessary - for example, if you need to capture evidence of your impact on patients you might refer straight to the relevant part of Section 5 that focuses on patients.

You can also use the toolkit as a reflective tool to work through systematically, especially the activities in Sections 2-3. This might be particularly beneficial if you are relatively new in post or if you want to complete an overall review your role and its impact.

The toolkit is divided into the following sections:

- Section 1 - Capturing impact
    - This section introduces you to what we mean by impact and why you might want to capture your impact as a nurse consultant. It also prompts you to think about the stakeholders for your post, who they are and what aspects of your impact might be important to them.
- Section 2 - Your impact - identifying areas and priorities
    - In this section several activities are introduced to help you think through the impact that you have. We start by asking you to think about what you do on a day-to-day basis, and then move on to focus on the impact those activities have on patients, staff and the organisation as a whole. We introduce a framework for identifying impact to prompt you to identify additional areas of impact. We also consider prioritising which areas of impact are most important for you to capture at this moment in time.
- Section 3 - Guidance on capturing impact
    - This section explores a number of challenges to capturing impact which have been identified by nurse consultants, and then presents some tips to overcome or manage these challenges. We also introduce several different approaches to capturing impact and provide some guidance and key questions that you should consider if you decide to use data from existing sources or if you are undertaking new data collection.
- Section 4 – Evaluating economic aspects of the nurse consultant contribution
    - This section provides guidance on evaluating some economic aspects of a nurse consultant's role. We present a practical framework, based upon the Option Appraisal methods used for the assessment of capital investment projects in the NHS, which nurse consultants can use to guide evaluation of a particular service that they provide. We then present a worked example of how the framework has been applied to an individual nurse consultant.
- Section 5 - Examples of capturing impact
    - In this section we present several examples of capturing impact in each of the three domains of impact: Patients, Staff and Organisation
    - We draw upon our project and published examples to illustrate how data relating to the different areas of impact might be captured.
- Section 6 - Who needs to know?
    - This section considers the people with whom you might want to share evidence demonstrating your impact and provides ideas on different ways to disseminate this information.
- Section 7 - Examples of tools
    - This final section presents the tools referred to in Section 5 as examples that you could use or adapt in order to capture evidence on the three domains of impact.

Section 1 Capturing impact

1.1 The bigger picture

The review of the NHS 'High Quality Care for All' published in 2008 emphasised that quality should be integral to the NHS. The review identified several initiatives intended to enhance the measurement and monitoring of quality within the NHS at a national level, however it was recognised that if lasting improvements were to be made, quality improvement initiatives needed to be patient-centred, clinically-driven and locally-led.

Despite a change of government in 2010, health policy has continued to drive improvements in quality in order to make healthcare safer, more clinically effective and patient-centred. The recent White Paper 'Equity and excellence: liberating the NHS' (DH 2010a) sets out the government's intentions to put patients at the heart of NHS care, deliver improved healthcare outcomes and empower local organisations and healthcare professionals to improve the quality of healthcare services. Yet, the economic downturn has meant that healthcare organisations no longer benefit from year on year financial increases: instead they are being challenged to drive up quality while at the same time making efficiency savings (DH 2011a). National initiatives such as Quality, Innovation, Productivity and Prevention (QIPP) have focused on ensuring that the money spent in the NHS brings maximum benefit and quality of care to patients and the Commissioning for Quality and Innovation (CQIN) payment framework has enabled commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Nurses have a pivotal part to play in driving up quality within the NHS. Initiatives such as the eight high impact actions for nursing (NHS Institute for Innovation and Improvement 2009) and the Energising for Excellence in Care initiative (DH 2010b) have reinforced nursing's contribution in terms of improving the quality of care, the experiences of patients and health outcomes across a broad range of health services. In clinical areas where nurse consultants are in post, they are uniquely positioned to add significant value to this agenda and assist in achieving its ambitions.

The changes outlined above are enormously challenging for healthcare organisations and for the individuals who work within them. Within a framework of quality governance, NHS Provider Boards are now called upon to assume greater responsibility for overseeing the quality of care being delivered across all services within the organisation and ensuring that quality and good health outcomes are being achieved throughout the organisation (DH 2011a). Part of this process requires the collection of information to demonstrate improvements. As a result, nurses, together with other healthcare professionals are called upon to provide evidence of their impact on improving patient outcomes, the patient experience and healthcare services. The development of nurse sensitive indicators (Griffiths et al 2008; DH 2011b), essence of care benchmarks (DH 2010c) and patient reported outcome measures (PROMS) (http://www.ic.nhs.uk/proms) provide a means of demonstrating improvements in quality for which nurses, in collaboration with professional colleagues, are responsible. However, at present, these indicators are not sufficiently comprehensive to capture the diversity and complexity of the nurse consultant's contribution.

Indeed, capturing the impact of nurse consultant roles is a difficult and complex process (Guest et al. 2004). This is due to the diversity of these roles, which often span organisational and professional boundaries, the difficulty of attributing changes in outcomes to one individual who works as part of a multi-disciplinary team (MDT) and the fact that many nurse consultants work through influencing the practice of other staff (Coster et al. 2006).

1.2 What do we mean by impact?

There is a growing need within the NHS for provider units and the individuals that work within them to show that the services they provide are effective. In this context 'impact' is the 'influence' or 'difference' brought about by providing a service or having specific healthcare professionals in post. In relation to your role as a nurse consultant, it might also be useful to view impact as the 'added value'

that you, with all your experience and expertise, bring to the organisation. It involves thinking about what is 'unique' to your role.

It is important to highlight the difference between process and outcome when evaluating impact. These concepts were defined by Donabedian (1966) and have been incorporated into various frameworks for assessing advanced practice nursing (APN) roles (e.g. Irvine et al. 1998):

Process relates to what you do in your role, so the activities and services that you provide. These can be explored in relation to the four core functions of the nurse consultant role, namely: expert practice; professional leadership and consultancy; education, training and development; and practice and service development, research and evaluation. These will be examined in Section 2.2. For example, you might provide nurse-led follow-up clinics to patients. This is the *process* of how you might make a difference, but it does not identify the impact you actually have on patients.

Outcome relates to the end result of the provision of care, and captures the impact you have through the processes you engage in. For example, providing a nurse-led follow-up clinic may lead to improved patient outcomes and enhanced patient experience, both of which provide an indication of impact.

It might be easier to think about the process, but it is crucial that outcomes are explored to show the difference that you make in practice. The impact you have might also be felt in a range of areas – for example on your patients, the staff you work alongside, your clinical speciality, the organisation as a whole, or health services more broadly. Furthermore, within each of these areas the impact may manifest itself in a variety of different ways - for example on patients' symptoms or functioning, their quality of life or their satisfaction with care received. We explore these different dimensions of impact later in the toolkit.

1.3 Why would you want to capture impact?

There are several reasons that might prompt you to want to capture the impact of your role.

It may be useful in order to make a personal assessment of your post and plan future developments.

At both an individual and organisational level, capturing impact may be important in order to demonstrate that the investment in your post represents value for money.

It may be beneficial to clarify role boundaries and determine the added value of your post compared to other posts. For example, the advanced complex decision-making and strategic skills that differentiate a nurse consultant from a clinical nurse specialist.

> *If you can capture your impact then you can develop more. If you feel you're doing a good job then you continue to do a good job. (advanced nurse practitioner)*
>
> *If we get clarity on what the benefits of having a nurse consultant are then that may encourage the development of more posts. (clinical director)*

Capturing impact may also help you continually to develop the services you are involved in, particularly to improve the outcomes for patients.

You may also feel a sense of professional and public responsibility to demonstrate that the money invested into healthcare posts is being used to best effect. This issue was often raised in the interviews we conducted as important for all posts, not just nurse consultants.

Finally, capturing impact may be important in order to firmly establish the role of the nurse consultant and demonstrate the senior clinical leadership contribution of nurse consultants nationally.

1.4 Who are the stakeholders for your post and what impact is important to them?

In addition to your own views about what aspects of impact are important to capture, it is also useful to explore the perspectives of other stakeholders. The stakeholders to your post could be a wide range of individuals, but typically they include: line manager, clinical director/medical consultants, other

senior nursing staff (e.g. matron) or advanced practice nurses (e.g. clinical nurse specialists), members of the multi-disciplinary team, front-line staff, and patients and/or family carers. Those identified as stakeholders will depend on your remit, who you interact with on a regular basis, whether you cross department al or organisational boundaries, and whether you work with external individuals or groups.

Activity 1: Who are the stakeholders for your post?

The box for Activity 1 includes an illustration of the stakeholders identified by some of the nurse consultants in our project. Having looked at the illustration, complete the final column with the stakeholders for *your* post, who you think may be aware of the impact you have.

Activity 1 ***Examples of stakeholders identified by nurse consultants***		***Identify the stakeholders for your post***
Nurse consultant in stroke:	**Nurse consultant in gynaecology:**	
Medical consultant	Medical consultant/clinical lead	
Line manager/nurse director	Line manager/nurse director	
Clinical psychologist	Ward sister	
Clinical nurse specialist	Clinical educator	
Commissioner	Staff nurse	
Speech & language therapist	Matron	
Regional manager of patient charity	Deputy lead nurse in local service	
	Colleague at national nursing group	
Patients and carers	Patients	

It is a good idea to identify a variety of stakeholders in order to look at different perspectives, for example junior and senior staff, internal and external to your organisation, as well as patients or people who can provide a service user perspective such as carers or charity representatives. Bearing in mind the complexity of nurse consultant posts, the number of stakeholders could be large. It is therefore important to identify the key stakeholders who are best placed to contribute to an understanding of your impact.

These stakeholders may share valuable insights into the impact you have on patients, staff or the organisation. You may not be aware of all of these aspects because as individuals we are often entrenched in our own role and sometimes fail to see important ways that we influence those around us! In our project several nurse consultants were surprised by the range of different areas of impact identified by their stakeholders.

Stakeholders' views can be gathered in a variety of ways, including talking to trusted colleagues, discussion with your line manager at annual appraisal, or using a 360 degree scoping of impact feedback tool (see example tool 1 in Section 7). Additionally, the forthcoming toolkit activities can be used to complete a mini scoping of impact relating to the key areas of your post which could be informed by consultation with stakeholders.

Section 2 Your impact – identifying areas and priorities

This section examines the different areas of impact that you might have as a nurse consultant. Several reflective activities are presented to help you unpick the key areas you might wish to consider. Remember you don't have to complete all of the activities - you can dip in and out of them, and just complete those that you feel you would benefit from.

We begin by focusing on the processes that you engage in as a way to start thinking about impact. We then consider the outcomes and impact of those processes. As discussed in Section 1.1, it is important to differentiate between *process* and *outcome*. For example, you may provide professional leadership to other staff - this is a *process*. The impact of this leadership is the *outcome* and may include increasing knowledge of staff, improved team working or staff morale. Furthermore, activities can impact on a variety of different areas. For example, engaging in expert clinical practice could impact on patient outcomes (e.g. symptoms, quality of life), but through providing a role model for other staff this activity could also impact on staff competence.

2.1 What do you do on a day-to-day basis?

Activity 2 – Identify the processes and activities you engage in

Think about the processes that you engage in on a day-to-day basis (e.g. patient clinics, service developments). Your job description may help you to do this, and you can jot these down in box below. Try to identify the key activities relating to the four core functions of your role:

- Expert practice
- Leadership and consultancy
- Education and training
- Service development, research and evaluation

It might also help to consider your activities in the unit in which you work, within the wider organisation and external to the organisation (e.g. membership of external committees, presenting at conferences). You may wish to asterisk (*) those that you consider to be particularly unique to your post.

Activity 2	***Clinical / Expert Practice***	***Education / Training***	***Leadership / Consultancy***	***Service development / Research***
Within the service or unit				
Within the organisation				
External to the organisation				

2.2 What impact do these activities have?

Next, we would like you to consider the impact you have through engaging in the activities you identified in Activity 2.

Activity 3 – Identify the impact of your activities

Think about the impact you have through these activities and complete Activity 3. It may be helpful to try to identify what difference you think that activity has on patients, staff or the organisation. Nurse consultant posts vary considerably, so you may not be able to complete all of the sections.

Activity 3 ***Processes/Activities***	***Impact***
E.g. Teaching clinical skills to nursing staff on ward	*- Patients* *- Staff – Increase in knowledge, skills & confidence of nursing staff on ward.* *- Organisation*
1	- Patients - Staff - Organisation
2	- Patients - Staff - Organisation
3	- Patients - Staff - Organisation
4	- Patients - Staff - Organisation

2.3 What is the difference between direct and indirect impact?

Many of the ways in which you have an impact will be direct – i.e. where the impact is focused on the recipient of the activity. For example, a nurse consultant who trains ward nurses on patient group directives (PGD) would directly influence the nurses' knowledge and competence to prescribe and administer authorised PGD drugs to patients. However, your impact may also be indirect when it takes place through the activities of another person whose practice you have influenced. For instance, an indirect impact in this example might be that patients receive treatment in a timelier manner because they do not have to wait for a doctor to prescribe their medication. Thus, the nurse consultant may have an indirect impact on the patient's symptoms, satisfaction with care, or ultimately length of stay.

Therefore, if you work primarily through influencing other staff, in addition to capturing your direct impact on those staff, it is valuable to capture the indirect impact of these activities on patients or the wider organisation. However, indirect impacts are not only achieved through influencing other staff. For example, a nurse consultant who introduces a telephone clinic may have a direct impact on patients in terms of timeliness and satisfaction with care, but may also have an indirect impact on reducing 'did not attend' (DNA) rates for outpatient clinics. It is important therefore to consider not only the direct impact of your activities, but also the indirect impacts which may arise.

It is also important to consider how soon you can measure your impact. Some impacts might be felt immediately, whilst other outcomes may only occur some time after the intervention took place. For example, a nurse consultant working in public health may wish to capture the impact of providing community-based contraceptive clinics on teenage pregnancy rates. This impact cannot be captured in the short-term. Instead, the satisfaction of those who attend the clinics could provide a measure of the immediate impact and value of the activity. Figure 1 illustrates the direct (dark blue arrows) and indirect (dotted arrows) impact of nurse consultant activities on three key domains: patients, staff and the organisation.

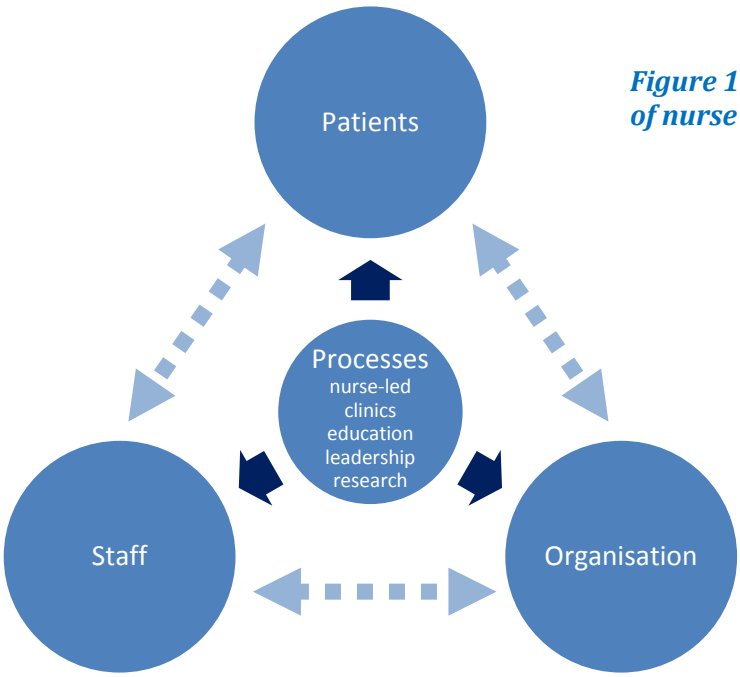

Figure 1: Direct and indirect impact of nurse consultant roles

In summary, when considering the impact of your role:

- Focus on an activity
- First, think about the direct impact of that activity – i.e. what did you set out to directly influence in relation to patients, staff or the organisation?
- Then, think about whether there are any indirect knock-on impacts – either within the same domain (e.g. training to raise the competence of staff may also improve team working across the MDT) or on another domain (e.g. having more skilled staff might positively impact on patient experience of care or increase the meeting of Trust targets).
- In some roles such as in public health it may be important to consider the long-term impact of some activities, but you should still identify any short-term indicators of impact.

You may wish to return to Activity 3 and consider whether there are any additional important indicators of impact relating to the activities you previously identified. However, the list of possible impacts could be huge, so take a pragmatic approach and identify those that you think are most relevant to your post.

2.4 A framework of impact

If you are working through the activities in this toolkit in sequence you will have begun to think about direct and indirect impact in relation to the four dimensions of your role. We would now like to offer you a framework for capturing impact. You will be able to map the impacts you have already identified against this framework, which may prompt you to identify additional areas that you haven't yet considered.

This framework for identifying the impact of nurse consultant roles was developed as part of our research project (Gerrish et al 2011). The framework was initially tested with existing literature

exploring the impact of nurse consultants (Kennedy et al. 2011), and was subsequently refined through the interviews we carried out with nurse consultants and their stakeholders. The resulting framework incorporates impact on three domains: patients, staff and the organisation, each with several indicators of impact.

Patients – The first domain is the impact on patients, which has four indicators of impact.

- *Physical and psychological wellbeing* - relates to the physical and/or psychological outcomes for the patient and/or family members. For example, a nurse consultant could impact on patients by reducing their pain through changing their prescribed medication or reducing anxiety amongst patients and/or family members through follow-up consultations.
- *Quality of life (QoL) and social wellbeing* - relates to the broad impact on a patient's quality of life, activities of daily living and social wellbeing. Following on from the example above, a nurse consultant might also influence a patient's ability to work or engage in hobbies.
- *Patient behaviour* - relates to the impact on patient behaviour (e.g. smoking cessation, planned weight loss). For example, through the provision of nurse-led services a neonatal nurse consultant might influence women to successfully engage with breastfeeding.
- *Experience of healthcare* - relates to the impact on the patient's experience of healthcare services. This might include how satisfied the patient is with the consultation with the nurse consultant, their understanding about their condition and involvement with decision-making.

Staff - The second domain is the impact on staff, which has four indicators of impact.

- *Competence* - relates to the impact on the competence of the healthcare workforce, influencing their knowledge, skills, behaviour and attitudes. For example, a training course on discussing sexual health concerns might increase nurses' awareness and provide them with the appropriate communication skills to talk to patients about these issues.
- *Quality of working life* - relates to the impact on the work experience of the healthcare workforce, such as influencing morale and job satisfaction.
- *Work distribution and workload* - relates to the impact on staffing issues such as workload or the distribution of work across the workforce. For example, if a nurse consultant sets up a new clinic for patients this might reduce the workload of medical colleagues.
- *Team working* - relates to influencing teamwork across organisational and professional boundaries, leading to the provision of high quality care. For example, a nurse consultant might facilitate communication with other departments or external services (e.g. GP practices).

Organisation - The third domain is the impact on the organisation, which has three indicators of impact.

- Organisational priorities and targets - relates to the impact on meeting targets set by commissioners, such as waiting times and length of stay, or other priorities and strategies identified by the organisation.
- Development of policy - relates to influencing and contributing to the development of both local and national policy (e.g. guidelines, care pathways).
- Generation of new knowledge - relates to the impact on the generation of new knowledge through involvement in research. This could include being a primary researcher, co-applicant, clinical advisor, member of research advisory group, etc.

Within this framework, various aspects that are largely external to the organisation (e.g. contributing to the development of national guidelines) are located in the organisation domain because it was clear in our interviews that these were highly valued by senior managers in terms of the benefit that the organisation accrued from such activity. For example, contributing to external guideline development raises the profile of the organisation and provides key information to develop services locally.

In Activity 4 below, a summary of these different domains is presented. This box also provides space where you can identify examples of these impacts from your own practice. If you can complete an example for each category then do so, but don't worry if there are areas that are not relevant to your role.

This framework and the specific indicators should help you start to think about the different ways in which you are making a difference. However, the framework is meant to be used flexibly – if you are unsure of which domain an area of impact goes in, put it where it works best for you. For example, team working and quality of working life might be difficult to disentangle. So, you may want to focus on your primary intention – are you trying to improve how the team works together or are you concerned about the work experience amongst the staff? Similarly, outcomes relating to patient behaviour (e.g. smoking cessation) and organisational CQIN targets for promoting smoking cessation may overlap. In some cases it may be appropriate to put an outcome in more than one domain.

There is also a degree of personal judgement in using the framework. Outcomes can be entered in different domains depending on the current focus for the organisation, for example if you have been challenged to demonstrate your impact on patients, smoking cessation might be placed in the patient behaviour area, whereas another nurse consultant might use this outcome to illustrate their impact on the organisational CQIN target relating to smoking cessation.

Again, it is important to note that the different framework areas may not always apply to each and every nurse consultant post, so don't worry if there are gaps when you complete the table.

Activity 4 - Use the table below to identify examples of impact from your own work relating to the different areas

Activity 4 ***Impact on…***		***Definition***	***Examples from your own work***
Patients	Physical and psychological wellbeing	Individuals return to normal functioning or experience a change of symptoms – i.e. physical or psychological outcomes of the patient and/or family members.	
	Quality of life (QoL) and social wellbeing	Improving an individual's QoL and self-efficacy, specifically the impact the disease has on activities of daily living (e.g. health-related QoL), but also any broad influence on social wellbeing (e.g. ability to work, engage in hobbies).	
	Patient behaviour	Influencing outcomes relating to patient behaviour - for example, smoking cessation rates, breastfeeding rates.	
	Experience of healthcare	Influencing patient experience of healthcare services (e.g. satisfaction with consultation, understanding of condition).	
Staff	Competence	Influence on the competence of the healthcare workforce (e.g. affecting knowledge, skills, behaviour, attitudes).	
	Quality of working life	Influence on quality of work experience in the healthcare workforce (e.g. job satisfaction, motivation).	
	Work distribution and workload	Impact on staff societal outcomes such as the work distribution, turnover and workload of other staff.	
	Team working	Impact on effective team working across organisational (e.g. internal / external) and professional boundaries (both uni- and multi-professional) leading to the provision of high quality care.	
Organisation	Organisational priorities and targets	Meeting targets set by commissioners such as CQINs, length of stay, waiting times and other organisational priorities.	
	Development of policy	Impact on the development of policy (local / national) - e.g. protocols, guidelines.	
	Generation of new knowledge	Impact on the generation of new knowledge through involvement in research - e.g. as a primary researcher, co-applicant, member of research advisory group.	

2.5 Case study example

Figure 2 below presents an overview of the areas of impact relating to a nurse consultant in stroke who was involved our study.

As suggested in Section 1.3, this overall scoping of impact could be achieved through informal discussions with key stakeholders, and is a useful starting point if you wish to demonstrate the full impact of your role on different areas.

Figure 2 – Example of the areas of impact for a nurse consultant working in stroke

Impact on…	Areas of impact
PATIENTS *Physical and psychological wellbeing*	Prevention of progression to full stroke by treating symptoms via TIA clinics Reduction/prevention of long-term impairment through prompt assessment and admission Reduced patient impairment/improved functioning (e.g. movement) and confidence via timely referral to rehab services or intermediate care (e.g. long-term care packages) Positive impact on patients/carers psychologically through variety of initiatives (e.g. Tell your story initiative, referral to support groups, referral to psychologist)
Quality of life & social wellbeing	Improved patient/carer QoL and social wellbeing through on-going NC support, carer support group, referral to social workers to help with finances/benefits
Patient behaviour	Behaviour change relating to the prevention of stroke (e.g. providing advice on blood pressure checks)
Experience of healthcare	Positive influence on patient journey/satisfaction in continuity of care / streamlined services through NC led clinics, consistency in treatment/care (through guidelines/protocols), positive information / communication, community links, rehabilitation in the community Increased understanding of stroke and stroke services amongst patients & carers
STAFF *Competence*	Increased skill of nurses/AHPs/junior doctors in various aspects of stroke care through providing education locally and via stroke network Enhanced staff skills/competencies through involvement with projects (e.g. swallowing management, mood assessment, district nurse review) Increased staff knowledge via ad-hoc problem solving of complex cases or service issues Increased knowledge and skills of CNS/therapists through NC involvement in development of national competency framework for CNS/whole of stroke workforce Improve d practice/stroke awareness of primary care staff through development of guidelines (e.g. TIA/follow-up
Quality of working life	Improved confidence/wellbeing on CNS team via clinical supervision and advice Positive influence on work environment/team and nursing morale - people feel valued
Work distribution / workload	Re-profiled workload of others - indirectly through development of CNS posts which reduce speech & language therapist workload and directly via development of nurse-led clinics/redistribution of responsibilities within pathway/introduction of targets which reduce workload for doctors Retention of staff (low turnover / sickness) through enhancing job satisfaction Positive influence on the development of CNS posts and contribution to increasing number of CNS/therapists
Team working	Improved team working to give high quality care across stroke department and other ward areas through training / advice given / protocols developed NC Improved team working - including MDT involvement in national audits and subsequent work to address issues Improved care pathways/communication across boundaries (e.g. neuro/medicine, acute/ community) to provide seamless care for all
ORGANISATION *Organisation priorities & targets*	Achievement of targets - e.g. national audit/stroke vital signs Reduced length of stay through organisation of pathway/community rehab Reduced readmissions via NC clinic/review and management of patient at home Achieved cost savings via service redesign and income generated through clinics
Development of policy	Contribution to development of national guidelines in stroke (influences other Trusts' pathway) Development of local / regional protocols / guidelines Influenced national agenda for stroke through national committee membership
Generation of new knowledge	Advanced knowledge in field via research involvement / activities / publications

2.6 What are the most important areas currently?

It's about 'what is the focus of her role at this moment in time?' If you'd said to me a month ago 'what was important?', it would be different to what's important now. (governance coordinator)

By working your way through the toolkit activities, you will have identified various ways in which you may be having an impact. However, capturing every aspect of the impact that you have would be a mammoth task!

You will need to prioritise which elements of impact to focus on. These priorities might change over time as the service develops or the climate in the organisation changes.

Therefore, it may be useful to think about the most important clinical or organisational elements of your post at this moment in time. Informal discussions with key stakeholders in the service, such as your line manager or the clinical lead for the service, may help to determine current priorities.

Priorities may also be identified by considering the reasons for wanting to capture impact in the first place. For example, if the purpose is to demonstrate the need for a replacement at nurse consultant level, i.e. if you are planning to retire, it may be important to focus on the areas of impact that are unique to the role – for example how it is different to the impact of clinical nurse specialist or medical colleagues, and what would be missed if the nurse consultant was not replaced?

Although there are advantages to looking at your *direct* impact in relation to the three domains (patients, staff, and organisation) – it is also worth challenging yourself to consider your *indirect* impact – for example, your impact on how patients experience the service as a whole or key organisational targets through the training of other staff.

Activity 5 - Identify your current priorities in relation to capturing impact

In the box below identify the most important areas of impact to capture at this moment in time in relation to patients, staff, and the organisation, and note down your rationale for each.

Activity 5	***Current priority area of impact***	***Rationale for prioritising***
Patients		
Staff		
Organisation		

Section 3 Guidance on capturing impact

This section provides general guidance on how to capture impact. We first look at some of the common challenges to capturing impact that were identified by the nurse consultants and their stakeholders in our project. The activities in this section aim to get you thinking about the barriers, facilitators and approaches you could use to capture evidence of impact.

3.1 Challenges of capturing impact

Activity 6 - Barriers and facilitators to capturing evidence of impact

For the priority areas you identified in Activity 5, think about the barriers you might encounter if you tried to capture this impact and what facilitators might help you to succeed.

Activity 6 **Priority area from Activity 5**	**Barriers**	**Facilitators**
Patients		
E.g. Evaluating the impact on patient outcomes and experience of attending a nurse consultant led clinic	- *Feeling uncomfortable approaching patients directly & social desirability bias* - *Lack of suitable comparator*	- *Third party approaching patients & emphasising confidentiality* - *Benchmark the outcomes achieved in clinics over time*
Staff		
E.g. Evaluating the impact of learning on practice of a national staff training course on motivational interviewing	- *Lack of time/resources* - *Diverse geographical location of participants* - *Lack of expertise in capturing impact*	- *Online survey software* - *Partnership with academic link to advise on methods, questions, software, analysis.*
Organisation		
E.g. Evaluating the impact of meeting national targets for the service/speciality (e.g. stroke vital signs)	- *Difficulty attributing impact to an individual if team effort*	- *Try to focus on outcomes attributable to you or the services you lead* - *Get others to validate your contribution*

In our project, we identified several challenges that may be encountered when trying to capture the impact of a nurse consultant. These are discussed below, together with suggestions about ways to address them.

1) Attributing impact to an individual.

As discussed in Section 2.3, your impact may be indirect or might be achieved through teamwork. In this context it is difficult to identify your individual contribution to the outcome. Furthermore, you might feel uncomfortable claiming that the outcome can be linked to your contribution specifically.

In some situations it might be possible to identify what part you played in contributing towards the overall outcome. For example,

When I get involved with something I try to take somebody else with me. I try to do it as a joint project rather than a one man show, which means that it's difficult to unpick the effects that I've had. (nurse consultant)

I think our breastfeeding figures are very good. So that's something that could be measured. But then, it couldn't be attributed solely to my role. But it's one of several things that I have an input on. (nurse consultant)

a nurse consultant might have developed guidelines on the prompt assessment of patients that other staff follow, which has led to a national target being met. Staff following the guidelines (i.e. their behaviour) is a *direct* impact of the nurse consultant, which is potentially auditable. The *indirect* impact on the service of meeting the national target might be tricky to link to an individual. However, it might be appropriate to ask team members to validate how you contributed to an outcome – see Section 5.3 for examples of undertaking this sort of evaluation.

2) Lack of time.

Lack of time is always a difficult barrier to address in healthcare and may place constraints on the ways in which evaluation of impact can take place. Ultimately, there is a need to be realistic about what you can achieve. The methods used should be pragmatic and feasible within the time available. The use of existing data should be considered to save the time involved in collecting new information.

3) Lack of resources.

Limited resources are also a significant constraint for some nurse consultants, this may include lack of expertise in undertaking data collection and analysis, and the lack of finances to release individuals to collect data.

> *The best way of getting feedback is by a fairly senior person who can coax patients to get more out of them, such as a patient experience tracker or go through a paper based question. If you've got the resource to be able to do that, then that is the best way but they have to be led by people who've been trained in interview techniques. (matron)*

Again, there is a need to be realistic! Options might include using existing data, or adapting established data collection opportunities in your organisation. Some of these will be explored in Section 5. There may be other resources and individuals in your organisation or externally that you could make use of to help and support you to assess the impact of your role. For example:

- the Clinical Audit Department will have expertise in collecting and analysing audit data
- Patient Advice and Liaison Service (PALS) staff, hospital volunteers, or support groups may be able to help administer a patient survey
- specialist networks or patient charities may have tools or resources to help undertake a patient or staff survey – see section 5.1 and 5.2 for examples
- colleagues undertaking projects as part of an education course may be willing to collect and analyse relevant data, or you could approach local universities with ideas for projects, which could be undertaken by students

4) Practicalities in gaining a patient perspective

Obtaining the perspective of patients is important when trying to illustrate the impact of your post on patient outcomes and experiences. However, this can be challenging for a number of reasons.

Involving vulnerable patient groups can be difficult. You need to consider the most appropriate time to ask patients for their feedback, whilst also recognising the value of obtaining real-time feedback in order to enable improvements to the service to be made promptly.

> *We do patient feedback surveys: because of the particular client group they have to be run within the clinic and we accept that people will not necessarily have traceable identifiers. (clinical director)*

In order to obtain honest and accurate feedback, patients need to be assured that their involvement is confidential. This might require involving a third party to approach patients or help with the data collection.

Communication barriers may be an issue as some patients may need additional support in order to provide feedback, for example patients who are not fluent in written or spoken English or who have cognitive difficulties.

When obtaining information from patients it needs to be recognised that very positive responses might suggest a social desirability bias where patients over-report positive aspects and under-report

negative aspects. To help overcome this, emphasise to patients the value of receiving constructive criticism and suggestions on the areas where the service could be improved.

Obtaining patient feedback about your post may be particularly challenging if you do not have formal direct interaction with patients or if you interact briefly with patients with complex needs. In these situations the value of obtaining the patient perspective is still important, but the focus may need to shift away from your specific post, and instead gather patients' views on the service in general.

It's about 'can patients pick her out?'. Those that have met her would say that she's had an impact, those that haven't met her wouldn't, although what she's done has had an impact on them. (governance coordinator)

5) Lack of expertise in measuring impact

Although most nurse consultants have experience of undertaking audit and service evaluation, they may not have looked specifically at capturing impact. When an evaluation of a service or an intervention has focused on process rather than outcomes, it is difficult to judge what impact has been made. For example, a nurse consultant might undertake an evaluation at the end of a teaching session on assessing and managing pain to ascertain the extent to which the session met the perceived needs of the participants. However, in order to judge the *impact* of the session the nurse consultant would need to consider whether staff had increased their knowledge and skills and whether they were able to apply this new knowledge when caring for patients. As mentioned previously there may be individuals and departments in your organisation to assist you in selecting outcome measures.

There are also various evaluation frameworks which may help you plan how to go about capturing your impact. Robson (2010) provides an overview of several approaches to evaluation. In addition, the Logic model is gaining in popularity as a means of evaluating new initiatives in health care, including evaluating advanced practice nursing (Canadian Nurses Association 2006). Developed initially to guide the logical planning of new initiatives to include consideration of the outputs and outcomes, the logic model comprises four stages

1) inputs (resources such as staff, equipment, finance)
2) work activities, programs or processes
3) the immediate outputs of the work that are delivered to the end user e.g. patients
4) outcomes or results that are the long-term consequences of delivering outputs.

Other versions of a logic model set out a series of intermediate outcomes or results, explaining in more detail how an intervention contributes to intended or observed results. These include outcomes or impacts that may be:

- Short Term (learning: awareness, knowledge, skills, motivations)
- Medium Term (action: behavior, practice, decisions, policies)
- Long Term (consequences: social, economic, environmental etc.)

The University of Wisconsin's website has an extensive resource, including training materials, templates and examples of the logic model:
http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

6) Identifying suitable outcome measures

There may be a lack of suitable tools to capture outcomes in some specialist areas. For example, although there are validated questionnaires for measuring quality of life amongst cancer and diabetes patients, such tools do not cover all medical conditions. In this situation it may be appropriate to use a generic measure (see Sections 5 & 7 for examples) or adapt an existing tool from a different speciality.

7) Lack of suitable comparator

Previous studies evaluating services provided by nurses in advanced practice roles have often involved making a comparison to the usual care provided, for example comparing outcomes of a nurse-led clinic to the existing service provided by a medical doctor. Several published studies illustrate the use of a rigorous approach to evaluate the impact of services provided by advanced practice nurses (see Box 1).

Box 1 - Published examples of evaluation approaches

Ball et al. (2003) conducted a before-after study to explore the impact of introducing a Critical Care Outreach Team (CCOT). Data were routinely collected as part of an existing audit. The data collected in the year before the CCOT introduction were compared to data during the first year of the new service. The results showed a significant increase in survival to hospital discharge and decrease in readmissions to critical care.

Kinnersley et al. (2000) describe conducting a randomised control trial to compare the care provided by nurse practitioners and general practitioners in primary care. Patients who were willing to take part were allocated a provider by day or within day. The outcomes collected included patient satisfaction, length of consultation, resolution of symptoms/concerns, etc. The results illustrate similar outcomes relating to most measures, although patients were generally more satisfied consulting with nurse practitioners.

It is unlikely that you would have the time, resources or expertise to undertake such detailed evaluation studies, but some of the principles from these studies might be adapted for a smaller scale evaluation of the impact of a local service you have developed.

One of our medics will see eight patients in two hours. In the same time I'll see three patients. It's a different clinic, that's not a criticism of him. When you've got a team approach there are benefits of somebody being exposed to the medic's clinic rather than mine, because it's the overall package that's important. (nurse consultant)

In some situations it may be possible to make comparisons between the services you provide and those provided by another practitioner, for example if you substitute for a medical consultant in running follow-up clinics. However such comparisons are not always appropriate as the care you provide may be notably different from that provided by a medical consultant.

An alternative might be to collect data before and after you introduce a new service. For example, a nurse consultant might collect data from family carers prior to introducing a carer support group, and then collect data once the support network is well established. If the evaluation is small scale the number of carers may not be sufficient to demonstrate statistically significant differences. Nevertheless, some important differences may still be evident that are valuable to capture.

In situations where it is not possible to make comparisons between a nurse consultant-led service and an alternative service, or to collect data before and after a service has been introduced, benchmarking might be used instead. For instance, a service provided by a nurse consultant might be audited against national standards. In our project, for example, a nurse consultant in neonatal care audited the service against the national standards for the provision of high quality care outlined by the patient charity, BLISS. Where no such standards exist, local ones may be developed and the service audited on successive occasions to ensure that outcomes are maintained or improved where appropriate.

Box 2 - Example from our project – evaluating improvements in a service

A nurse consultant in gynaecology conducted a service evaluation, involving a review of patient notes during a one week period. Based on the results, the nurse consultant implemented several changes; appointment times were reviewed, emphasis was placed on the nurse discharge protocol, patients were provided with information and invited to the follow-up service but were not given a routine follow up appointment. A repeat review was carried out five months later, which focused on whether the changes had improved the total time spent in clinic by patients, utilisation of nurse discharge protocol and 'did not attend' rates.

Even in the absence of a suitable comparator, many of the nurse consultants in our study saw value in capturing information at regular time points (i.e. an audit cycle - see Benjamin, 2008) in order to monitor and provide a benchmark of their impact and to ensure that those standards remained high.

Tips for overcoming challenges of capturing impact

Tips that may help you to overcome some of these challenges include:

- Be realistic in terms of time available
- Use existing data where possible
- Adapt existing data collection mechanisms where feasible
- Identify other individuals or resources that might help - think of the expertise available within your own organisation and externally
- Ensure that the procedures for capturing patient feedback are considered
- Seek out additional advice, support or resources on capturing impact
- Consider benchmarking impact over time to review outcomes
- Where possible identify impact that is attributable to your role or the service that you lead, and get others involved to highlight what difference you have made to obtaining those outcomes

3.2 Approaches to capturing impact

There are two broad approaches to obtaining information to demonstrate impact.

1) Using data from other sources. It may be possible to use data that are collected for routine purposes in the organisation such as length of stay, number of untoward incidents, MRSA rates or number of pressure sores. Data that are collected for CQIN audits, patient satisfaction surveys, patient reported outcome measures (PROMS) and other national audits may be useful to explore the impact of some nurse consultant roles. It may also be possible to influence planned data collection in order to capture additional dimensions which relate more explicitly to your contribution, for example, by adding a couple of questions to a forthcoming patient satisfaction survey. Further examples will be presented in Section 5.

2) Starting from scratch. Where there are no routinely collected data which are appropriate for demonstrating your impact new methods may need to be developed.

These two approaches could involve using quantitative, qualitative or mixed methods data collection and analysis techniques.

Quantitative methods focus on numerical, quantifiable data that can be analysed statistically to describe and compare results, for example recording the number of ward nurses trained in a particular procedure, or survey data showing an improvement in the knowledge and confidence of staff after training.

Qualitative methods focus on the quality of the issue under scrutiny, in particular exploring in detail the 'how' and 'why'. For example in exploring patient experiences of attending a nurse consultant clinic questions might be asked about 'how did it make the patient feel, what was good, what could be improved'. Qualitative methods involve asking open questions and allowing participants to respond in their own words.

Mixed methods use a combination of quantitative and qualitative approaches. This might involve conducting an audit to identify the extent to which a service meets agreed standards, but also asking patients about what aspects of their care they value and what could be improved.

Activity 7 – What approaches might be used to capture evidence of impact relating to the current priorities of your role

Returning to the three priority areas identified in Activity 5, in the activity below identify what approach(es) might be appropriate. Think about whether there are any existing data you could use, for example, length of stay, waiting times, patient satisfaction scores. If you need to collect new data, think about whether quantitative or qualitative information or a blend of both approaches is most appropriate. Selecting a method that best captures the type of information you need is key, and it is also important to consider the feasibility of collecting the data and what you plan to do with it, i.e. who you will present the results to.

Activity 7 **Priority area from Activity 5**	**Existing data**	**Quantitative**	**Qualitative**
E.g. Evaluating the impact of learning on practice of national staff training on motivational interviewing	*Some data on staff knowledge and skills but only before training*	*Survey of participants' knowledge and skills in a follow-up questionnaire*	*Ask participants for examples of how the training has influenced their practice*
Patients			
Staff			
Organisation			

3.3 Guidance on using the different approaches to capture impact

Using data from other sources

There are obvious benefits to using data that has already been collected in terms of saving time and resources. However, there are several issues that you should consider before using existing data.

- Who owns the original data and do you have access to the raw data?
- Are there data protection issues that need to be addressed?
- Do the existing data provide all of the appropriate information to answer your question?
- Is the sample of the existing data suitable and representative?
- Is the measurement tool used the most relevant (especially when there are different ways of measuring some outcomes such as pain) and up-to-date?
- By whom and how were the data initially collected? Ideally, individuals should be trained to collect data on standardised forms in a systematic way.
- Are there any flaws to the original data collection methods that should be considered? For example, if you are using the patient administration system (PAS) to calculate length of stay, remember that if the patient was transferred to a different medical consultant, the information may not be complete.
- How accurate and complete was the original data collection and data entry (e.g. were there a lot of missing data, or were patients lost to follow-up)?
- Does the reliability of the data need to be checked (e.g. by reviewing a subset of patient records and comparing these to the existing dataset)?
- Does the existing analysis meet your needs (e.g. what level are the data at – patient, ward, directorate)?

If you plan to draw upon data which will be collected in the future, you should also consider:

- Whether you need to gain the agreement of the individuals or organisation concerned?
- Are others in the service on board (e.g. clinical lead, manager) and do they understand the importance of gathering information specific to your role?

Starting from scratch

If you are starting data collection from scratch the questions you need to consider will be different and will depend on the type of data you are collecting.

Quantitative

- What kind of outcomes are you interested in? Are objective physiological measures such as blood pressure of interest, or would subjective measures such as pain scores, quality of life, patient satisfaction be more appropriate?
- What sort of validated instruments are available to capture these outcomes?
- Have they been developed using rigorous methods to ensure that they are valid and reliable measurement tools? (for example, see Chapter 23 in Waltz, Strictland & Lenz, 2010)
- Do you need to adapt an existing instrument?
- Do you need to gain permission to use or adapt an existing tool?
- If you need to devise a new instrument what scale should you use? (e.g. 1-5 or 1-10 likert ratings, or more qualitative anchors such as never/rarely/ sometimes/frequently/always)
- How should you administer the questionnaire? (by post, online)
- At what point in time should the data be collected?
- How many participants should be surveyed or records reviewed?
- How frequently should the data be collected? (ongoing versus snapshot)
- How will you manage the information? (database to collect/input responses)
- How will you make sense of the information?
- How will you interpret and use the information? (e.g. benchmark your service against other similar services or existing standards, or against yourself over time to ensure that you maintain your own high standards)

Qualitative

- What questions do you want to answer?
- How will you gather the information? (using written open questions, interviews or focus groups)
- Who should ask the questions?
- At what point in time should the data be collected?
- How many participants should be involved?
- How frequently should the data be collected? (ongoing versus snapshot)
- How will you manage the information?
- How will you make sense of the information?
- How will you interpret and use the information?

Mixed methods

In addition to the points raised above, consider:

- How will you integrate the two types of data?
- How will you make sense of the collective information (especially if the different methods show contradictory findings)?

There are a huge number of resources and texts which provide detailed information on the issues we have touched on here. Some that we have found useful include:

- Andrew & Halcomb (2009) Mixed methods research for nursing and the health sciences.
- Bryman & Burgess (1999) Qualitative Research.
- Gerrish & Lacey (2010) The Research Process in Nursing.
- Polit & Beck (2010) Essentials of nursing research: appraising the evidence for nursing practice.
- Silverman (2010) Doing qualitative research: a practical handbook.
- A series of papers by Petra Boynton in the BMJ about questionnaire research

See reference list on page 75 for full details of all these resources.

Section 4 Evaluating economic aspects of the nurse consultant contribution

(authored by Christopher McCabe & Carolyn Czoski-Murray)

This section provides guidance for nurse consultants who may wish to consider evaluating some economic aspects of their role. We recognise that many nurse consultants will have limited understanding of health economics and may not have someone locally with specialist expertise to advise them. Our approach, therefore, is on providing pragmatic guidance for nurse consultants to use without having to draw upon specialist expertise.

We begin by presenting a practical framework, based upon the Option Appraisal methods used for the assessment of capital investment projects in the NHS, which we believe nurse consultants can use to guide evaluation of their roles. We then provide a worked example of how the framework has been applied to an individual nurse consultant. The framework is not appropriate for evaluating all aspects of a nurse consultant's role, but we believe it will be most useful in evaluating a particular service that a nurse consultant provides, for example, a carer support group, or where a nurse consultant may provide a service which was previously delivered by a different healthcare professional, such as a medical consultant.

Whereas we have taken a pragmatic approach in this Section, we do think that it is beneficial for nurse consultants to have some understanding of the 'theory' of health economics. Therefore, in Appendix 1 we have provided a brief review of the main methods of economic evaluation used to inform healthcare resource allocation decisions and their suitability for capturing the value of nurse consultant roles. We have also included some useful references if you are interested in learning more.

4.1 A framework for evaluating economic aspects of the role

Our proposed framework for evaluating nurse consultant roles in the NHS is derived from the Option Appraisal (OA) (see Appendix 1) framework and consists of 7 stages [Figure 3]. Each stage can be delivered in a more or less resource intensive manner, and the resources utilised should reflect the scale of the resources that will be (are being) consumed by the service and the strategic importance of the objectives to the 'client' for the evaluation; i.e. the decision maker for whom the evaluation is being provided.

Figure 3: Seven stages of evaluation framework for nurse consultant roles

Evaluation framework	
1	Define objective(s) and constraints
2	Identify and describe the options
3	Identify and quantify monetary costs and benefits of each option
4	Identify and quantify (where possible) the non-monetary costs and benefits of each option
5	Assess risks of each option
6	Weigh the non-monetary costs and benefits of each option
7	Assess balance of advantage between options

Stage 1: Define objectives and constraints

The objective of a service or intervention should be clearly defined prior to developing alternative options for achieving those objectives. An objective is a statement of the outcome(s) to be achieved. Increasingly, it is regarded as good practice that objectives should be SMART – *S*pecific, *M*easurable, *A*ttainable, *R*ealistic and *T*ime-bound.

Specific means detailed and well-defined; for example improving patients' health is not well defined; whilst reducing hospital admissions is.

Measurable means quantifiable and capable of comparison; i.e. it is possible to assess the degree to which an objective has been met. A report of 'few hospital admissions' is not comparative whilst 5 hospital admissions per 100 patients vs. 30 hospital admissions, is. In addition, for an objective to be truly measurable, the source of the measurement data must be identified.

Attainable means that it is feasible to achieve the objective. For example, treating all patients within 2 minutes of presentation at Accident and Emergency will not be attainable, whilst treating 80% of patients within 2 hours may be.

Realistic means that the objective is achievable within the current constraints; such as money, skill mix of staff, capital equipment and the expertise within the service. Many objectives are achievable if sufficient resources are allocated to them, however, there are always resource constraints and therefore not all objectives that are attainable are realistic.

Time-bound means that there is a time by which the objective should be achieved. Reducing hospital admissions by 50% is not a time-bound objective, but reducing hospital admissions by 50% within 2 years is. Given that measurements need to be taken at a point in time, the lack of a deadline may also impact upon the measurability of an objective. In addition, the frequency of re-organisation and reconfiguration means that objectives that do not consider timing may become obsolete before they have been achieved.

Constraints are conditions that any option for achieving the objective must also meet. For example the options are likely to have a budgetary constraint. In addition, the options will certainly have to comply with legal requirements and be consistent with national policies and directives from the Secretary of State for Health. The realistic, attainable and time-bound aspects of SMART objectives are a means of examining some of the constraints that options must operate within; for example, a legal constraint would make some objectives unattainable and a resource constraint would make other objectives unrealistic, as would a time constraint.

It is vital that the objectives are endorsed by the decision maker(s) that the evaluation is being undertaken to inform, for example the Clinical Director, General Manager, Finance Director. If the objectives are not endorsed then they must be developed and refined until they are.

Stage 2: Identify and describe the options

A nurse consultant role will be one option for achieving the objective. However, there will be alternative options. When the nurse consultant role is one that was previously provided by other health care professionals, such as a medical consultant, the previous service model should be included in the range of options. Other options to consider might include a nurse practitioner role or a therapist role. It is important to be as comprehensive as possible in identifying the alternative options for achieving these objectives.

Having identified them a detailed description of each option is required. This description should consider the standard questions 'Who, what, when, how and why?'

This will provide a statement of all staff involved in delivering each option (who); what they will do; when they will do it in the care process and approximately how much of their time it will take; how they will do it including what premises, equipment, consumables and other services they will use in doing it; and why doing those things will achieve the objective(s) identified in Stage 1.

This detailed description for each of the options represents the information required to undertake Stage 3 of the evaluation.

Stage 3: Identify and quantify the monetary costs and benefits of each option

Normally the appropriate perspective for evaluating a nurse consultant role will be that of the employing organisation / service funder. The perspective may even be that of a clinical directorate

within a Trust. The perspective is important as it will determine which monetary costs and benefits are to be included in the evaluation.

Monetary costs and benefits include everything associated with the option that will either be charged to a budget or create income (cost savings) to a budget. To an extent this means that the cost data for the evaluation will be more straightforward to obtain because it is likely that someone in the finance department has the information. Frequently a service will share equipment, premises and even staff. When a service uses part of a shared resource, the cost of the resource will need to be apportioned correctly and the NHS has well defined rules for doing this. Consulting with the finance department will avoid making errors in cost apportionment.

The more accurate the description of the option, the more robust will be the quantification of the monetary costs and benefits.

Stage 4: Identify and quantify the non-monetary costs and benefits of each option

This stage is more difficult than Stage 3 simply because NHS systems are designed to capture financial flows particularly carefully. Historically, capturing data on other effects has been less of a focus.

Non-monetary costs and benefits may also be particularly important for nurse consultant roles, with their potential to impact upon staff morale, staff skill levels, patient satisfaction etc. It is likely that these areas will differentiate nurse consultant roles and alternative options for achieving the objectives. It will be important therefore, to obtain agreement from the 'client' for the evaluation as to which effects should be included in this part of the evaluation.

The description of the non-monetary costs and benefits associated with each of the options is likely to have value. A statement of the likely direction of effect will be useful even when the magnitude of effect cannot be specified.

Stage 5: Assess the risks of each option

The future is inherently uncertain and the impact of the uncertainties is unlikely to be uniform across the options. The categories of risk that should be considered include:

- Technical failure; i.e. the option does not deliver the service that it is designed to deliver.
- Adverse events and/or patient safety problems
- Clinical governance risk
- Financial risk; e.g. funding for the service is withdrawn
- Competitive risks; e.g. private sector providers picking up
- Impact upon other aspects of the service; e.g. deskilling of clinical staff

Consultation with the decision maker on the risks they consider relevant to the evaluation is also desirable.

Stage 6: Weigh up the non-monetary costs and benefits of each option

Stages 1 to 5 provide a portfolio of monetary and non-monetary information on the costs and effects of the different options. Stage 6 allows the systematic comparison of the options in terms of the non-monetary costs and benefits, to complement the comparison of the monetary costs and benefits.

There are a number of approaches for weighting these costs and benefits. The simplest is to identify a target threshold for each non-monetary cost and benefit and then state whether each option meets the target or not. A more sophisticated approach is to ascribe a numerical weight to each factor (non-monetary cost and benefit) and then score the performance of each option on each factor. The factor weight is then applied to each score and the weighted scores for each factor can be summed. The performance of each option on the weighted scores can then be compared.

The factor weights are obviously critical to determining the relative performance of different options, therefore it is important that they reflect the values of the decision maker. Where resources allow,

these weights should be derived formally from the stakeholders involved in the decision making using a suite of methods called multi-criteria decision making. Frequently this will not be possible, but the decision maker should at minimum approve the factor weights to be utilised. More details of the method can be obtained from Appendix 3 of the NHS Scotland (2009) guide to Option Appraisal.

Stage 7: Present the advantages and disadvantages of each of the options

Stages 1 to 6 provide the information required to provide a decision maker with a systematic description of the monetary and non-monetary costs and benefits of achieving a given objective using a nurse consultant service compared to alternative methods, using a transparent and systematic framework.

For each domain in the evaluation framework it will be possible to describe the incremental cost/benefit of the nurse consultant option compared to each of the alternative options.

Given the engagement with the decision maker at a number of stages throughout the process, the information produced should be deemed to be relevant and valid, and thus represent an acceptable basis for their decision making. Its systematic nature has the advantage of making the process more transparent to stakeholders in the decision as well as reducing the risk of accusations of bias in the manner that the evaluation has been undertaken.

4.2 Applying the framework in practice: a worked example

Having outlined the proposed framework for evaluating nurse consultant roles we now present a worked example to illustrate how it can be used in practice. The example is drawn from a nurse consultant working in the field of gynaecology who was keen to develop a new alternative service for women to be able to choose. We outline each of the stages in the framework, and summarise the key considerations for evaluating this particular development. By way of reminder, the seven stages of the evaluation framework are:

- Define objective and constraints
- Identify and describe the options
- Identify and quantify monetary costs and benefits of each option
- Identify and quantify (where possible) the non-monetary costs and benefits of each option
- Assess risks of each option
- Weigh the non-monetary costs and benefits of each option
- Assess balance of advantage between options

Stage 1: Define objectives and constraints

The nurse consultant in early pregnancy is reviewing the service currently provided to women experiencing a miscarriage. The early pregnancy service represents one third of the activity within gynaecology. Interventions for miscarriage are not normally provided out of office hours except in an emergency where surgical intervention under general anaesthetic is provided.

Objective: The objective is to *provide effective and efficient management of miscarriage in early pregnancy.*

The decision that this option appraisal is to inform is whether the Trust should invest in an additional option for patients experiencing miscarriage.

The perspective in this example is from the Trust.

Constraints: Operating theatre slots, bed availability and medical consultant capacity are all constraints on the options to be considered. The nurse consultant's time capacity is also a constraint on some of the options.

Stage 2: Identify and describe the options

There are three existing options for the management of miscarriage and retained products of conception (RPOC) in the UK NHS. In this example the treatment options available to the patient are:

- Expectant management - following diagnosis of a miscarriage by ultrasound assessment the patient does not require admission. The ultrasound assessment is undertaken by a qualified sonographer, this could be the nurse consultant or another grade of staff depending on availability and expertise. Following diagnosis, the patient then goes home with an information leaflet and a telephone follow up appointment two weeks later from a nurse. The patient must carry out a pregnancy test on the day of the phone call so that they can report accurately to the nurse making the call. This option was made available in recent years for those patients who did not want have a surgical or medical intervention and preferred to 'let nature take its course'. This option is not recommended for all patients with clinical presentation and gestation being the determining factors.
- Medical management - this option can be offered after diagnosis by ultrasound scan depending on the type of miscarriage (by staff as above). The patient would usually be given oral medication on day one, and allowed home and then returns to the ward two days later for a vaginal pessary. The patient remains on the ward until the products of conception are expelled. This option is nurse led and overseen by the nurse consultant but is usually provided by nursing staff other than the nurse consultant. Follow up is similar for option one above. This option offers patients an intervention that speeds up the process of miscarriage without the need for surgery.
- Surgical intervention under general anaesthetic – this option is provided in theatre by a gynaecologist, either training grades or consultant depending on list allocation. The patient is usually admitted as a day case following diagnosis from scan (by staff as above). Follow up is not normally necessary. Research evidence supports this option as the 'best' option for patients in terms of their clinical outcomes. The other options are provided to reflect patient treatment preferences.
- The **new option** would be for the nurse consultant to provide surgical vacuum evacuation under local anaesthetic administered in a gel form. This option is currently offered to some patients provided by a consultant gynaecologist. The nurse consultant would be able to offer the intervention to patients after diagnosis by scan as above. This would be either by appointment to return to the ward or at the time of diagnosis. This option provides a surgical intervention without the visit to theatre. The service will be initially provided by the nurse consultant but **with the expectation that the training package developed by the nurse consultant will be** cascaded to more junior staff.

Stage 3: Identify and quantify the monetary costs and benefits of each option

Option 1

Monetary costs include the cost of the nurse's time to counsel and explain to the patient what is likely to happen to them. This would vary from between 15 to 30 minutes. The information on the costs of staff time can be obtained from the Trust or PSSRU online, and will include on-costs (http://www.pssru.ac.uk/uc/uc2010contents.htm). The finance department will be able to help with the breakdown of these costs. The other costs are a pregnancy test and a telephone call from a nurse. The unit costs for these would be available from pharmacy and the finance department. The potential costs are an admission to hospital for the patient to have one of the other options if they change their mind or if complications occur such as heavy bleeding or bacterial infection develops. The Trust will have details of the tariff cost of an emergency admission and an elective admission. Audit figures should have the number of patients who take up this option who have a successful outcome. The figures for elective admission and emergency admission for further treatment should be taken into account.

Monetary benefits to the Trust are substantial if patients chose this option more frequently. The monetary benefits to the patients are potential savings in childcare, transport and parking costs in

trips to hospital. The patient can continue at work, if in employment, avoiding loss of earnings. The later is more difficult to quantify but average earnings can be used to calculate a broad figure.

Option 2

Monetary costs include the cost of the bed occupancy for the duration of the procedure. Bed occupancy figures obtained from the Trust or NHS reference costs are likely to have already included the cost of nursing care during the admission. It is best to check if this is the case. The cost of the medication can be obtained from pharmacy. The monetary costs to the patients include potential loss of earnings for a stay in hospital and transport or parking costs. Childcare provision may be an issue for some patients. When itemising costs, they should be calculated with and without childcare. The cost of training new staff to undertake this procedure can be quantified. Routine audit data will have the numbers of patients in this group and their clinical outcomes.

Monetary benefits In this option there are less likely to be monetary benefits to the Trust. However, the nurse consultant has already cascaded the training responsibilities to other staff of a lower grade than the nurse consultant. The patient is unlikely to have any monetary benefits.

Option 3

Monetary costs include the cost of a hospital episode. The figures can be obtained on the tariff and include all the costs associated with the procedure. The actual costs for surgery may be underrepresented in the tariff. The costs to the patients are likely to be similar to those above. As before audit data would provide the figures on the number of patients in this group.

Monetary benefits there are no monetary benefits for the trust. There is a potential benefit to the patient as they will be in hospital only as a day case.

Option 4 (the new option)

Monetary costs. Include the additional equipment costs, nurse consultant time and local anaesthetic gel. The proportion of procedures that have to be abandoned for whatever reason that will go on to have a surgical intervention. The failure figures from the current service provided by a consultant may be extrapolated to the nurse consultant's practice. The potential complications are damage to the uterus without the full back up if they had occurred in theatre. The medical consultant will provide training to the nurse consultant in the first instance and input to the training package developed by the nurse consultant for other staff. The medical consultant will provide ongoing supervision and troubleshooting as the service is established. The nurse consultant will be providing the training package and ongoing supervision for more junior staff. The nurse consultant will also provide backup to these staff. Other grades of nursing staff will not be available for other duties when undertaking this procedure.

Monetary benefits include the savings on the avoided more expensive theatre option. Medical staff of all grades who would be involved in undertaking these procedures in theatre are now free to undertake other duties. This option is carried out as an out-patient procedure. The patient would be offered this option on diagnosis of RPOC or a miscarriage/non-viable pregnancy at less than nine weeks gestation. Potentially, the patient would not have to come back for another visit, (unless the patient does not want the procedure immediately) with likely saving to the Trust and the patient.

Stage 4: Identify and quantify (where possible) the non-monetary costs and benefits of each option

Option 1

Non-monetary costs These include the potential for emergency readmission for the patient at a later date with the anxiety associated with this. The process can take a long time for the patient with increased anxiety. Patient surveys can help identify their perception of the service which will help quantify this.

Non-monetary benefits include patient preference. The potential benefit to patients is in taking control of the process by being in their own home and avoiding a hospital admission. This option is offered at the point of diagnosis without going to theatre. As mentioned above, patient surveys can feedback benefits from this option.

Option 2

Non-monetary costs include possible uncertainty of the outcome, i.e. will there be complications of heavy bleeding?

Non-monetary benefits include the perception by the patient of being looked after and supported in a safe environment of the hospital ward. The treatment has been offered in a timely manner and is managed. The potential benefit to the Trust is that this is a predictable care pathway. The nurse consultant has cascaded training down to more junior nurses to undertake this procedure replacing her involvement in this, giving them more experience and responsibility. An audit and evaluation will show which nurses are currently carrying out this with positive outcomes to patients and staff satisfaction surveys. This is part of the remit of the nurse consultant role.

Option 3

Non-monetary costs This includes a low risk of damage to the uterus during the procedure. (Data available from the Trust audits)

Non-monetary benefits to the patient are that they are unaware of the procedure and it is 'over and done with' in a timely manner. Patient feedback can be obtained to confirm this assumption. Published research evidence may also confirm this. The surgical/theatre option as detailed above is the evidence-based treatment option for patients. (Research available to be incorporated into the appraisal)

Option 4 (the new option)

Non-monetary costs include the potential loss to junior medical staff in training opportunity to undertake routine surgical evacuation under general anaesthetic. The requirements for training junior medical staff could be checked and appraised. Research papers may be available.

Non-monetary benefits include providing AfC Band 7 or above nurses with new skills to undertake the procedure with benefits to the service. The training responsibilities will eventually be cascaded following audit and evaluation of the service by the nurse consultant. The nurse consultant has been innovative in developing the options for patients which do not involve a general anaesthetic. The impetus in gynaecology is to provide more services as an outpatient under local anaesthetic which has been in part driven by patient preferences. This can be measured by published research and an audit of patient choices in the current services.

Stage 5: Assess the risks of each option

Option 1: the risks associated with this are related to the patient developing complications that require further intervention as an emergency admission. The patient may also develop a bacterial infection requiring treatment with a small risk of potential long term implication for the patient.

Option 2: the risks associated with this option are also related to complications for the patient requiring further intervention including theatre involvement.

Option 3: includes the small risk of a serious adverse event (e.g. uterine perforation).

Option 4: carries the risk of potential uterine perforation by the operator. This risk is potentially smaller than under a general anaesthetic as the patient would feel pain and be aware that something was wrong with the procedure. (Published research evidence) There is also the risk of abandoning the procedure for other reasons e.g. the is patient unable to tolerate this procedure.

All of the above interventions carry a possibility of medico-legal risks.

There are also the risks in the system of withdrawal of the services, other than option three. In times of high nursing staff absence the medical staff must cover the service. There is a reported higher incidence of interventions. There is a potential risk of loss of patient choice due to unavailability of nursing staff.

Stage 6: Weigh the non-monetary costs and benefits of each option

It is necessary to identify the weight that the decision maker and/or stakeholders in the decision attach to the non-monetary costs and benefits of each option. For example, some of the options avoid hospitalisation, whilst others avoid the need for general anaesthetic. These are two possible non-monetary costs/benefits.

Patients could be asked to rate the importance of these attributes on a likert scale (scaled 1 to 5; not important to very important). Alternatively the decision maker (NHS budget holder) could be asked to undertake the same exercise. This could be repeated for other non-monetary costs/benefits of the different options.

Options could then be scored as 0=not applicable or 1= applicable for each cost/benefit and a total score produced for each option using the sum of the weight times score for each non-monetary cost/benefit.

Stage 7: Assess the balance of advantage between the options

To assess the different options the following pages provide four tables which summarise the results for each option in terms of (1) cost; (2) monetary benefits; (3) non-monetary costs; (4) non-monetary benefit; (5) risks; and (6) weighted score for non-monetary costs and benefits. In your evaluation the actual monetary values must be included. In the other sections evidence from patient or staff satisfaction and any other evidence should be summarised.

The tables provide the decision maker with a summary of the evidence on which they can make their decision about the value of the nurse consultant role compared to alternative means of achieving the stated objectives. A blank version of this summary table is also provided on our website and available for download for you to use (http://research.shu.ac.uk/hwb/ncimpact/).

Option 1 – expectant management

Perspective Patient/staff/organisation	Monetary Costs (insert actual figures)	Monetary benefits (insert actual figures)	Non-monetary costs	Non-monetary benefits	Risks	Weighted score for non-monetary costs and benefits
Patient	None identified	Can continue to work, care for any existing children etc	Increased anxiety if takes long time	Patient preference	Adverse event	
Other staff	None identified	Medical staff free for other duties.	None identified	Medical staff free for other duties Nurses job satisfaction	Medico legal	
Organisation	Nurse time pregnancy test, telephone call **Potential cost**: Emergency admission	Considerable cost saving to the trust.	Unpredictable care pathway	None identified	Possible emergency admission Medico legal Potential withdrawal of service if nursing shortage	

Option 2 – medical management

Perspective Patient/staff/organisation	Monetary costs (Insert actual figures)	Monetary benefits (Insert actual figures)	Non-monetary cost	Non-monetary benefits	Risks	Weighted score for non-monetary costs and benefits
Patient	Loss of earnings /childcare cost/ multiple hospital visits/ travel costs	None identified	Hospital admission	Reassurance/cared for	Averse event	
Other Staff	None identified	Allows medical staff to do other duties	None identified	Nurse led, medical staff free for other duties	Medico legal	
Organisation	Bed occupancy Drug costs Examination equipment costs Nursing time/ training to perform extended roles	More junior nurses can carry out	None identified	Predictable care pathway	Possible escalation to involve theatre Medico legal Potential withdrawal of service if nursing shortage	

Option 3 – surgical management under general anaesthetic

Perspective Patient/staff/organisation	Monetary costs (Insert actual figures)	Monetary benefits (Insert actual figures)	Non-monetary costs	Non-monetary benefits	Risks	Weighted score for non-monetary costs and benefits
Patient	Loss of earnings/cost of childcare/ travel costs	Day case less time off work	Low risk of adverse event	Anaesthetised so unaware of the procedure	Potential adverse event e.g. uterine perforation	
Other staff	None identified	None identified	None identified	Training opportunity for junior doctor	Medical staff medico-legal	
Organisation	Hospital surgical episode under general anaesthetic	None identified	Low risk of adverse event	Evidence-based care	Potential adverse event e.g. uterine perforation Medico-legal	

Option 4 – manual vacuum aspiration under local anaesthetic

Perspective Patient/staff/organisation	Monetary costs (Insert actual figures)	Monetary benefits (Insert actual figures)	Non-monetary costs	Non-monetary benefits	Risks	Weighted score for non-monetary costs and benefits
Patient	Travel, parking	Outpatient	Aware/discomfort Adverse event	Preference	Adverse event Abandon procedure	
Other staff	None identified	Medical staff free for other duties	Loss of training opportunity for junior doctors in GA surgical procedure	AfC Band 7 and above job satisfaction Patient preference in Gynae towards LA Outpatient activity Training opportunity for junior doctors in LA surgical procedure	Nurse consultant medico-legal	
Organisation	Equipment cost Nurse consultant time Training/supervision Training cascade time (nurse consultant) Nurses not available for other duties No emergency back up as in theatre	Outpatient No theatre/release lists Reduction in bed occupancy	Loss of training opportunity for junior doctors	Evidence-based care	Adverse event with limited back up Medico-legal Potential withdrawal of service if nursing shortage	

Section 5 Examples of capturing impact

In this section we provide several examples drawn from real life experiences of nurse consultants and the published literature of how impact can be captured in the different framework areas. Some use existing data and others involve starting from scratch using both quantitative and qualitative methods.

We envisage that nurse consultants could adapt the methods and tools presented in this section to suit their specific needs.

5.1 Patients

Physical and psychological wellbeing

Data on physical symptoms may be routinely captured in patient notes. The types of symptoms will vary extensively between specialities, but could include physiological measures such as blood pressure, pain, physical impairment, incontinence, and fatigue. A retrospective review of patient notes could be undertaken to determine your impact on the maintenance or improvement in symptoms experienced by patients that you see.

However, you should also consider your impact on psychological symptoms such as anxiety. This could be relevant to both patients and family carers. There are several validated tools that can be used to assess anxiety which have been used extensively in research studies:

- 7 item anxiety subscale of the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983)
- State-Trait Anxiety Inventory (STAI) (Spielberger et al. 1983)

Box 3 - Published studies exploring anxiety

Koinberg et al. (2004) used the HADS to explore anxiety and depression levels amongst women newly diagnosed with breast cancer who were randomised to receiving nurse-led follow-up on demand or routine physician follow-up. Outcome measures were completed at baseline and twice a year over a 5 year period. Results illustrated no significant differences between the groups on anxiety, depression, satisfaction, time to recurrence or mortality.

Marshall et al. (2005) conducted a small uncontrolled before-and-after study to evaluate the use of a brief cognitive behaviour intervention with angina patients led by a nurse consultant. Anxiety was measured by the HADS, alongside items to assess patient's level of understanding, activity and confidence. Results indicated reduced anxiety for patients who were at least borderline anxious before the intervention.

Quality of life (QoL) and social wellbeing

Nurse consultants can make a difference to the QoL and broader social wellbeing of patients or carers. This could be explored in relation to the direct consultations you have with patients or more broadly if you have developed patient-focused services and initiatives.

QoL is increasingly recognised as an important dimension to measure in health care, especially when the management of many long-term conditions may not lead to a significant improvement in symptoms (Bowling, 2005). A number of generic validated QoL tools have been developed, and in some areas condition specific measures exist (e.g. cancer, arthritis, asthma, heart disease – see Bowling, 2001 for specific details relating to various condition-specific questionnaires).

The Short-Form-36 (SF-36) questionnaire (Stewart & Ware, 1992) is a generic measure of subjective health status that has been used in a range of settings to explore QoL (Bowling, 2005). It measures eight dimensions, including physical functioning, social functioning, role limitations due to emotional problems, energy/vitality. The original version, terms of use and scoring manual can be found at: http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html.

More recent versions (including a UK specific version – Jenkinson et al. 1999) are available but many researchers continue to use the original, free version (Bowling, 2005). Shorter versions (e.g. SF-12, SF-8) have also been developed and validated.

Box 4 - Published study exploring quality of life

Mundinger et al. (2000) conducted a randomised control trial exploring the outcomes, including QoL, of patients assigned to either nurse practitioners or physicians in a primary care setting. The SF-36 was the main outcome measure at baseline (time of primary care appointment) and follow-up (6 months later). Results illustrated that patient outcomes were comparable.

QoL and social wellbeing (e.g. return to work, engagement/enjoyment of hobbies, relationships with others) assessments may be explored in both patients and carers. For example, in our project a nurse consultant in stroke provided joint patient and family carer review clinics. She undertook informal assessments of anxiety and depression (using the validated Hospital Anxiety and Depression Scale - HADS) amongst both patients and family carers, plus she used tools to explore family carer stress (Hanson et al. 2006).

Box 5 - Example from our project – impact of carer support group

The nurse consultant in stroke ran a carer support group and wanted to explore the impact of this service on family carers - for example whether it provides knowledge, awareness and support. A bespoke survey (see example tool 2 in Section 7) to evaluate the family carers experiences of attending the support group was developed based on a questionnaire in Schure et al. (2006). This included exploring carers' satisfaction and perceived benefits of attending the group, and an open-ended item where carers were encouraged to provide additional comments relating to their perception of the service.

Patient behaviour

Collecting information on outcomes relating to patient behaviour will often involve reviewing or auditing quantitative hospital data. For example, the auditing of CQIN targets on breastfeeding rates may be indicative of the contribution of a neonatal nurse consultant with responsibility for overseeing a transitional care unit. This could also be supplemented with additional qualitative information to demonstrate the reasons why certain initiatives may have worked or not worked. For instance, in the example above to explore why breastfeeding rates have not increased an open-ended survey could be distributed to women and staff on the transitional care unit.

Patient experience of healthcare

One aspect that consistently emerged in our project was how the nurse consultants impacted on patients' or carers' experiences of healthcare, for example providing a patient-focused experience, which was valued by patients. This was evident in nurse consultant-led clinics, other one-to-one encounters with patients or in the care that patients received within the service as a whole.

You may wish to explore patient satisfaction with the consultations you provide. To explore this there are various validated instruments that could be used, such as:

- Consultation Satisfaction Questionnaire (Baker, 1990)
- Medical Interview Satisfaction Scale (Wolf et al. 1978)
- Patient Enablement Instrument (Howie et al. 1998, 1999)

Box 6 - Example from our project – satisfaction with consultation

A nurse consultant in urology used a shortened version of the Consultation Satisfaction Questionnaire, added three further questions that were pertinent to the focus of her consultations and an open question at the end for patients to write additional comments. She wanted to focus on the new patients that she saw in clinic, rather than those who were returning for follow-up visits. New patients who attended her clinics were asked if they were willing to complete the survey at the end of their consultation. Those who were happy to do so completed it before leaving the department and gave it to the healthcare assistant who worked in the waiting area. The responses were useful and the nurse consultant planned to use the tool to benchmark her consultations on a regular basis.

Although, the above questionnaires have been developed for medical consultations they could be adapted to evaluate nurse consultant led clinics or the clinics conducted by other staff who are trained and overseen by the nurse consultant. The Consultation Satisfaction Questionnaire (Baker, 1990), which is presented as example tool 3 in Section 7, has been used in various studies exploring the

impact of advanced practice nurse roles (Kinnersley et al. 2000; Shum et al. 2000), and a revised version has been validated for use in community nursing roles (Poulton, 1996). The nurse consultants in our project who used this tool adapted it to meet their individual needs.

Another tool that was used by some of the nurse consultants in our project explored patients' views of the communication during their consultation with the nurse consultant (see Box 7 and example tool 4 in Section 7). This tool was developed by the Yorkshire Cancer Network with input from service users. However, it could be appropriate to use in a variety of specialities.

Box 7 - Example from our project – satisfaction with communication during consultation

A nurse consultant in pulmonary hypertension wished to evaluate his patient consultation clinics. The Yorkshire Cancer Network communication survey was used to explore patients' views about the consultation. At the end of the consultation, the clinical nurse specialist who supported the nurse consultant clinic approached patients to complete the questionnaire before they left the department. Patients were happy to participate. The results provided useful patient feedback on their satisfaction with the clinics.

How could you use these tools? Here are some options to consider:

- Give to all patients during a short period (e.g. for 2-4 weeks) or with every 3rd patient during a longer period (e.g. 3 months). Repeat on an annual or bi-annual basis.
- Give to patients at the end of your consultation or involve a third party (e.g. reception staff who support the clinics).
- Note in the patient records when the questionnaire was given to avoid duplication.
- Ask patients to complete it before they leave (hand into reception or put in box) or provide a stamped addressed envelope for patients to return by post.
- Record responses in a database. A simple database can be devised in Excel that automatically calculates the mean/number of responses (see our website for examples) or this webpage may help with undertaking statistical analysis in Excel - http://office.microsoft.com/en-us/excel-help/about-statistical-analysis-tools-HP005203873.aspx.
- The results could be used to identify areas where you may wish to develop your skills further in order to enhance patients' experiences.

In other circumstances, you may wish to capture information relating to patients' experiences of receiving care in the service more generally. This might provide you with evidence on the indirect impact you have on the care environment as experienced by patients, which might be influenced through the initiatives you develop or the training you provide to up-skill other staff members.

Box 8 - Example from our project – staff and parent satisfaction with a service

A nurse consultant in neonatal care was already working closely with the national charity for premature and sick babies (BLISS) to evaluate the effect of an initiative aimed at providing a high quality service. The nurse consultant was the clinical lead for this evaluation, which included an audit of the standards in the unit, alongside both staff and parent surveys. After an initial evaluation of current practice, an action plan was agreed, appropriate changes implemented, and the evaluation was repeated. The parent survey explored experiences of receiving care on the unit. This survey used an existing method and data (rather than undertaking a separate new evaluation of the same parents) that captured a key aspect that the nurse consultant influenced and would be further influencing through the initiative/action plan, etc. In this case, another significant benefit of using this existing mechanism and data was that BLISS would undertake the analysis of the data for the unit, and provide the unit with a report illustrating the results. This would save the nurse consultant and wider team considerable time and resources.

The example in Box 8 illustrates the benefits of identifying other resources that can be used such as medical charities or the clinical audit department.

In contrast, if starting from scratch to capture information on patient experience, there are a number of survey instruments that could be used, including:

- A questionnaire to explore patient and carer experience of the care environment (Patterson et al. 2011). The full questionnaire is presented as an example tool 5 in Section 7
- Picker Patient Experience (PPE-15) questionnaire (Jenkinson et al. 2002)

- Patient satisfaction with intermediate care questionnaire (Wilson et al. 2006)
- Patient Satisfaction Questionnaire (Grogan et al. 2000)
- Patient Satisfaction Questionnaire – long-form (51 items; Ware et al. 1983); and short form (18 items; Marshall & Hays, 1994)

In contrast to the previous survey techniques that rely largely on closed questions, qualitative methods (see Box 9) can provide more detailed information on patients' perspectives of the care they have received or their views about the difference a nurse consultant has made to their experience.

Box 9 - Published study exploring patient experience of healthcare

Ryan et al. (2006) used qualitative interviews to obtain information about rheumatology patients' views of the nurse consultant role and the impact of the role. Patients who attended a nurse consultant review clinic on at least two occasions were recruited. Interviews were carried out by an independent nurse researcher. This was important in order to encourage patients to be open and honest about their views. Patients were interviewed within one week of their appointment with the nurse consultant in order to aid recall. Patients were asked the following questions:

1. Can you describe what happens when you have a clinic appointment with the nurse consultant?
2. What is it like to be cared for by the nurse consultant?
3. What kind of problems/issues are discussed?

Interviews were recorded, transcribed and analysed using a method called Thematic Analysis (Braun & Clarke, 2006). The findings illustrate how patients experienced the holistic nature of the role.

Although the time and resource implications of the above example might make this a difficult method for many, it should not be discounted. There may be opportunities to undertake this type of project as part of an education programme, either by yourself or by a colleague.

Other pragmatic approaches to collecting qualitative data from patients include:

- routinely recording the informal feedback received from patients in the course of consultations
- undertaking focus groups with patients or carers as part of a support group
- asking 2-3 open-ended questions at the end of a consultation and making a note of the key areas in the responses (see Box 10)

Box 10 - Example from our project – evaluating a consultation using open questions

Several nurse consultants asked patients the following questions at the end of their consultation:

- In terms of your experience today, what did we get right?
- Is there anything we could have done better?
- Is there anything we could do to improve your experience in the future?

The patients' responses were recorded on a standard proforma (see example tool 6 in the Section 7) and were reviewed at team meetings. However, it is important to consider who might ask the questions because patients may feel able to be more open about their views if asked by someone not directly involved in their care or if they are able to complete a written response anonymously.

There are numerous resources which provide hints and tips for capturing data relating to patient experience, including the following that we found useful:

- Department of Health (2009) Understanding what matters: a guide to using patient feedback to transform services.
- Picker Institute (2009) Using patient feedback.

5.2 Staff

Competence

As a nurse consultant you will often be involved with teaching to up-skill other healthcare staff via formal sessions or informal on-the-job teaching.

Formal training sessions are often evaluated in terms of the participants' views at the end of the session, for example by asking about their perceptions of the extent to which their learning needs have been met or the quality of the speakers. However this provides little, if any, information about the actual impact of the teaching. In order to judge the impact, it is important to consider the extent to which participants are able to put the knowledge and skills they have gained into practice.

In some instances it may be possible to judge the impact of your training on the actual performance of staff by assessing their performance in practice. For example, a nurse consultant in stroke who is involved in educating other clinical staff to undertake a swallowing assessment following patient admission could gather evidence to illustrate whether staff are undertaking the assessment appropriately (e.g. by checking routine stroke data that all patients have their swallow screen carried out in the recommended time scale). However, it may not always be feasible to observe outcomes in practice directly. An alternative might be to assess staff members' knowledge or confidence before and after the training, preferably allowing some time to elapse before a follow up assessment is undertaken in order to assess retention of learning (see Box 11).

Box 11 - Examples from our project – impact of training

A nurse consultant in sexual health involved in running national training on motivational interviewing (delivered by the nurse consultant and other trainers) was already asking participants to complete a survey at the start and the end of the training session. She was keen to evaluate the impact of the training on participants' knowledge, skills and confidence 6 months after the course and had the contact details of previous participants who were willing. The online software Survey Gizmo (www.surveygizmo.com) was identified as a tool that could provide a way of administering and collecting both the future pre- and the 6 month follow-up data. Survey Gizmo allowed the nurse consultant to send out the surveys to individuals via email, and participants completed by clicking a link and submitting responses. Survey Gizmo has a free package which has a facility that enables the results to be downloaded into a database. This allows the analysis to be performed without requiring all the data to be entered by hand. The items for both surveys are available as example tool 7a & b in Section 7.

A nurse consultant in gynaecology wanted to evaluate the informal on-the-job clinical skills training that she provided to junior doctors. In this situation, it was also identified that because the nursing staff on the ward had been up-skilled considerably through the nurse consultant's initiatives and training packages, they often provided informal advice to junior doctors during their rotations on the ward. Therefore, it was important to explore both the direct (nurse consultant) and indirect (through the nursing staff) impact of the nurse consultant on junior doctors. A before-after evaluation using a bespoke survey (see example tool 8a & b in Section 7) was designed and junior doctors were surveyed at the start and end of their rotation on the ward. This survey has questions about various members of the clinical team, but some specific to the nurse consultant and the other nursing staff.

Issues to consider relating to surveys (see also Jones & Rattray, 2010; Boynton, 2004):

- Who to send it to? If it is a large training course it may not be necessary to survey everyone.
- Whether to use postal or online surveys.
- When to send out the pre and follow-up surveys. This may depend on whether you are using postal or online versions. You should also consider when you would expect the learning to have been put into practice. For example it may be appropriate to survey after one month, or you may consider it necessary to wait longer to see if the learning is embedded in practice.
- How to link the responses from participants at each survey point. Most often participants are not asked to identify themselves by using their name, instead you could ask them to develop a code that they enter each time – for example, month of birth and mother's maiden name.

- How to encourage participants to complete the follow up survey. You may want to consider sending a written reminder or a telephone follow-up to participants who have not returned the questionnaire by the deadline date.

Nurse consultants often have formal links with higher education. This can involve developing curricula and supervising student projects. In order to capture the impact of this area of your work, we developed a survey that could be completed by colleagues in higher education to assess your contribution and identify areas where you could be involved further (example tool 9 in Section 7).

In addition, a number of approaches can be used to gather qualitative information about your impact on the knowledge and skills of other staff (see Box 12). These include:

- group discussions with staff, which could be set up specifically for this purpose or incorporated into regular team meetings in which minutes might be taken.
- asking training participants several open-ended questions, either face-to-face contact after the training or via email. Suitable questions might be:
    - Describe to what extent the training you attended on [topic of training] has influenced your clinical practice?
    - Give at least one example of when you have used the knowledge and/or skills you gained on the course?

Box 12 - Published study exploring impact on learning and practice amongst staff

Jarman et al (2009) used a mixture of quantitative (Yes/No) and qualitative items in an evaluation of a clinical nursing round set up by a nurse consultant. The following questions were asked:

- Have you changed/improved any aspects of your practice as a direct result of participating in the clinical nursing round? If yes, what have you changed?
- What impact has participating in a clinical nursing round had on your practice?

Qualitative responses were examined for the most frequent learning themes identified by staff. The above questions could be adapted to other situations in order to obtain qualitative information about the impact of an initiative carried out or developed by a nurse consultant on the learning and practice of clinical staff

Nurse consultants are often consulted by colleagues within and external to their own organisation to provide advice on a range of issues. The impact of the advice they give may vary considerably. However, unless these 'ad-hoc' consultations are captured, they may go unnoticed in the organisation.

Box 13 - Example from our project – capturing consultancy activity

Several nurse consultants used a bespoke proforma to capture their consultancy activity. They were encouraged to record details about episodes where they demonstrated a level of expertise commensurate with their role as nurse consultant. A copy of the proforma is presented as example tool 10 in Section 7, which includes illustrations from some of the nurse consultants involved in our project.

A nurse consultant in stroke highlighted the wide ranging impact of this consultancy in two examples:

- A cardiology registrar contacted her with concern about a patient who attended his clinic with cardiac problems and stroke. The nurse consultant conducted a joint clinic with the registrar, referred the patient for specific investigations *(impact on patient)* and ensured the registrar had new stroke guidelines *(impact on staff)*.
- A PCT commissioner of intermediate care contacted her after receiving complaints from GPs about the lack of clarity in the pathway. The nurse consultant clarified the process, met with the chair of the local PCT executive committee, redistributed the guidelines and arranged a training day for GPs *(impact on staff and organisation)*.

Quality of working life

By providing clinical leadership, you may have an impact on how other staff experience their work. This may be achieved directly through the leadership, advice and support that you offer staff or indirectly through providing training to up-skill junior staff. In our study, both junior and senior clinical staff identified the impact of working alongside a nurse consultant in terms of enhancing their motivation, morale and job satisfaction.

Various tools explore satisfaction with the work environment. Nolan et al. (1998) developed the Assessment of Work Environment Schedule (AWES), questionnaire which assesses 6 subscales relating to the working environment:

- recognition and regard – e.g. I am given respect by my superiors
- workload – e.g. the workload is shared fairly
- professional development – e.g. there are sufficient opportunities for me to participate in continuing professional education
- quality of care – e.g. the overall quality of nursing care provided is high
- working relationships – e.g. I am part of a team
- autonomy/decision-making – e.g. I have the opportunity to make decisions on my own

This questionnaire has been used to explore nurses' views of their experiences at work and provide a benchmark from which the impact of new initiatives can be measured (Nolan et al. 1998). The full questionnaire is presented as example tool 12 in Section 7. This type of questionnaire could be supplemented with additional qualitative information (collected through regular group meetings) exploring the impact of service changes or new initiatives on staff experiences.

Other tools that might help capture information relating to the working life of staff include:

- NHS Staff Survey that all Trusts are required to conduct annually. This explores staff satisfaction and team working. Results are reported by individual Trusts, but it may be possible to obtain a breakdown of the results relating to each clinical directorate.
- Group Clinical Supervision Questionnaire (Arvidsson et al. 2008), which can be used to capture perceptions of group clinical supervision.

There may also be existing questionnaires that explore the views of staff members, and which might provide valuable information (see Box 14).

Box 14 - Example from our project – evaluating impact on staff morale

A nurse consultant in neonatal care who was involved in leading an initiative (developed by the national charity BLISS) to provide high quality care for babies and parents (see Box 8) also used a survey to evaluate staff morale. The survey was distributed before and after an action plan was implemented and included aspects that measure the quality of the working life amongst staff, for example:

- I believe that the unit is a happy and healthy place to work
- My contribution to the unit is recognised and valued

The results illustrated whether the changes to the service were accepted by the staff, but also provided an assessment of staff morale that could be used to benchmark and monitor in the future if the nurse consultant introduces new initiatives or training programmes.

Work distribution and workload

As a senior nurse, you might impact on the work distribution and workload of others in your team. In our project this was seen directly when the nurse consultant took over responsibility of an aspect of the service that would have ordinarily required medical staff input, for example running a clinic, or indirectly when nurse consultants trained other staff enabling their scope of practice to be expanded.

Box 15 - Example from our project – impact of guideline implementation

A nurse consultant in gynaecology developed and introduced a set of guidelines for nursing staff to follow to discharge patients, where appropriate. A service evaluation that explored several outcomes such as waiting times also measured the utilisation and adherence to the nurse discharge protocol. The initial evaluation identified several recommendations, including the need for additional training and promotion of the nurse discharge protocol. This led to a significant increase in nurse-led discharge which meant that patients were sent home in a timely fashion, rather than having to wait for medical review.

The initiatives you develop can have important implications for work distribution and workload. However, as illustrated in Box 15, rather than look at workload outcomes in isolation it may be more

appropriate to consider them alongside the impact of staff training or introduction of new initiatives on service outcomes, such as waiting times (for example see Box 16).

Box 16 - Example from our project – impact on workforce and workload

A nurse consultant in emergency medicine trained paramedic practitioners to undertake extended skills in order to assess, treat and discharge older patients with minor conditions in the community. This initiative was evaluated by a cluster randomised control trial (see Mason et al. 2007) and outcomes included A&E attendance or hospital admission between 0-28 days, interval from time of call to time of discharge, and patient satisfaction with service. Overall, the results indicated a highly positive impact of the initiative, with patients being significantly less likely to attend the A&E department, require hospital admission, and were significantly more satisfied. Although this example does not include any specific workload or work redistribution outcomes, the organisational outcomes (reduction in A&E attendance and hospital admission) have workload implications in that the paramedic practitioners were able to undertake work that previously would have required input from other healthcare professionals (e.g. staff in A&E).

Box 17 - Published studies exploring workload

Laurant et al. (2004) conducted a study to evaluate the impact on GP workload of adding a nurse practitioner to the primary care team. Two measures of workload were used 6 months before and 18 months after the introduction of the nurse practitioner: 1) objective workload was measured by a 28 consecutive day diary recording GP start and end time of working day, and for patients with specific conditions (e.g. cancer, asthma, dementia) the number of consultations in practice, on telephone, and home visits, and 2) subjective workload was measured by a validated questionnaire exploring satisfaction with the availability of time for practice management, job satisfaction, level of inappropriate demand by patients, and perceived discrepancy between investment and reward.

Richards et al. (2002) conducted a study to compare the workloads of GPs and nurses of nurse telephone triage and standard management of same day appointment requests in primary care. Data were collected (for one week per month) through standardised diaries completed by GP or nurse on same day appointment patients. The diaries recorded the type of consultation (practice, telephone, visit), consultation time, and up to three presenting complaints. Data were validated against clinical notes in the electronic patient record.

Team working

If your nurse consultant role spans organisational and professional boundaries, you may impact on the effectiveness of team working amongst the staff in your service. In this context effective team working is an outcome in its own right, but it can also impact on other staff outcomes such as enhancing knowledge, increasing morale and job satisfaction which in turn leads to high quality patient care.

Some nurse consultants provide clinical and professional leadership to a team of advanced practice nurses. Capturing the impact of this leadership role can be useful.

Box 18 - Example from our project – impact on team working

A nurse consultant in sexual health who provided clinical leadership to a team of Agenda for Change band 7 nursing staff used a short 7-item measure of global transformational leadership developed by Carless et al. (2000). This was identified as suitable to evaluate how the team members viewed the nurse consultants' leadership and its impact on effective team working. This measure has been shown to be reliable and valid (Carless et al. 2000), including correlating strongly with other more lengthy leadership questionnaires, and has been used in healthcare settings (e.g. Nielsen et al. 2009). The full instrument is presented as example tool 11 in Section 7, but examples of the questions include:

- Treats staff as individuals, supports and encourages their development
- Fosters trust, involvement and co-operation among team members

The authors of this tool determine that it can be completed by subordinate roles (as above) or by a direct superior (e.g. line manager, clinical lead).

Other surveys that could be used to evaluate team working include:

- Team Climate Inventory (West, 1990) – also a validated 14-item version in Kivimaki & Elovainio (1999)
- Healthcare Team Vitality Instrument (Upenieks et al. 2009)
- Nursing Teamwork Survey (Kalisch et al. 2010)

5.3 Organisation

Organisational priorities and targets

Most organisational priorities and targets are captured by routine audit work (see Box 19). It may be possible to use some of this information to demonstrate the outcomes of services you have developed or lead, for example the waiting times for a nurse consultant-led clinic could be compared with the waiting times for a medical consultant.

Box 19 - Examples from our project – impact on organisational priorities and targets

A nurse consultant in urology actively managed the waiting lists for her nurse-led clinics to ensure that waiting times were kept to a minimum by screening out inappropriate referrals and ensuring that these patients were seen by more appropriate services. Data on waiting times was routinely monitored and readily available in the trust.

A nurse consultant in gynaecology reorganised the provision of care provided to women attending the department with hyperemesis (severe morning sickness). The reorganisation involved providing a day case service (with reclining chairs, rather than beds) instead of the previous service that often admitted women for an average stay of 2 nights. To review the new service a sample of 40 randomly selected sets of case notes were reviewed retrospectively before and after the new service was introduced. The results indicated a significant decrease in length of stay and overnight admissions.

Development of policy

As a senior clinical nurse you will often contribute to the development of policy initiatives, locally, regionally and nationally. This may involve membership of committees responsible for standard setting, developing clinical guidelines or protocols relating the workforce initiatives or responding to consultations. When contributing to regional or national initiatives, you are uniquely placed to bring back intelligence to your own organisation to help shape local services. Therefore, it is worth capturing the impact of this work, both within and outside the organisation. In our project a proforma (see Box 20) was devised to capture the nurse consultants' external work.

Box 20 - Example from our project – impact external to the organisation

Several nurse consultants used a bespoke proforma (see example tool 13 in Section 7) in order to capture the broad scope of the nurse consultant's external activities. These included committee membership, stakeholder meetings, education/training, research/consultancy projects, feedback on consultation documents, review activities (e.g. journals articles), as well as outputs such as conference presentations, publications, grant proposals, and guidelines/protocols. The form also prompts the nurse consultant to reflect on the outcomes of that activity and what is brought back to the organisation as a result.
All of the nurse consultants found this form very useful to complete, discuss at their annual review with their line manager and prioritise the activities that they would continue to undertake. Some also felt that the form could be adapted to incorporate internal activity as well.

Another, more specific way to evaluate your impact on policy might be through reviewing the minutes of key meetings that relate to the development or implementation of policy. These minutes will often detail the work being undertaken, by whom (i.e. if you have led a particular aspect this should be detailed) and the outcomes on the service or organisation. This kind of review may also provide evidence relating to the previous category - organisational priorities and targets.

This is another example of how existing data or information can be reviewed in order to provide evidence. In our project, a proforma was devised to pull together evidence of achievements from the minutes of meetings (see example tool 14 in Section 7). You could complete this form to demonstrate the achievements of the key meetings that you attend relating to the development and implementation of policy or associated organisational outcomes.

Generation of new knowledge

A key component of the nurse consultant role is the remit for involvement in research. The external activity proforma previously described in Box 20 has a section in which you could detail your research activity. This could range from being a principal investigator or a co-applicant, through to being a clinical advisor or member of a research project advisory group. The form also collects information on the direct outputs relating to this research activity, such as publications, presentations and grant income.

However, it may also be valuable to capture additional information to specifically demonstrate your involvement in research projects (for an example see Box 21).

Box 22 - Example from our project – impact of involvement in projects

A nurse consultant in stroke who was actively involved in an education research project wanted to obtain more specific evidence of her contribution and impact on this project initiative. A brief '360-degree' type questionnaire (both quantitative and qualitative items) was devised to gain in-depth feedback (see example tool 15 in Section 7), which was completed by the other project team members. This provided the nurse consultant with valuable information relating to her perceived role and influence on the project development and outcomes.

Section 6 Who needs to know about your impact?

Once evidence has been collected to demonstrate your impact it is worthwhile considering with whom you will share this information. This will be influenced largely by the reasons for capturing impact outlined in Section 1.3. So, for example, if a case is to be made for continuing a nurse consultant led service it will be important to share the information on the impact of this with managers responsible for making key decisions about service developments. It may also be useful to share the information as part of your annual appraisal with your line manager.

Information on the impact of the services you are responsible for may also be important to the Trust Board in fulfilling its responsibility for quality governance. Your clinical director, or equivalent senior manager should have an overview of the information the Board requires.

Information on the impact of nurse consultant roles can also be useful to senior nurse managers in justifying the value of these posts to the organisation and to develop a business case for new or replacement nurse consultant posts.

You may also want to summarise the findings for the individuals (patients, staff) who contributed feedback or were involved in the process of data collection.

Disseminating the findings relating to impact is also important in raising your profile and visibility in the Trust and externally. Most Trusts have a communication lead who may be able to assist you to identify the key messages you want to share and appropriate avenues for internal and external communication.

The specific approach undertaken to sharing the evidence of your impact will depend on the audience you are aiming for, but might include:

- a written report for disseminating information within the organisation
- a written account in the Trust newsletter
- a workshop or seminar in the Trust or at a local clinical network event
- a journal article
- a conference presentation

It is important that you present information about your impact in a format that is relevant to the audience you wish to communicate with. A report prepared for your line manager as part of the appraisal process will link your impact to the objectives you have been working to achieve. By contrast a report to the Trust Board will need to be written in a succinct way that addresses their priorities and summarises the key messages they need to know. Likewise, if you want to use evidence of your impact to support a business case for service development, you will need to present the information in a way that justifies the resources and investment necessary to bring about the proposed change.

Various strategies relating to dissemination to external audiences, for example publications and conference presentation, are discussed in Chapter 37 of Gerrish & Lacey (2010), which also provides some useful tips and links to additional resources.

Section 7 Examples of tools for capturing impact

This section includes copies of the tools that were referred to in the examples presented in Section 5.

We have structured the tools according to their main focus and have colour-coded them in order to make it easy for you to refer to the area you are looking to capture evidence of your impact on:

- Patients green
- Staff mauve
- Organisation peach

Once again, it is important to emphasise that we envisage that nurse consultants may need to adapt the example tools presented in this section to suit their specific needs.

Furthermore, you may already have a specific tool that you use to capture patient experience. The example tools in this section are not being presented as the 'best' tools available, rather they provide some generic examples that may be useful and can be adapted to suit your needs.

Individual copies of the tools are available as Word documents on our website:
http://research.shu.ac.uk/hwb/ncimpact/

Some of the tools presented in this section are validated measures and permission has been sought from the authors to include their tool in this toolkit. Reference to any published work validating the tool and details of the authors are presented below.

For all of the tools in this section, you are advised to contact the authors (detailed below) for permission to use or adapt their tools in practice.

The tools presented in this section and the corresponding authors are as follows:

Tool 1 – Scoping of impact feedback tool *
Tool 2 – Carer support group evaluation (adapted from Schure et al. 2006)
Tool 3 - Consultation Satisfaction Questionnaire (Baker, 1990)
Tool 4 - Communication feedback survey (Yorkshire Cancer Network)
Tool 5 - Patient experience of care environment (Patterson et al. 2011)
Tool 6 - Patient experience proforma *
Tool 7a/b - Evaluation of training (pre/post) *
Tool 8a/b - Evaluation of rotation in gynaecology department (pre/post) *
Tool 9 - Higher education questionnaire *
Tool 10 - Consultancy proforma *
Tool 11 - Team leadership questionnaire (Carless et al. 2000)
Tool 12 - Assessment of Work Environment Schedule (AWES) (Nolan et al. 1998)
Tool 13 - External activity proforma *
Tool 14 - Meeting achievement proforma *
Tool 15 - Project leadership/contributor questionnaire *

* The tools with an asterisk were developed by the authors of this toolkit, therefore please contact us for permission to use any of these tools because we would like to keep track of who is using them and we are keen to receive feedback on how they are being used or adapted.

Tool 1 - Generic 360° feedback tool

Scoping the range of impact feedback tool

Date: ..... Name of Nurse Consultant: .....

Please indicate your role by ticking the appropriate box below:

Nurse	☐	Manager	☐	Other agency	☐	Other	☐
Doctor	☐	AHP	☐	Educator	☐		

I would like to find out your views about the impact of my post over the last 12 months. Please feel free to include more than one example when giving your answers.

How has the nurse consultant post benefited the service over the past year in relation to having an impact on patients, staff, service provision, income etc? Please comment in relation to the four dimensions of the nurse consultant role identified below.

a) Expert practice

.....

.....

.....

.....

.....

b) Professional leadership and consultancy

.....

.....

.....

.....

.....

c) Education, training and service development

.....

.....

.....

.....

.....

d) Research, audit and evaluation

.....

.....

.....

.....

.....

What impact has the nurse consultant post had on **you/your role** over the past year?

.....

.....

.....

.....

.....

What other initiatives/developments could the nurse consultant post contribute to the service / organisation in the coming year?

.....

.....

.....

.....

.....

Please return this form via email to (enter name and email address).....

Carer support group evaluation

We are always striving to further improve and develop the [X service], and we want to ensure that the service we provide is of the highest quality, not just for patients but also for family carers. One particular aspect of the service we want to focus on is the carer's stroke support group.

This questionnaire seeks your views about attending the carer's support group, and your contact with [name of Nurse Consultant]. It will give us with valuable feedback to ensure the service is providing appropriate support to meet your needs.

Please answer all of the questions. Your answers are anonymous and are kept entirely confidential, so feel free to say whatever you wish. At the end of the questionnaire specific comments are particularly welcome and valued.

If you do not understand any of the questions please discuss it with [insert name/contact number].

Please return the completed questionnaire to (insert name and address) by (insert date). A pre-paid envelope is enclosed for this purpose.

Thank you very much for your help.

(insert name)

Date: _____

Below is a list of aspects that you may have found helpful when attending the carer's support group. Please read each item carefully and tick the box that is nearest to your view of whether or not you have experienced this whilst attending the support group: *"Neutral"* means you have no views either way.

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
1. Having a better understanding about [condition]	☐	☐	☐	☐	☐
2. Gaining information about the effects of [condition] from various professionals	☐	☐	☐	☐	☐
3. Gaining information on how best to care for the person who has [condition].	☐	☐	☐	☐	☐
4. Gaining support from my peers	☐	☐	☐	☐	☐
5. Feeling supported by the nurse consultant who runs the carers group	☐	☐	☐	☐	☐
6. Gaining information about forms of support I can ask for if the need arises	☐	☐	☐	☐	☐
7. Discovering that my situation is similar to that of others	☐	☐	☐	☐	☐
8. Understanding the psychological consequences of [condition]	☐	☐	☐	☐	☐
9. Understanding the problems in caring for the person who has [condition]	☐	☐	☐	☐	☐
10. Discovering what is challenging in the care for a [condition] patient	☐	☐	☐	☐	☐
11. Seeing how others cope with problems that are comparable to mine	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
12. Receiving advice and practical suggestions on how to deal with certain situations or problems	☐	☐	☐	☐	☐
13. Being encouraged to try new ways of dealing with problems	☐	☐	☐	☐	☐
14. Being encouraged to take time off from my responsibilities as a family caregiver occasionally and find time for myself	☐	☐	☐	☐	☐
15. Being reminded to consider myself as well as the patient	☐	☐	☐	☐	☐
16. Being encouraged to seek additional outside help for looking after the patient	☐	☐	☐	☐	☐
17. Learning that my problems are not unique and that others in similar circumstances have the same experiences	☐	☐	☐	☐	☐
18. Learning that there are people to whom I can turn for help, so that I no longer feel alone	☐	☐	☐	☐	☐
19. Learning to accept the situation of the patient	☐	☐	☐	☐	☐
20. Being encouraged by the successful coping of others	☐	☐	☐	☐	☐
21. Feeling supported by others	☐	☐	☐	☐	☐
22. Being able to talk through my worries with others	☐	☐	☐	☐	☐
23. Being able to share my fears and feelings of uncertainty with someone else or others	☐	☐	☐	☐	☐
24. Discovering new ways of looking at my problems and trying to control my emotions	☐	☐	☐	☐	☐

Please add any other comments about your experience of attending the carer support group and your contact with [name of nurse consultant] that you think is helpful for us to know about. We value constructive criticism as well as positive comments. Please make suggestions on how we can improve the carer support group, anything else you feel is needed to help support you in your caring role, let us know what has been particularly good about the group, or any other aspects of support you have received in caring for the person who has [condition].

……
……
……
……
……
……

Thank you for completing this survey. If there are any points raised by this questionnaire that you would like to discuss with someone personally and in confidence, please contact: [Insert name/contact number].

Nurse consultant consultation satisfaction questionnaire

We are seeking your assistance to continue to develop the [X] Service. This questionnaire aims to explore your satisfaction with your consultation with the nurse consultant. It has been developed to help us improve our service. Please complete this questionnaire in relation to your experience ***today*** with the nurse consultant.

Please answer all of the questions. Your answers are anonymous and are kept entirely confidential, so feel free to say whatever you wish. Your answers will not have any affect on the care that you receive. If you do not understand any of the questions please feel free to discuss it with [Insert name/contact details].

[Insert details about returning survey].

Thank you very much for your help.

Please read each item carefully and tick the box that is nearest to your opinion of how you felt during your experience of attending the clinic today: *"Neutral"* means you have no views either way.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I am totally satisfied with my visit to the nurse consultant	☐	☐	☐	☐	☐
2. The nurse consultant was very careful to check everything when examining me	☐	☐	☐	☐	☐
3. I will follow the nurse consultant's advice because I think he/she is absolutely right	☐	☐	☐	☐	☐
4. I felt able to tell the nurse consultant about very personal things	☐	☐	☐	☐	☐
5. The time I was able to spend with the nurse consultant was a bit too short	☐	☐	☐	☐	☐
6. The nurse consultant told me everything about my treatment	☐	☐	☐	☐	☐
7 Some things about my consultation with the nurse consultant could have been better	☐	☐	☐	☐	☐
8. There are some things the nurse consultant does not know about me	☐	☐	☐	☐	☐
9. The nurse consultant examined me very thoroughly	☐	☐	☐	☐	☐
10. I thought the nurse consultant took notice of me as a person	☐	☐	☐	☐	☐
11. The time I was allowed to spend with the nurse consultant was not long enough to deal with everything I wanted	☐	☐	☐	☐	☐
12. I understand my condition much better after seeing the nurse consultant	☐	☐	☐	☐	☐
13. The nurse consultant was interested in me as a person, not just my illness	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
14. The nurse consultant knows all about me	☐	☐	☐	☐	☐
15. I felt the nurse consultant really knew what I was thinking	☐	☐	☐	☐	☐
16. I wish it had been possible to spend a little more time with the nurse consultant	☐	☐	☐	☐	☐
17. I am not completely satisfied with my visit to the nurse consultant	☐	☐	☐	☐	☐
18. I would find it difficult to tell the nurse consultant about some private things	☐	☐	☐	☐	☐

Please add any other comments about your consultation that you think might be helpful for us to know about.

……
……
……
……
……
……
……

Thank you for completing this survey. If there are any points raised by this questionnaire about your care that you would like to discuss with someone personally and in confidence, please contact: [Insert name/contact details]

Communication feedback survey

We need your help to continue to develop the [insert name] service. This questionnaire aims to explore how we communicate with patients. It has been developed to help us improve our service.

Please complete this questionnaire in relation to your experience ***today*** with the nurse consultant. Your responses are strictly confidential and anonymous.

Please hand in your completed questionnaire today using the envelope provided into the box in reception OR return it using the pre-paid envelope as soon as possible.

If you do not understand any of the questions please feel free to discuss it with (insert named contact and contact details).

Thank you very much for your help.

(insert name)
(insert date)

Please read each item carefully and tick the box that is nearest to your opinion of how you felt during your experience of attending the clinic today.

	Agree	Don't know	Disagree	Doesn't apply
1. I was greeted in a way that suited me	☐	☐	☐	☐
2. I was spoken to like an equal	☐	☐	☐	☐
3. The person speaking to me did not maintain appropriate eye contact	☐	☐	☐	☐
4. The person speaking to me made real efforts to put me at my ease	☐	☐	☐	☐
5. I was encouraged to ask questions	☐	☐	☐	☐
6. I did not trust the person who was talking to me	☐	☐	☐	☐
7. I was given information in a clear and understandable manner	☐	☐	☐	☐
8. We were interrupted by phone calls	☐	☐	☐	☐
9. I felt rushed and hurried	☐	☐	☐	☐
10. I was asked about my feelings as well as my physical health	☐	☐	☐	☐
11. I was spoken to in a manner that was open and honest	☐	☐	☐	☐
12. I was given helpful written information to take away with me	☐	☐	☐	☐

	Agree	Don't know	Disagree	Doesn't apply
13. The person speaking to me showed appropriate body language	☐	☐	☐	☐
14. I did not feel the person was paying attention to me	☐	☐	☐	☐
15. The person showed emotions appropriate to the content of the conversation	☐	☐	☐	☐
16. I felt the staff talked about me as if I was not there	☐	☐	☐	☐
17. I was given as much choice as I wanted to be involved in important decisions	☐	☐	☐	☐
18. I found that all the professionals involved in my care were giving me the same information	☐	☐	☐	☐
19. I felt I was given credit for knowing my own body	☐	☐	☐	☐
20. I was not given the information I wanted	☐	☐	☐	☐
21. I was given enough time and encouragement to voice my concerns	☐	☐	☐	☐
22. I was not encouraged to express my own ideas	☐	☐	☐	☐
23. I was given too much information to deal with all at once	☐	☐	☐	☐
24. The person who came with me was made welcome and included where appropriate	☐	☐	☐	☐

Please add any comments that you think might be important for us to know about.

……
……
……
……
……
……
……
……

If there are any points raised by this questionnaire about your care that you would like to discuss with someone personally and in confidence, please contact [named contact & contact details].

Thank you very much for your help

Patient experience of care environment questionnaire

Below are a number of statements about your recent stay in hospital. Please indicate how much you agree with each statement by placing a tick in the box that best reflects your opinion.

	Thinking about my recent stay in hospital I feel that:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does not apply
1	I was given enough information about my condition and its treatment	☐	☐	☐	☐	☐	☐
2	I always understood the information I was given about my condition and its treatment	☐	☐	☐	☐	☐	☐
3	Staff did not respond quickly if I needed help	☐	☐	☐	☐	☐	☐
4	Staff were unaware of my personal likes and dislikes	☐	☐	☐	☐	☐	☐
5	I was always consulted about any changes to my treatment	☐	☐	☐	☐	☐	☐
6	Staff took time to get to know me as a person	☐	☐	☐	☐	☐	☐
7	My visitors were not made to feel welcome	☐	☐	☐	☐	☐	☐
8	The ward was always clean and tidy	☐	☐	☐	☐	☐	☐
9	My family were not encouraged to help with my care if they wanted to	☐	☐	☐	☐	☐	☐
10	I was provided with appetizing food and drinks	☐	☐	☐	☐	☐	☐
11	Staff regularly discussed my progress with me	☐	☐	☐	☐	☐	☐
12	My care was always delivered by the same nurse or group of nurses	☐	☐	☐	☐	☐	☐
13	My family were able to talk to staff about my care when they wanted to	☐	☐	☐	☐	☐	☐
14	If I needed it, I had regular access to therapy staff (physiotherapy, occupational therapy etc.)	☐	☐	☐	☐	☐	☐
15	I could always talk to a doctor if I wanted to	☐	☐	☐	☐	☐	☐
16	If I had any questions staff always answered these promptly	☐	☐	☐	☐	☐	☐
17	Overall the ward was a happy and welcoming place	☐	☐	☐	☐	☐	☐
18	Staff did not have enough time to give patients good care	☐	☐	☐	☐	☐	☐

	Thinking about my recent stay in hospital I feel that:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does not apply
19	Staff did not treat patients (me) with dignity and respect	☐	☐	☐	☐	☐	☐
20	There were always enough staff to meet patients' needs (or my needs)	☐	☐	☐	☐	☐	☐
21	If I had any complaints about my care staff always attended to these promptly	☐	☐	☐	☐	☐	☐
22	I did not feel confident that staff had the right knowledge and skills to give good care	☐	☐	☐	☐	☐	☐
23	Staff always seemed happy in their work	☐	☐	☐	☐	☐	☐
24	Patients were not encouraged to get to know each other	☐	☐	☐	☐	☐	☐
25	Staff always introduced themselves so I knew who I was talking to	☐	☐	☐	☐	☐	☐
26	Staff always explained any treatment or procedure to me	☐	☐	☐	☐	☐	☐
27	My personal possessions were not safe on the ward	☐	☐	☐	☐	☐	☐
28	There was always enough to do to help me pass the time	☐	☐	☐	☐	☐	☐
29	The date and time of my discharge were discussed fully with me	☐	☐	☐	☐	☐	☐
30	I did not have sufficient time to prepare myself for discharge	☐	☐	☐	☐	☐	☐
31	I had enough information about my future treatment prior to discharge	☐	☐	☐	☐	☐	☐
32	Overall the quality of care I received was very good	☐	☐	☐	☐	☐	☐

Your comments

We are very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions - or if you would like to make any further comments, please use the space provided below.

……
……
……
……
……
……
……

Patient experience proforma for use in out-patient clinics

Date: _____ Clinic: _____ HCP Initials: _____

Nature of discussion with patient: _____

Please ask the patient questions 1-3 and complete this form after the consultation to record any details that the patient mentioned.

1) In terms of your experience today, what did we get right?

……
……
……
……
……
……
……

2) Is there anything we could have done better? OR What did we get wrong?

……
……
……
……
……
……

3) Is there anything we could do to improve your experience in the future?

……
……
……
……
……
……
……

Please answer the following questions yourself.

4) If the patient declines to comment or if you feel it is inappropriate to ask them the above questions please indicate below, including any reason (if known).

……
……
……
……

5) From ***your perspective as a healthcare professional,*** please indicate how you felt this patient consultation went on a scale of 1-10? (where 1 = not very well / not very successful, and 10 = very well / very successful): ___

Please add any further comments about the consultation:

……
……
……
……

Please return this form to [name]

Training evaluation - pre-training questionnaire

Date of training …….. Location…… Job title……

Please answer the questions below by circling the appropriate response in relation to your experiences prior to undertaking training in motivational interviewing [tailor to specific training].

1) How often do you use motivation interviewing [tailor to specific training]?

1	**2**	**3**	**4**
Frequently	Sometimes	Occasionally	Never

2) On a scale of 1-10, how would you describe your current level of **understanding** of motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Little understanding									Considerable understanding

3) On a scale of 1-10, how **skilled** do you feel in using motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not skilled									Very skilled

4) On a scale of 1-10, how **confident** do you feel in using motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not confident									Very confident

5) Have you ever undertaken any training in motivational interviewing?

Yes No

If you answered yes please give details below:

……
……
……

6) What do you hope to get out of the training course?

……
……
……

Please answer the following two questions so that we can match your responses to the survey you will be sent after the training course:

Mother's maiden name (e.g. Taylor) ……..
Your birthday (e.g. 25th April) ……..

Thank you for completing this pre-training questionnaire. A follow-up evaluation will assess the long term benefit of the training course. A short questionnaire will be sent to you via [post/email] in [6 weeks/3 or 6 months]. Your feedback at this time will be valuable in helping to shape future courses.

Training evaluation - follow-up questionnaire

Please answer the questions below by circling the appropriate response in relation to your experiences of motivational interviewing [tailor to specific focus/aim of training].

1) How often do you use motivational interviewing in your practice?

1	**2**	**3**	**4**
Frequently	Sometimes	Occasionally	Never

2) On a scale of 1-10, how would you describe your current level of **understanding** of motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Little understanding									Considerable understanding

3) On a scale of 1-10, how **skilled** do you feel in using motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not skilled									Very skilled

4) On a scale of 1-10, how **useful** have you found motivational interviewing ?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not very useful									Very useful

5) On a scale of 1-10, how **confident** do you feel in using motivational interviewing?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not confident									Very confident

6) On a scale of 1-10, how useful have the following resources been in further supporting your training needs in motivational interviewing (1 = not useful; 10 = very useful). Alternatively, please indicate in the right hand column if you have not viewed these resources.

The learning CD provided at the training course	1	2	3	4	5	6	7	8	9	10	Not viewed
Reading materials	1	2	3	4	5	6	7	8	9	10	Not viewed

Any comments:

……
……
……
……

7) Since attending the course, have you received supervision from someone more experienced in motivational interviewing?

Yes No

If yes, please give details below:

……
……
……
……

8) Have you attended other training courses on motivational interviewing?

Yes No

If yes, please give details below:

……
……
……
……
……
……

9) Please give at least one example of when you feel you have successfully used the knowledge and/or skills you gained at the training session:

Example(s): -

……
……
……
……
……
……

10) Please add any additional comments you wish to make:

……
……
……
……
……
……

Please answer the following two questions so that we can match your responses to the survey you completed on the day of the training:

Mother's maiden name (e.g. Taylor) ……
Your birthday (e.g. 25th April) ……

Many thanks for taking the time to complete this questionnaire.

Evaluation questionnaire – junior doctor pre-rotation in gynaecology department

We need your help to continue to develop the medical training experience in the gynaecology department. This questionnaire explores your knowledge, skills and confidence at the start of your rotation. It has been developed to help us to examine, and where necessary improve, the training experience we provide for junior doctors.

We would very much appreciate you completing this questionnaire. It should take you about 5 minutes. All replies will be treated confidentially.

Please return your completed questionnaire to [insert name/place].

Thank you
[Insert name/on behalf of…]

Please answer the questions below by circling the appropriate response in relation to your experience/views of working in gynaecology.

Knowledge
1) In the context of gynaecology, how would you describe you current **knowledge** of the following areas (where 1 = little knowledge, 10 = considerable knowledge):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

Skills
2) In the context of gynaecology, how would you describe your current **skills** in the following areas (where 1 = not skilled, 10 = considerably skilled):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

Confidence
3) In the context of gynaecology, how **confident** do you feel in relation to the following areas (where 1 = not confident, 10 = very confident):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

Training

4) Have you undertaken any training in any of the following areas (please tick all that apply):

Scanning	☐
Internal examination	☐
Breaking bad news	☐
Discussing treatment options	☐

If you ticked any of the above please give details below:

……
……
……
……
……

5) Do any of the following cause you concern in advance of working in the gynaecology department? (please circle one answer on each line):

Lack of knowledge	Yes	No
Lack of training	Yes	No
Patient of the opposite sex to you	Yes	No
Embarrassment	Yes	No
Lack of experience	Yes	No
Your own attitudes and beliefs relating to gynaecology issues	Yes	No
Concerns about increasing patients anxiety & discomfort	Yes	No
Issues relating to culture and religion	Yes	No
Issues relating to language and ethnicity	Yes	No
Other – please specify:	Yes	No

6) Please add any further comments you wish to make:

……
……
……
……
……

Please answer the following two questions so that we can match your responses to the survey you will be sent at the end of your rotation:

Mother's maiden name (e.g. Taylor) ……
Your birthday (e.g. 25th April) ……

Many thanks for completing this pre-rotation survey. A short follow-up survey will be given to you at the end of your rotation. Your feedback at this time will be valuable in helping to shape future gynaecology rotations for junior doctors.

Follow-up evaluation questionnaire – junior doctor experience of rotation in gynaecology department

We need your help to continue to develop the medical training experience in the gynaecology department. This questionnaire explores your knowledge, skills and confidence at the end of your rotation. It has been developed to help us to examine, and where necessary improve, the training experience we provide to junior doctors.

We would very much appreciate it if you could complete the survey below. It should take about 10 minutes. All replies will be treated confidentially.

Please return your completed survey to [Insert name/location]

Thank you
[Insert name/ on behalf of…]

Please answer the questions below in relation to your experience/views of working in gynaecology and in the gynaecology department.

Knowledge
1) In the context of gynaecology, how would you describe you current **knowledge** of the following areas (where 1 = little knowledge, 10 = considerable knowledge):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

Skills
2) In the context of gynaecology, how would you describe your current **skills** in the following areas (where 1 = not skilled, 10 = considerably skilled):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

Confidence
3) In the context of gynaecology, how **confident** do you feel in relation to the following areas (where 1 = not confident, 10 = very confident):

Scanning (interpreting images/ reports)	1	2	3	4	5	6	7	8	9	10
Internal examination	1	2	3	4	5	6	7	8	9	10
Breaking bad news	1	2	3	4	5	6	7	8	9	10
Discussing treatment options	1	2	3	4	5	6	7	8	9	10

4) During your rotation in the gynaecology department, to what extent has your practice relating to each of the following areas (e.g. scanning, internal examination) been influenced by the following staff members (where 1 = not influenced, 10 = considerably influenced):

Scanning										
- Senior medical staff	1	2	3	4	5	6	7	8	9	10
- Other medical staff	1	2	3	4	5	6	7	8	9	10
- Nurse consultant	1	2	3	4	5	6	7	8	9	10
- Ward sisters	1	2	3	4	5	6	7	8	9	10
- Staff nurses	1	2	3	4	5	6	7	8	9	10
- Other – please specify:……	1	2	3	4	5	6	7	8	9	10
Internal examination										
- Senior medical staff	1	2	3	4	5	6	7	8	9	10
- Other medical staff	1	2	3	4	5	6	7	8	9	10
- Nurse consultant	1	2	3	4	5	6	7	8	9	10
- Ward sisters	1	2	3	4	5	6	7	8	9	10
- Staff nurses	1	2	3	4	5	6	7	8	9	10
- Other – please specify: ……	1	2	3	4	5	6	7	8	9	10
Breaking bad news										
- Senior medical staff	1	2	3	4	5	6	7	8	9	10
- Other medical staff	1	2	3	4	5	6	7	8	9	10
- Nurse consultant	1	2	3	4	5	6	7	8	9	10
- Ward sisters	1	2	3	4	5	6	7	8	9	10
- Staff nurses	1	2	3	4	5	6	7	8	9	10
- Other – please specify:……	1	2	3	4	5	6	7	8	9	10
Discussing treatment options										
- Senior medical staff	1	2	3	4	5	6	7	8	9	10
- Other medical staff	1	2	3	4	5	6	7	8	9	10
- Nurse consultant	1	2	3	4	5	6	7	8	9	10
- Ward sisters	1	2	3	4	5	6	7	8	9	10
- Staff nurses	1	2	3	4	5	6	7	8	9	10
- Other – please specify:……	1	2	3	4	5	6	7	8	9	10

5) Do any of the following currently cause you concern when working in the gynaecology department? (please circle one answer on each line):

Lack of knowledge	Yes	No
Lack of training	Yes	No
Patient of the opposite sex to you	Yes	No
Embarrassment	Yes	No
Lack of experience	Yes	No
Your own attitudes and beliefs relating to gynaecology issues	Yes	No
Concerns about increasing patients anxiety & discomfort	Yes	No
Issues relating to culture and religion	Yes	No
Issues relating to language and ethnicity	Yes	No
Other – please specify: ……	Yes	No

6) Please add any further comments you wish to make:

……
……
……
……
……
……
……
……
……
……
……

Please answer the following two questions so that we can match your responses to the survey you completed at the start of your rotation:

Mother's maiden name (e.g. Taylor) ……..
Your birthday (e.g. 25th April) ……

Many thanks for completing this survey. Your feedback at this time is valuable in helping to shape future gynaecology rotations for junior doctors.

Nurse consultant higher education contribution questionnaire

Nurse consultant: .....

This questionnaire explores the contribution that the above-mentioned individual has made to education within your organisation. Please answer all items below. If an item is not applicable, please indicate by circling NA. Please answer this questionnaire anonymously. All responses will be kept strictly confidential.

Several descriptive statements are listed below. Judge how frequently each statement fits the person you are describing in relation to their contribution to education initiatives you have both been involved with. Use the following rating scale to circle the number which corresponds to your views.

1 Never	2 Almost never	3 Sometimes	4 Average	5 Often	6 Almost Always	7 Always

1	Values and uses a range of teaching and learning strategies	1	2	3	4	5	6	7	NA
2	Adapts the style and methods of teaching to appeal to relevant groups	1	2	3	4	5	6	7	NA
3	Uses the latest research evidence to inform teaching	1	2	3	4	5	6	7	NA
4	Contributes towards raising the profile of the clinical specialism in the university	1	2	3	4	5	6	7	NA
5	Acts as an expert resource to lecturing staff on the specialist area	1	2	3	4	5	6	7	NA
6	Acts as a positive role model to inspire students	1	2	3	4	5	6	7	NA
7	Acts as an expert resource to educators on leading edge practice	1	2	3	4	5	6	7	NA
8	Demonstrates a detailed understanding of the clinical context and can clearly articulate NHS needs and requirements	1	2	3	4	5	6	7	NA
9	Clearly articulates standards required to achieve fitness for practice in the specialism	1	2	3	4	5	6	7	NA
10	Contributes specialist expertise to curriculum development	1	2	3	4	5	6	7	NA
11	Participates effectively in curriculum evaluation and review	1	2	3	4	5	6	7	NA
12	Consistently advocates the patient / service point of view with academic colleagues	1	2	3	4	5	6	7	NA
13	Interprets local politics perceptively and accurately to inform education initiatives	1	2	3	4	5	6	7	NA
14	Actively promotes a high quality learning environment for students in practice settings	1	2	3	4	5	6	7	NA
15	Promotes innovation in learning and teaching in practice settings	1	2	3	4	5	6	7	NA
16	Provides leadership to clinical staff in supporting students in practice	1	2	3	4	5	6	7	NA
17	Engages in problem solving to enable effective learning in practice	1	2	3	4	5	6	7	NA
18	Facilitates research links between the NHS and university sectors	1	2	3	4	5	6	7	NA

19	Undertakes research in collaboration with academic colleagues	1	2	3	4	5	6	7	NA
20	Provides high quality clinical academic supervision for undergraduate students	1	2	3	4	5	6	7	NA
21	Provides high quality clinical academic supervision for masters students	1	2	3	4	5	6	7	NA
22	Provides high quality clinical academic supervision for doctoral students	1	2	3	4	5	6	7	NA

You comments on the following questions are particularly welcomed.

What should this nurse consultant continue to do in terms of education contribution?

……
……
……
……
……
……
……
……

What could this nurse consultant do to be more effective in terms of education contribution?

……
……
……
……
……
……
……
……

Thank you very much for your help. Please return your completed questionnaire to [insert location]

Nurse consultant - consultancy activity

This form is designed to document the consultancy activity (e.g. specialist advice, problem solving in complex cases etc.) that you are consulted about.

Complete the table below to record any specific incidents / queries where you felt you demonstrated a level of consultancy commensurate with your role of nurse consultant. Please ensure anonymity of patients when giving details of particular cases.

	Date	**Who raised**	**Nature of incident / query / issue**	**Action taken as a result.** record details of action taken and when	**Outcome of incident.** record any immediate or subsequent outcomes, e.g. training.
E.g.	*25/02/2011*	*Cardiology registrar*	*Concerned about patient who attended his clinic who had cardiac problems & stroke*	*Saw and examined jointly with registrar – I referred patient for specific investigations*	*Patient had appropriate tests leading to timely diagnosis. Ensured registrar had new stroke guidelines & wrote back to registrar*
E.g.	*02/03/2011*	*PCT commissioner of intermediate care*	*Complaints from GP about lack of clarity in stroke care pathway*	*Clarified process. Met with chair of local primary care executive committee.*	*Guidelines of process disseminated again. Arranging a full training day for GPs.*
1.					
2.					
3.					
4.					

Team leadership questionnaire

Team leader - [name]

This questionnaire describes the leadership style of the above-mentioned individual as you perceive it. Please answer all items. If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank. Please answer this questionnaire anonymously. All responses will be kept strictly confidential.

Seven descriptive statements are listed below. Judge how frequently each statement fits the person you are describing. Use the following rating scale and tick the box which corresponds to your views.

		Rarely or never	Sometimes	Fairly often	Frequently	Very frequently, if not always
1	Communicates a clear positive vision of the future	☐	☐	☐	☐	☐
2	Treats staff as individuals, supports and encourages their development	☐	☐	☐	☐	☐
3	Gives encouragement and recognition to staff	☐	☐	☐	☐	☐
4	Fosters trust, involvement and co-operation among team members	☐	☐	☐	☐	☐
5	Encourages thinking about problems in new ways and questions assumptions	☐	☐	☐	☐	☐
6	Is clear about his/her values and practises what he/she preaches	☐	☐	☐	☐	☐
7	Instils pride and respect in others and inspires me by being highly competent	☐	☐	☐	☐	☐

Please include any further comments you wish to make:

……
……
……
……
……
……
……
……
……
……

Thank you very much for your help. Please return your completed questionnaire to [insert name/location]

Assessment of Work Environment Schedule (AWES)

Below are a number of statements about the place in which you work. Please indicate how much you agree with each statement by placing a tick in the box that best reflects your opinion.

	Thinking about the place in which I work I feel that:	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	The workload is shared fairly	☐	☐	☐	☐	☐
2	Criticism is given in a just way	☐	☐	☐	☐	☐
3	The environment of care for patients is good	☐	☐	☐	☐	☐
4	Study leave is allocated in a fair manner	☐	☐	☐	☐	☐
5	I have the opportunity to give total patient care	☐	☐	☐	☐	☐
6	I am encouraged to develop my full potential as a nurse	☐	☐	☐	☐	☐
7	There is a good spirit of cooperation with my co-workers	☐	☐	☐	☐	☐
8	I am an active participant when important decisions about patients are made	☐	☐	☐	☐	☐
9	Leadership in this organisation is democratic	☐	☐	☐	☐	☐
10	The amount of work I am given to do is realistic	☐	☐	☐	☐	☐
11	The overall quality of nursing care provided is high	☐	☐	☐	☐	☐
12	I am part of a team	☐	☐	☐	☐	☐
13	I am able to get easy access to my manager	☐	☐	☐	☐	☐
14	My overall working conditions are good	☐	☐	☐	☐	☐
15	There are sufficient opportunities for me to participate in continuing professional education	☐	☐	☐	☐	☐
16	I am allowed to use my full range of skills	☐	☐	☐	☐	☐
17	I am given respect by my superiors	☐	☐	☐	☐	☐
18	My work is interesting	☐	☐	☐	☐	☐
19	My personal career development is given a high priority by my manager	☐	☐	☐	☐	☐
20	I am regularly given the opportunity to assume a leadership role	☐	☐	☐	☐	☐
21	I am congratulated when I do things well	☐	☐	☐	☐	☐
22	I have the opportunity to perform the type of work I do best	☐	☐	☐	☐	☐
23	I am actively encouraged to develop my skills	☐	☐	☐	☐	☐

	Thinking about the place in which I work I feel that:	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
24	I would be supported if I applied for study leave	☐	☐	☐	☐	☐
25	I am consulted when changes in working conditions are planned	☐	☐	☐	☐	☐
26	There is sufficient time to provide the type of care I would like to	☐	☐	☐	☐	☐
27	My opinions are listened to by my superiors	☐	☐	☐	☐	☐
28	I can try new ideas without fear of criticism	☐	☐	☐	☐	☐
29	Staff are given the opportunity to develop new ways of doing things	☐	☐	☐	☐	☐
30	It is possible to influence the decisions of senior nurse managers	☐	☐	☐	☐	☐
31	Staffing levels are adequate for the workload	☐	☐	☐	☐	☐
32	There are adequate resources to provide good care	☐	☐	☐	☐	☐
33	I have the opportunity to make decisions on my own	☐	☐	☐	☐	☐

Your comments

We are very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions – or if you would like to make any further comments, please use the space provided.

……
……
……
……
……
……
……
……
……
……
……
……

Thank you for sparing the time to complete the questionnaire.

Please return your completed questionnaire by (insert date) to: [insert name/location]

External activity proforma

This form is to gather details of your **external work over the last 12 months** and record any identifiable outputs or outcomes (e.g. committee membership may have resulted in the production of guidelines). When completing the table below, briefly describing any local / regional / national work in each area and any outputs or outcomes of this activity. In addition, and where relevant, detail what is brought back to the organisation as a result of this work, e.g. adoption of guidelines / patient information leaflets within the Trust / feedback to wider team on national developments. Not all sections will apply to every nurse consultant post.

	Describe your involvement	**Local, Regional or National**	**Date or duration**	**Any outputs/ outcomes of this activity ***	**Impact within your organisation**
Committee membership (including networks) – e.g. group meetings (usually regular basis) with a particular remit/terms of reference. Could be task and finish group or ongoing.	*E.g. Care Quality Commission member for stroke following discharge*	*National*	*Monthly, 2 years*	*Regional and local protocol developed for stroke care post-discharge from hospital.*	*More effective cross organisational working, leading to reduction in LOS and readmissions. Produced joint health & social care plan for patients/ relatives*
	1.				
	2.				
	3.				
	4.				
Stakeholder meetings – e.g. one-off or ad hoc meetings with key individual(s) such as the PCT or general practitioner.	*E.g. Liaison with prison services about partner notification interviews with offenders with HIV*	*Regional*	*2 meetings, Nov-Dec '10*	*Strategy discussed in regional public health meeting. Proforma for prisons drafted.*	*Smooth running across primary/ secondary interface, leading to better management of partner notification across region.*
	1.				
	2.				
	3.				
	4.				
Education/training	*E.g. Motivational interviewing training (in response to NICE guidance)*	*National*	*Ongoing*	*3 x 2 day courses*	*Income generation £----- Raised profile of department*
	1.				
	2.				
	3.				
	4.				

Tool 13 - Organisation

Research / consultancy project involvement e.g. principal investigator, co-applicant, collaborator, member of advisory group, clinical advisor/supervisor.	*E.g. clinical supervisor for project exploring nurses' experiences of working with women undergoing termination*	*Local*	*2 years*	*Project report/dissertation. Publication of findings.*	*Intelligence to inform provision of group clinical supervision to nursing staff in unit*
	1.				
	2.				
	3.				
	4.				
Feedback on consultation documents	1.				
	2.				
	3.				
	4.				
Review activities - e.g. journal articles/research protocols, editorial board membership.	1.				
	2.				
	3.				
	4.				
Radio/media appearances	1.				
	2.				
	3.				
Other activities	1.				
	2.				

* In addition to describing the outputs / outcomes, please indicate any evidence of the impact of this external work on clinical / professional practice locally, regionally and nationally (e.g. guidelines / protocols being adopted by other units)

Outputs/outcomes

Conference presentations

Name of conference	Oral or poster	Date	Title of presentation/poster

Publications

Provide full reference of publications	Status (e.g. submitted, revisions in progress, accepted, in press, published)

Tool 13 - Organisation

Grant capture

Investigators	Title of project	Duration of project	Source of funding	Amount

Production of patient information materials

Title	Date	Format (e.g. leaflet, DVD)	If applicable, list any collaborators (e.g. charitable organisations)	If applicable, provide details of the use of this information in other units/hospitals

Other outputs (e.g. reports, guidelines, protocols)

Title	Date	Description of other output	If applicable, list any collaborators (e.g. charitable organisations)	If applicable, provide details of the use of this information in other units/hospitals

Proforma to capture key achievements/outputs from committee meetings

The purpose of this form is to document the key achievements/outputs from the committee meetings / working groups you attend as a nurse consultant. Complete the table below to record the details of the group/meetings and the key achievements/outputs of the meetings. You do not need to record details from every meeting, unless it is appropriate. This form can be used at the end of a short-term meeting group or completed intermittently for ongoing meeting groups (e.g. at 6 month intervals).

Name of committee	
Remit/objectives of committee	
Frequency of meetings	
Duration and/or timeframe	
Membership	
Role in committee(e.g. Chair / Member)	

Date	**Key achievements/outputs of the committee** (for example, development / review / implementation of guidelines, rolling out staff training in Trust/elsewhere etc)

Project [leadership or contributor] questionnaire

Project leader – [Name of nurse consultant]

This questionnaire explores the [leadership or contributor] role of the above-mentioned individual as you perceive it in relation to the [name of project]. Please answer all items. If an item is not applicable, indicate by circling NA. Please answer this questionnaire anonymously. All responses will be kept strictly confidential.

Several descriptive statements are listed below. Judge how frequently each statement fits the person you are describing in relation to the project you were both involved with. Use the following rating scale and circle the number which corresponds to your views:

1	2	3	4	5	6	7
Never	Almost never	Sometimes	Average	Often	Almost Always	Always

1	Explains the benefits of the project to our organisation, services and /or patients	1	2	3	4	5	6	7	NA
2	Keeps focused on the bigger picture even when there are distractions	1	2	3	4	5	6	7	NA
3	Pushes to get things done when they are scheduled	1	2	3	4	5	6	7	NA
4	Effectively addresses resistance with stakeholders who inhibit progress with the project	1	2	3	4	5	6	7	NA
5	Emphasises the importance of team work to the project group	1	2	3	4	5	6	7	NA
6	Encourages people to contribute ideas to solving problems	1	2	3	4	5	6	7	NA
7	Understands the local context and can adapt the project according to local needs.	1	2	3	4	5	6	7	NA
8	Involves the whole team in discussions about project goals and how they relate to each other	1	2	3	4	5	6	7	NA
9	Displays good judgement in making day to day decisions	1	2	3	4	5	6	7	NA
10	Actively includes team members in planning process	1	2	3	4	5	6	7	NA
11	Interprets internal politics perceptively and accurately	1	2	3	4	5	6	7	NA
12	Creates an environment of openness and trust in order to deliver results	1	2	3	4	5	6	7	NA
13	Anticipates the reactions of different stakeholders when solving problems	1	2	3	4	5	6	7	NA
14	Adapts the style and methods of communication to appeal to relevant groups	1	2	3	4	5	6	7	NA
15	Ensures project goals are defined clearly to avoid confusion	1	2	3	4	5	6	7	NA

16	Actively searches for information from a wide range of sources	1	2	3	4	5	6	7	NA
17	Values and uses the range of different skills and perspectives that the project team members bring	1	2	3	4	5	6	7	NA
18	Flexible / able to adapt to changing circumstances yet sticks with unpopular decisions if it is the right thing to do	1	2	3	4	5	6	7	NA
19	Works effectively across different groups and locations	1	2	3	4	5	6	7	NA
20	Makes sure the right people are at the table in order to take responsibility and make decisions	1	2	3	4	5	6	7	NA
21	Consistently advocates the patient / service point of view with team members	1	2	3	4	5	6	7	NA
22	Clearly articulates the agenda and a shared understanding of the issues during discussions	1	2	3	4	5	6	7	NA
23	Confidently makes decisions in uncertain situations and is able to deal with ambiguity	1	2	3	4	5	6	7	NA

Your comments on the following questions are particularly welcomed.

What should this nurse consultant continue to do when leading/contributing to projects?

……
……
……
……
……
……
……
……

What should this nurse consultant do to be more effective when leading/contributing to projects?

……
……
……
……
……
……
……
……

Thank you very much for your help. Please return your completed questionnaire to [insert name/location].

Acknowledgements

We would like to thank the Burdett Trust for Nursing who provided the funding to undertake the research project that led to the development of this toolkit.

Many people have been involved in helping us to develop the toolkit. We are grateful to the following individuals for their valuable contribution:

Iain Armstrong, Sheffield Teaching Hospitals NHS Foundation Trust
Derek Bainbridge, The Rotherham NHS Foundation Trust
Gill Bell, Sheffield Teaching Hospitals NHS Foundation Trust
Jackie Bird, The Rotherham NHS Foundation Trust
Janine Birley, The Rotherham NHS Foundation Trust
Alison Broderick, Sheffield Teaching Hospitals NHS Foundation Trust
Professor Hilary Chapman, Sheffield Teaching Hospitals NHS Foundation Trust
Maureen Coombs, University of Southampton
Carolyn Czoski-Murray, Academic Unit of Health Economics, University of Leeds
Jan Farrell, The Rotherham NHS Foundation Trust
Joanne Fletcher, Sheffield Teaching Hospitals NHS Foundation Trust
Mary Freeman, Sheffield Teaching Hospitals NHS Foundation Trust
Jacqui Gath, North Trent Cancer Network Consumer Research Panel
Dr Diana Greenfield, Sheffield Teaching Hospitals NHS Foundation Trust
Tom Grew, North Trent Cancer Network Consumer Research Panel
Marie Harris, North Trent Cancer Network Consumer Research Panel & Governor of Sheffield Health and Social Care NHS Foundation Trust
Andrew Jackson, The Rotherham NHS Foundation Trust
Amanda Jones, Sheffield Teaching Hospitals NHS Foundation Trust
Dr Alison Leary, Independent Healthcare Consultant
Professor Chris McCabe, Academic Unit of Health Economics, University of Leeds
Julie Perrin, Sheffield Teaching Hospitals NHS Foundation Trust
Ray Poll, Sheffield Teaching Hospitals NHS Foundation Trust
Dr Caryl Skeen, Sheffield Teaching Hospitals NHS Foundation Trust
Professor Annie Topping, University of Huddersfield

References

Andrew S. & Halcomb E.J. (2009) *Mixed method research in nursing and the health sciences.* Wiley-Blackwell: London.

Arvidsson B., Skarsater I., Baigi A. & Fridlund B. (2008) The development of a questionnaire for evaluating process-oriented group supervision during nursing education. *Nurse Education in Practice* 8, 88-93.

Ball C., Kirkby M. & Williams S. (2003) Effect of the critical care outreach team on patient survival to discharge from hospital and readmission to critical care: non-randomised population based study. *BMJ* 327, 1014 -1017.

Baker R. (1990) Development of a questionnaire to assess patients' satisfaction with consultation in general practice. *British Journal of General Practice* 40, 487-490.

Benjamin A. (2008) Audit: how to do it in practice. *BMJ* 336, 1241-1245.

Bowling A. (2001) *Measuring disease: a review of disease specific quality of life measurement scales.* 2nd edition. Open University Press: Buckingham.

Bowling A. (2005) *Measuring health: a review of quality of life measurement scales.* 3rd edition. Open University Press: Maidenhead.

Boynton P.M. & Greenhalgh T. (2004) Hands on guide to questionnaire research: selecting, designing, and developing your questionnaire. *BMJ* 328, 1312-1315.

Boynton P.M. (2004) Hands on guide to questionnaire research: administering, analysing, and reporting your questionnaire. *BMJ* 328, 1372-1375.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology 3*, 77-101.

Bryman A. & Burgess, R.G. (1999) *Qualitative Research* (vol 1-4). Sage: London.

Canadian Nurses Association (2006) *Canadian Nurse Practitioner Initiative: Implementation and evaluation toolkit for nurse practitioners in Canada*. Canadian Nurses Association: Ottawa

Carless S.A., Wearing A.J. & Mann L. (2000) A short measure of transformational leadership. *Journal of Business & Psychology* 14(3), 389-405.

Coster S., Redfern S., Wilson-Barnett J., Evans A., Peccei R. & Guest D. (2006) Impact of the role of nurse, midwife and health visitor consultant. *Journal of Advanced Nursing* 55(3), 352-363.

Department of Health (2009) *Understanding what matters: A guide to using patient feedback to transform services.* Department of Health: Leeds.

Department of Health (2010a) *Equity and excellence: liberating the NHS.* Department of Health: London.

Department of Health (2010b) *Energising for excellence in care (E4E),* http://www.dh.gov.uk/en/Aboutus/Features/DH_121747 (accessed 27th April 2011).

Department of Health (2010c) *Essence of Care 2010: benchmarks for the fundamental aspects of care*. Department of Health: London.

Department of Health (2011a) Quality governance in the NHS: a guide for provider boards. Department of Health: London.

Department of Health (2011b) *Modernising nursing careers: nurse sensitive indicators*, http://www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/DH_108368 (accessed 27th April 2011).

Donabedian A. (1966) Evaluating the quality of medical care. *The Milbank Quarterly* 44, 3(2), 166-203.

Gerrish K., McDonnell A., Kennedy F (2011) *Approaches to measuring the impact of nurse consultants on patient, professional and organisational outcomes.* Report submitted to the Burdett Trust for Nursing. Sheffield Hallam University: Sheffield.

Gerrish K. & Lacey A. (2010) *The Research Process in Nursing.* Wiley-Blackwell: Chichester.

Grogan S., Conner M., Norman P., Willits D. & Porter I. (2000) Validation of a questionnaire measuring patient satisfaction with general practitioner services. *Quality in Health Care* 9, 210-215.

Griffiths P., Jones S., Maben J. & Murrells T. (2008) *State of the art metrics for nursing: a rapid appraisal.* National Nursing Research Unit, King's College London: London.

Guest D.E., Peccei R., Rosenthal P., Redfern S., Wilson-Barnett J., Dewe P., Coster S., Evans A. & Sudbury A. (2004) *An evaluation of the impact of nurse, midwife and health visitor consultants.* King's College London: London.

Hanson E., Nolan J., Magnusson L., Sennemark E., Johansson L. & Nolan M. (2006) *COAT: The carers outcome agreement tool.* The University of Sheffield: Sheffield.

HM Treasury (2003) *The Green Book*. HM Treasury, London http://www.hm-treasury.gov.uk/data_greenbook_index.htm Accessed 11 July 2011

Howie J.G.R., Heaney D.J., Maxwell M. & Walker J. (1998) A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Family Practice* 15(2), 165-171.

Howie J.G.R., Heaney D.J., Maxwell M., Walker J., Freeman G.K. & Rai H. (1999) Quality at general practice consultations: cross sectional survey. *BMJ* 319, 738-743.

Irvine D., Sidani. & McGillis Hall L. (1998) Linking outcomes to nurses' roles in health care. *Nursing Economics* 16(2), 58-87.

Jarman H.J. (2009) Sharing expertise: using clinical nursing rounds to improve UK emergency nursing practice. *Australasian Emergency Nursing Journal* 12(3), 73-77.

Jenkinson C., Stewart-Brown S., Petersen S. & Paice C. (1999) Assessment of the SF-36 Mark 2 in the United Kingdom. *Journal of Epidemiology and Community Health* 53, 46-50.

Jenkinson C., Coulter A. & Bruster S. (2002) The Picker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries. *International Journal for Quality in Health Care* 14(5), 353-358.

Jones M. & Rattray J. (2010) Questionnaire design. In K. Gerrish & A. Lacey (Eds), *The Research Process in Nursing,* Wiley-Blackwell: Chichester. pp.369-381.

Kalisch B.J., Lee H. Salas E. (2010). The development and testing of the Nursing Teamwork Survey. *Nursing Research* 59(1), 42-50.

Kennedy F., McDonnell A., Gerrish K., Howarth A., Pollard C. & Redman J.H. (2011). Evaluation of the impact of nurse consultant roles in the United Kingdom: a mixed method systematic literature review. *Journal of Advanced Nursing* doi: 10.1111/j.1365-2648.2011.05811.x (Epub ahead of print)

Kinnersley P. Anderson E., Parry K., Clement J., Archard L., Turton P., Stainthorpe A., Fraser A., Butler C.C. & Rogers C. (2000) Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care. *BMJ* 320, 1043-1048.

Kivimaki M. & Elovainio M. (1999) A short version of the Team Climate Inventory: Development and psychometric properties. *Journal of Occupational and Organizational Psychology* 72, 241-246.

Koinberg I.L. Fridlund B., Engholm G.B. & Holmberg L. (2004) Nurse-led follow-up on demand or by a physician after breast cancer surgery: a randomised study. *European Journal of Oncology Nursing* 8(2), 109-117.

Laurant M.G., Hermens R.M., Braspenning J.C., Sibbald B. & Grol R.P. (2004) Impact of nurse practitioners on workload of general practitioners: randomised controlled trial. *BMJ* 328, 927-930.

Marshall K., Nelson S. & Sykes C. (2005) Analysing and improving a rapid-access chest pain clinic. *Nursing Times* 101(41), 32-3.

Marshall G.N. & Hays R.D. (1994) *Health Survey - patient satisfaction questionnaire - PSQ 18. The patient satisfaction questionnaire short-form (PSQ-18).* Rand Corporation.

Mason S., Knowles E., Colwell B., Dixon S., Wardrope J., Gorringe R., Snooks H., Perrin J. & Nicholl J. (2007) Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: cluster randomised controlled trial. *BMJ* 335, 919-925.

Mundinger M.O., Kane R.L., Lenz E.R., Totten A.M., Tsai W., Cleary P.D., Friedewald W.T., Siu A.L. & Shelanski M.L. (2000) Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association* 283(1), 59-68.

Nielsen K., Yarker J., Randall R. & Munir F. (2009) The mediating effects of team and self-efficacy on the relationship between transformational leadership, and job satisfaction and psychological well-being in healthcare professionals: A cross-sectional questionnaire survey. *International Journal of Nursing Studies* 46, 1236-1244.

NHS Scotland (2009) *A Practical Guide to the Appraisal, Evaluation, Approval and Management of Policies, Programmes and Projects* http://www.scim.scot.nhs.uk/Support/OA_Guide.htm Accessed 11 July 2011

Nolan M., Grant G., Brown J. & Nolan J. (1998) Assessing nurses' work environment: old dilemmas, new solutions. *Clinical Effectiveness in Nursing* 2, 145-156.

Patterson M., Nolan M., Rick J., Brown J., Adams R. & Musson G. (2011) *From Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People: Report for the National Institute for Health Research Service Delivery and Organisation programme.* University of Sheffield: Sheffield.

Picker Institute (2009) *Using patient feedback.* Picker Institute Europe: Oxford.

Polit D.F. & Beck C.T. (2010) *Essentials of nursing research: appraising evidence for nursing practice.* Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia.

Poulton B. C. (1996) Use of the consultation satisfaction questionnaire to examine patients' satisfaction with general practitioners and community nurses: reliability, replicability and discriminant validity. *British Journal of General Practice* 46, 26-31.

Richards D.A., Meakins J., Tawfik J., Godfrey L., Dutton E., Richardson G. & Russell D. (2002) Nurse telephone triage for same day appointments in general practice: multiple interrupted time series trial of effect on workload and costs. *BMJ* 325, 1214-1218.

Robson C. (2010) Evaluation Research. In K. Gerrish & A. Lacey (Eds), *The Research Process in Nursing.* Wiley-Blackwell: Chichester. pp.248-256.

Ryan S., Hassell A., Thwaites C., Manley K. & Home D. (2006) Exploring the perceived role and impact of the nurse consultant. *Musculoskeletal Care* 4(3), 167-73.

Schure L.M., van den Heuvel E.T.P., Stewart R.E., Sanderman R., de Witte L.P. & Meyboom-de Jong B. (2006) Beyond stroke: Description and evaluation of an effective intervention to support family caregivers of stroke patients. *Patient Education and Counselling* 62, 46-55.

Shum C., Humphreys A., Wheeler D., Cochrane M., Skoda S. & Clement S. (2000) Nurse management of patients with minor illnesses in general practice: multicentre, randomised controlled trial. *BMJ* 320, 1038-1043.

Silverman (2010) *Doing qualitative research: a practical handbook.* Sage: London.

Spielberger C.D., Gorsuch R.L., Luchene R.E. et al. (1983) *Manual for the State-Trait Anxiety Inventory (revised edition)*. Consulting Psychologists Press: Palo Alto: California.

Stewart A.L. & Ware J.E. (1992) *Measuring functioning and well-being: The Medical Outcomes Study Approach.* Duke University Press: Durham, NC.

Upenieks V.V., Lee E.A., Flanagan M.E. & Doebbeling B.N. (2009) Healthcare Team Vitality Instrument (HTVI): developing a tool assessing healthcare team functioning. *Journal of Advanced Nursing* 66(1), 168-176.

Ware J.E., Snyder M.K., Wright W.R. et al. (1983) Defining and measuring patient satisfaction with medical care. *Evaluation and Program Planning* 6, 247-263.

Waltz C.F., Strickland O.L. & Lenz E.R. (2010) *Measurement in nursing and health research.* 4th edition. Springer Publication Company: New York.

West M.A. (1990) The social psychology of innovation in groups. In M.A. West & J.L. Farr (Eds), *Innovation and creativity at work: Psychological and organizational strategies,* pp.309-333. Wiley: Chichester.

Wilson A., Hewitt G., Matthews R., Richards S.H. & Shepperd S. (2006) Development and testing of a questionnaire to measure patient satisfaction with intermediate care. *Quality and Safety in Health Care* 15, 314-319.

Wolf M.H., Putnam S.M., James A.J. & Stiles W.B. (1978) The medical interview satisfaction scale: development of a scale to measure patient perceptions of physician behavior. *Journal of Behavioral Medicine* 1, 391-401.

Zigmond, A. S., & Snaith, R. P. (1983) The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67*(6), 361-370.

Appendix

Economic Evaluation in health care

Authored by Christopher McCabe and Carolyn Czoski-Murray

The most common form of economic evaluation used in health care is Cost Effectiveness Analysis (CEA). It involves the comparison of two or more interventions in terms of costs and outcomes, with costs measured in financial terms (money) and outcomes are measured using some natural unit of effect, e.g. a year of life or a % reduction in HbA1c. The choice of measure of effect for a specific analysis should be determined by the decision which it is intended to inform. When the decision is concerned with alternative ways of achieving the same clinical effect such as reducing blood pressure, a clinical measure of outcome is appropriate; e.g. % reduction in m/mmol. However, when the decision is concerned achieving alternative effects, such a reducing blood sugar levels or blood pressure in people with type 2 diabetes, the outcome measure must be capable of placing the alternative effects on a common scale. This may be a clinical measure such as life years, however, increasingly cost effectiveness analyses use the Quality Adjusted Life Year (QALY) to measure effectiveness. Cost effectiveness analyses that use QALYs as the measure of effect are also known as Cost Utility Analyses (CUA).

The concept of the Quality Adjusted Life Year (QALY) is quite simple. Health care can improve the quality of an individual's life, their life expectancy or both. Therefore, a measure of health that captures changes in both domains of effect can, in principle, be used to compare any health care intervention with any other health care intervention. A QALY weights life years lived by the quality of life experienced in each time period.

Measuring the impact of an intervention on life expectancy is relatively straightforward. Measuring its impact on quality of life is less so. It requires a framework for describing health related quality of life and a method for attaching weights to each state in the descriptive system. Cost effectiveness analyses use preference weights. Preference weights express the relative desirability of a health state on a scale anchored at one and zero; where one is the value attached to 'Full Health'[1] and zero is the value attached to health states considered equivalent to being dead. There is a range of methods for obtaining these weights, but a discussion these is outside the remit the toolkit. They are well reviewed in Brazier et al 2007. Suffice to say that methods that involve choices are considered superior to those that do not.

Once the costs and effects of the alternative interventions have been measured, they are compared by calculating the incremental cost effectiveness ratio (ICER). The ICER is calculated as the difference in the expected costs of the two interventions, divided by the difference in the expected effects (QALYs) of the two interventions. [Equation 1 below].

$$ICER = \frac{C_{old} - C_{new}}{Q_{old} - Q_{new}} \quad (1)$$

The ICER is an estimate and as such, it is important to consider the nature and magnitude of the uncertainty around it. The uncertainty in the ICER is determined by the uncertainty in each of the individual components of costs and outcomes. There is an extensive literature on the appropriate methods for incorporating the uncertainty into the analysis, and we recommended that you consult Briggs et al (2006).

The uncertainty in estimate of the cost effectiveness of an intervention can be presented to the decision maker using a number of techniques including scatterplots on the cost effectiveness plane;

[1] The Upper Anchor has also been described as 'Perfect Health' and 'Best Imaginable Health'

cost effectiveness elipses; cost effectiveness acceptability curves (CEAC) and frontiers (CEAF). A CEAC plots the probability that the technology is cost effective over a range of possible values for the cost effectiveness threshold. The CEAF identifies the cost effective intervention over a range of threshold values when there is more than two technologies being compared. The cost effectiveness elipse is equivalent to the 95% confidence interval but in two dimensions – cost and effect. The interested reader can obtain more information about the analysis of uncertainty in Briggs et al (2006).

The cost effectiveness threshold is the maximum value for an ICER that the decision maker will accept as the basis for a positive reimbursement decision.

All forms of CEA are focussed on the health outcomes of the two alternatives. Many of the outputs nurse consultant activities are expected to achieve have important non-health effects, e.g. uplift in skills of junior nursing and clinical colleagues, improved patient experience, reduced cost of provision and increased flexibility in service provision. Therefore, the use of CEA will lead to an incomplete and potentially biased assessment of value when applied to nurse consultants.

There are other forms of economic evaluation, such as Cost Benefit Analysis (CBA), Cost Consequences Analysis and Option Appraisal. Each of these is capable of including non-health benefits in the assessment of value and therefore may be suitable for use in the economic evaluation of NCs.

Cost Benefit Analysis

Cost Benefit Analysis (CBA) expresses the value of the effects of an intervention or service in monetary terms. A CBA produces an estimate of the Net Present Value (NPV) of an intervention, this being the difference between the monetary value of the resources consumed in providing the intervention and the monetary value of its affects. Interventions with higher NPV are more valuable and interventions with a negative NPV should not be provided.

The key challenge to using CBA in health care is attaching a monetary value to the health affects an intervention. There are also equity concerns with regard to the standard methods for attaching monetary values to the impact of interventions on working time. If you are interested, more details on the CBA in health care are available in Drummond et al (2005). Given the portfolio of impacts of nurse consultant roles, obtaining monetary values would require resources on a scale only available to large research studies. It is this practical consideration, above all others, that means we cannot recommend CBA as an appropriate framework for the evaluation nurse consultant roles in the NHS.

Cost-Consequences Analysis

Cost-Consequences Analysis does not combine the portfolio of effects from an intervention on to a single scale such as money or QALYs; instead the individual effects are described and it is left to the decision maker to combine and make trade-offs between changes in different domains of effect. CCA does not provide a single result that can be interpreted as demonstrating that one intervention is superior to another. As a result, CCA is primarily a descriptive method and is not a truly evaluative process. Therefore, we cannot recommend CCA as a framework for evaluating nurse consultant roles in the NHS.

Option Appraisal

Option Appraisal (OA) is a systematic method for specifying objectives, identifying alternative options for meeting those objectives and analysing the (monetary and non-monetary) costs and benefits of each of those options to provide decision makers with an appropriately comprehensive assessment of the value for money of alternative strategies for achieving those objectives.

OA is recommended in the Treasury Green Book (2003) for evaluating substantial capital investments, and when done fully, is a resource and time intensive activity requiring the commitment of multiple stakeholders. NHS Scotland has developed an excellent on-line guide to undertaking an OA (http://www.scim.scot.nhs.uk/Support/OA_Guide.htm) However, the resources required for OA mean that is not a practical framework for evaluating nurse consultant roles in the NHS.

References

Brazier JE, Ratcliffe, J., Salomon, JA., Tsuchiya, A. (2007) *Measuring and valuing health for economic evaluation*. Oxford University Press: Oxford.

Briggs, A. Sculpher, M. Claxton, K. (2006) *Decision modelling for health economic evaluation*. Oxford University Press: Oxford.

Drummond M. Sculpher, M. Torrance, GW, O'Brien, B. Stoddart, GL. (2005) *Methods for the economic evaluation of health care programmes*. (3rd edition) Oxford University Press: Oxford.

HM Treasury (2003) *The Green Book.* HM Treasury: London http://www.hm-treasury.gov.uk/data_greenbook_index.htm Accessed 11 July 2011

NHS Scotland (2009). *A Practical Guide to the Appraisal, Evaluation, Approval and Management of Policies, Programmes and Projects* http://www.scim.scot.nhs.uk/Support/OA_Guide.htm Accessed 11 July 2011.

'It should be in the induction pack for new nurse consultants'

'It is reassuring that there are such common themes in what seem from the outside, such disparate posts'

'Once you've got the mindset, you will be able to collect the data to demonstrate impact as part of day-to-day practice'

Further information and copies of this toolkit can be obtained from:
http://research.shu.ac.uk/hwb/ncimpact/

Feedback on the use of the toolkit is welcomed- please see the website for contact details.