



All Ireland Institute of
Hospice and Palliative Care

Final Report

ALL IRELAND

Palliative Care Senior Nurses Network

May 2016

FINAL REPORT

Phase II – All Ireland Palliative Care Senior Nurse Network

Nursing Leadership Impacting Policy and Practice

1 Rationale

Global drivers such as in changes in patient demographics and workforce, with an emphasis on efficient resource utilisation, have resulted in calls for enhanced nurse leadership to ensure quality health care delivery (Adams 2014). The best way to support nurses to develop effective clinical leadership initiatives, which provide sustained positive impacts on quality of care and patient safety, remains a matter of some debate (Cummings et al 2010).

The Palliative Care Senior Nurses Network (PCSNN) was established by All Ireland Institute of Hospice & Palliative Care (AIHPC) in 2012. Its central aim was to facilitate senior nurses to collaboratively improve the standards of palliative care practice, service provision, and access to palliative care, based on need rather than diagnosis. The vision for the PCSNN was that it would help improve the quality of and access to palliative care for the populations of the Republic of Ireland and Northern Ireland. This would be achieved through the enhancement of leadership skills of senior nurses and by building cross-jurisdiction relationships to tackle political, organisational and resource barriers, limiting the delivery of optimal palliative and end-of-life care for people across the Island of Ireland. This report contains the findings from an evaluation of the second phase of the PCSNN, which commenced in January 2015 and was supported by a grant from the Burdett Trust for Nursing. This evaluation was undertaken by researchers at Ulster University.

2 Anticipated Benefits of the PCSNN

It was anticipated that membership of the PCSNN would:

- increase knowledge and awareness of palliative care contribution across the Republic of Ireland and Northern Ireland.
- increase sharing of expertise and palliative care awareness.
- increase palliative care capacity within the wider healthcare settings across the island
- impact policy development and implementation across the island.
- improve standards of palliative care practice and service provision – specifically the care and management of persons experiencing constipation.
- increase self-awareness and leadership capacity.
- improve service and leadership succession planning.

In addition it was anticipated that involvement in the PCSNN would enable members to:

- be better equipped to build strategic alliances.
- be able to identify their own leadership strengths and areas for improvement.
- acquire a deeper understanding of global palliative care challenges.

- be better positioned to effect positive policy change.
- be better equipped with strategic planning and thinking skills.
- be better able to take on higher leadership roles.
- help create a sustainable network.

3 Overview of PCSNN Meetings

Attendance from the 35 members averaged at approximately 90% across the six PCSNN meetings. The six meetings afforded networking opportunities, time to work on initiatives in addition to supplementary presentations and information. AllHPC employed an 'action-learning' approach which fostered strategic leadership in action, enhanced national and global palliative care knowledge and strategic skills, and enabled engagement in peer learning and development. The key themes of each day were

Day 1 (28 January 2015):	Leadership, Networks and Action Learning
Day 2 (4 March 2015):	Results of Leadership Characteristics Assessment
Day 3 (15 April 2015):	Development of the HSE Management of Constipation in Adult Patients Receiving Palliative Care and Neo-personality assessment workshop
Day 4 (20 May 2015):	Economics Issues in Palliative Care in Ireland
Day 5 (23 Sept 2015)	Succession planning, mentoring, social media, evaluation
Day 6 (21 October 2015)	Evaluation, Focus Group, Presentation Day

4 Methodology of Evaluation

4.1 Design: A “realistic evaluation” approach was undertaken (Pawson & Tilley, 1997), which sought to answer the question not simply “What works?” but “What works for whom in what circumstances?”

4.2 Data collection: A multi-methods approach was adopted, comprised of five strands of work:

1. Review of the literature pertaining to leadership in nursing and value of nursing networks and leadership in palliative and end-of-life care.
2. Secondary Data Analysis of documents and reports developed in relation to the work of the PCSNN.
3. Online Survey designed to gain insight into the demographic profile of the PCSNN members, gather information on the development of leadership behaviour, and to measure perceptions about the role of the PCSNN.
4. Semi-structured interviews with Key Stakeholders across the island of Ireland who had direct experience with the PCSNN or indirect experience through the input of senior nurses who worked with them.

5. Focus groups with PCSNN participants designed to explore members' views, experience, ability, and strategic influencing skills in mobilising support and engaging key stakeholders. This included any key barriers and facilitators to PCSNN membership and opinions on how to develop and build on achievements.

4.3 Analysis: Data were analysed using Newell and Burnard's (2011) framework of content analysis.

4.4 Ethics: A favourable ethical opinion was obtained through the Ulster University, Life and Health Sciences Ethics Committee, before data collection took place. Informed consent was obtained from all participants, including permission to audio tape and to transcribe focus group and telephone interviews. All identifying information was excluded from the resultant transcripts.

5 Findings

5.1. The work of the PCSNN: Findings from secondary analysis of documents

Phase II of the PCSNN was operationalised through the formation of five Network Development Teams (NDTs). Within these NDTs, senior nurses developed their leadership skills, through program development and improvements in palliative care delivery. Overall, the PCSNN contributed to several important regional and national initiatives, which could have a direct positive impact and resonance with clinical palliative care (see Table 1). For example, their work supported the implementation of the draft constipation management guidelines developed by the National Clinical Programme for Palliative Care, which have subsequently been launched by the National Clinical Effectiveness Committee (NCEC) (2015). Within the AIIHPC, the PCSNN nurses also contributed to the development and promotion of the AIIHPC Palliative Hub (www.thepalliativehub.com), a dedicated website helping people from a variety of backgrounds, including healthcare professionals and the public, to find the information and resources they need on palliative and end-of-life care.

Table 1: PCSNN Phase II: Nursing Development Team Initiatives

<ul style="list-style-type: none"> • NDT1. "Audit in Motion" Constipation Audit Tool Use of an existing audit tool in clinical environments to assist implementation of best practice guidelines for the Management of Constipation in Adult Patients Receiving Palliative Care. • NDT2. Online Education for Staff on Management of Constipation Development of content and creation of an online education programme for health and social care staff in general and/or specialist palliative care settings, based on the Management of Constipation in Adult Patients Receiving Palliative Care guidelines. • NDT3. An Online Resource for Carers/Users for managing constipation Development of an online awareness resource and general guidance for users and carers on Managing Constipation, based on the Management of Constipation in Adult Patients Receiving Palliative Care guidelines. • NDT4. "Asking the questions that matter" Design and development of an information resource to support users / carers in the formulation of personally relevant questions to ask of treating services post-diagnosis of a life-limiting or life-threatening illness. • NDT5. Promotion of Palliative Hub - Children and Young People including development and dissemination of marketing information to support awareness of the website for parents of children with palliative care needs.
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5.2 PCSNN Membership: Findings from self-report questionnaires and online survey

Thirty members of the PCSNN responded to an online survey conducted as part of the PCSNN evaluation, which comprised of a mixture of 24 open and closed questions exploring the following: Participant Demographics, Reasons for joining the PCSNN, Attitudes to PCSNN Membership, Involvement in PCSNN Development Teams (NDT) initiatives and Leadership Development.

Recruitment - PCSNN membership was derived from an All Island call for expressions of interest from registered nurses, providing generalist and/or specialist palliative care in Hospital, Community or Hospice settings in the statutory or voluntary sector. In order to be eligible nurses were required to be working at a minimum level of Clinical Nurse Specialist (CNS) or Clinical Nurse Manager level 2 (CNM2) in the Republic of Ireland or Band 7 (or equivalent in non-HSC settings) in Northern Ireland.

An initial cohort of 43 members agreed to participate as members of Phase II of the PCSNN. Nine participants withdrew, citing pressures of work and or family commitments as reasons for their withdrawal. This left a final cohort of 35 participants, of which ten had been members of Phase I.

Demographics of PCSNN members - Members had a breadth of professional qualifications, experience and role; ranging from general management to leadership of clinical palliative care services across the Island of Ireland (see Table 2). They mostly worked in full-time positions and had been in their current post for longer than five years. The majority of members had attained academic awards at postgraduate diploma or master's level and were qualified in a range of nursing specialties including public health, district nursing, gerontology, oncology, long term conditions, paediatrics, midwifery and palliative care.

Self-assessed leadership characteristics of PCSNN members - At the beginning of the programme members were asked to assess their leadership competence using a questionnaire adapted from the International Council of Nurses Leadership Ranking Tool (Shaw, 2007). This gave the PCSNN members and facilitators a broad picture of the collective membership's relative strengths and weaknesses as leaders (see Table 2, Characteristic Rank T1).

Table 2: Self-assessed leadership characteristics ranked from most developed to least developed

Characteristic (T1) n=37	Rank T1	Rank T2	Rank change
Being able to motivate	1	1	↔
Effective in interpersonal relationships	2	3	↓
Being accountable	3	4	↓
Having a customer focus	4	1	↑
Is decisive	5	9	↓
Able to be creative and think analytically	6	17	↓
Being effective in building networks, partnerships, alliances	7	11	↓
Having vision and being strategic	8	14	↓
Is effective in written communication	9	11	↓
Is open to review and change	10	15	↓
Inspiring confidence and trust	11	6	↑
Is able to be self-directed	12	7	↑
Able to problem-solve	13	13	↔
Is an effective oral communicator	14	9	↑

Able to build teams	15	4	↑
Able to influence and negotiate	16	7	↑
Having political skill	17	18	↓
Prepares future leaders	18	19	↓
Having policy making and influencing skills Policy	19	20	↓
Being externally aware	20	15	↑

Experience of membership - All of the respondents to the online survey, reported that they had formed a good working relationships with their PCSNN colleagues (100%, n=30 of 30) and the majority of respondents also agreed or strongly agreed that they felt they belonged to the PSCNN (87%, n=26 of 30). Findings from the online survey indicated that the PCSNN members were generally positive about their experience of the programme. Positive changes in leadership qualities were also noted, though the visibility of PCSNN beyond its members was questioned. PCSNN leadership development needs scores had generally improved from baseline across all 20 characteristics though an important limitation to this finding is the reduced number who undertook the test (n=37 at baseline and 30 at repeated assessment), preventing a direct comparison of results. Inspiring confidence and trust, ability to build teams, effectiveness as an oral communicator and ability to influence and negotiate appeared to be more developed within the PCSNN by the end of the Phase II programme (see Table 2, Characteristic Rank T2). Three of the leadership attributes that were identified at start of Phase II of the PCSNN to be least developed remained so: having political skill, preparing future leaders, having policy making and influencing skills.

Despite these findings less than half of members were committed to remaining as active members of the PCSNN. Barriers to continued participation included lack of organisational support, travel and time commitments and changes in personal circumstances.

5.3 Findings from Stakeholder Interviews

Nine individual semi-structured telephone interviews lasting an average of 20 minutes were conducted with a purposive sample of Key Stakeholders. These stakeholders represented healthcare organisations from all regions of the island of Ireland, occupying a variety of strategic and clinical positions. Interviewees were selected in consultation with AIIHPC, either because they had direct experience of the PCSNN or indirect experience through PCSNN involvement by their senior nurses and could therefore offer an informed view of the work the PCSNN across Northern Ireland and the Republic of Ireland.

Generally, stakeholders accurately perceived the PCSNN as *“a much needed and positive experience for staff”* (Participant 3), with a variety of real and potential roles. These included:

- To provide an opportunity for senior nurses to come together to share good practice.
- To develop leadership capacity among senior nurses of all levels working in palliative care across the island of Ireland.
- To develop leadership skills within a defined support structure and using a model of project work which challenged senior nurses to step beyond their daily routine and out of their comfort zones.

- To nurture collaborative working relationships, so that senior nurses might usefully engage with and learn from each other's experience and effect positive changes in clinical practice, education, research and policy.
- To exert influence at a strategic level, by informing work programmes from both the Health Service Executive in the Republic of Ireland and the Department of Health in the UK.

Findings from stakeholders indicated that the PCSNN could play a role in the development of nursing leadership capacity in palliative care across the island of Ireland. The supportive network model was reported to offer positive benefits in terms of professional relationship, network development, education and promotion of leadership skills – particularly for less senior nurses. Some instances of direct and indirect impacts on areas of palliative care education and practice were offered, but this was not a universal experience for stakeholders, who were often unaware of the PCSNN activities.

However, despite potential benefits of the PCSNN, perceived barriers existed to the network reaching its full potential to influence policy. Key concerns expressed by stakeholders included:

- Group structure and the definition of a 'senior' nurse.
- Inclusivity of non-specialist palliative care nurses.
- The need for a strategy to identify and disseminate outputs from the PCSNN to the wider palliative and healthcare community.
- The need for project work to be followed up beyond the life of the PCSNN.
- Defined and tangible outputs to be more widely disseminated from the network to enhance its reach and underpin value for money.

5.4 Findings from PCSNN Focus Groups

In total four focus groups, each comprising between six and eight participants, were conducted with PCSNN members (n=26). The following six key themes emerged from analysis: (1) recruitment and motivation, (2) role expectations, (3) professional experience and impact, (3) personal experience and impact, (4) Initiatives, role, experience and learning opportunities, (5) sessions, experience and learning opportunities and (6) strategic influence and the future role of the PCSNN.

The PCSNN was viewed by its members as a personal and professional forum which enabled networking, leadership's skills and personal development to be achieved. The very diversity of settings and scope of responsibilities, as well as the collective knowledge and experiences arising from members working across the island of Ireland, was felt to provide a unique context for the PCSNN members to grow as leaders and policy shapers. Nevertheless, there were difficulties associated with the time and workload demands, alongside personal and clinical work commitments. The lack of role clarity for new members and the allocation of pre-determined initiatives proved challenging, yet opportunities to build on and develop new skills were created. Recommendations to continue the PCSNN to build upon the skills momentum created, albeit with a revised agenda, were made.

Working on cross-jurisdiction initiatives laid and cemented the foundations for stronger social and professional connections which were viewed as a key motivator to stay within the PCSNN. As reflected:

“being in the room with all these senior nurses. Not just Island wide, but across management and clinical and different divisions but with the same sort of focus and desires of learning... There’s strength in coming together.”(FG 4 Participant 1)

6 Discussion

The PSCNN initiative was valuable at a personal and practice level and members were generally positive about its potential to foster professional growth and development, share current and best practice, develop informal supportive networks, enable cross-jurisdiction initiatives and promote the development of individual leadership skills. In addition, members and stakeholders identified the strategic potential which existed, in developing the political and influencing skill required of future leaders. Yet, four years following the commencement of the PCSNN and at the end of its second phase, concerns existed about the impact of leadership development, the translation of outcomes from PSCNN work for the benefit of the wider palliative care community and to the overall sustainability of the initiative.

For members, who managed competing work commitments, participation was warranted where practical outcomes were clear and personally and professionally relevant. However, lack of role clarity for new members and the allocation of pre-determined initiatives undermined members commitment. Whilst recognising that project work was primarily a vehicle to leadership skill development, ongoing organisational support of and commitment to future participation in the Network was linked to visible secondary outputs.

Recommendations to continue the PCSNN to build upon the skills momentum created, albeit with a revised agenda, were made by all parties.

7 Conclusions

There is a consensus within nursing literature that building the capacity of nurses to lead is valuable for the delivery of cost-effective patient-orientated services. This was echoed in the findings of the AIIHPC PCSNN Evaluation. Professional networks provide a vehicle for nurses to individually and collectively develop confidence and competence as positive influencers of healthcare policy development and practices, which support the delivery of effective, timely and resource efficient palliative and end-of-life care for all those who need it. Through the support of Networks, health care services can enable nurse leaders to develop individual skill, ensure effective mentorship and succession planning and support the establishment of sustainable professional cross-jurisdiction links.

Costs for Phase II of the Senior Palliative Care Nurses Network

All Ireland Palliative Care Senior Nursing Network Phase II				
Budget Item	Budgeted		Spend	Contributed by
	Total cost €	Total cost £stg	Total cost €	
		(€1=£0.81 27/5/14)		
6 Network meetings	27000.00	21600.00	27000.00	Burdett
Personality assessment exercise including expert facilitator for feedback	1800.00	1440.00	1800.00	Burdett
AllHPC will provide expert facilitation for six days of Network Development and Initiative activities plus six days of preparation of materials	7200.00	5760.00	7200.00	Burdett
Design and analysis of network leadership development materials	3600.00	2880.00	3600.00	AllHPC
Implementation of 3 Constipation Management National Guidelines initiatives and 2 Palliative Hub content development initiatives	18000.00	13000.00	18000.00	Burdett
Access to two half day sessions with AllHPC's Voices4Care panel to ensure patient and public involvement in the National Constipation initiative.	5000.00	4000.00	5000.00	AllHPC
Administration and programme manager support	9288.00	7430.00	9288.00	AllHPC
Evaluation (external evaluation of Phase II commissioned)	7000.00	5000.00	7000.00	Burdett
Dissemination of results and learning	Via Hub			AllHPC
Overall Total	€78,888	£ 63,110	€78,888	
Requested from Burdett	€61,000	£48,800	€61,000	
Committed by AllHPC	€17,888	£14,310	€17,888	

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