Compassionate Connections Workforce Development Programme to support implementation of the Refreshed Framework for Maternity Care in Scotland

Evaluation Report to NHS Education for Scotland

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Evaluation of the
Compassionate Connections Programme

EXECUTIVE SUMMARY

prepared by
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1 The Compassionate Connections workforce development programme

Compassionate Connections is a collaborative programme run by NHS Education for Scotland and
NHS Health Scotland. It was initiated to support implementation of the Refreshed Framework for

The programme began in early 2011 following the launch of the frameworks and associated policy
guidance. In November 2011 a learning needs analysis was commissioned¹ to support the project.
This was completed in March 2012 and in response to the findings of this report a flexible set of
interactive educational resources was developed through extensive stakeholder engagement and
consultation. The resources were designed to support a national workforce development programme
aiming to:

- Increase understanding of the impact of health and social circumstance on engagement with
services and clinical outcomes
- Enable staff to make the most of their individual and collective contributions towards improving
maternal, newborn and infant health and well-being.
- Build on the existing knowledge and skills staff currently have and connect them with new
insights, experiences and understanding

The resources comprised:

- Two Story Worlds which use a mixture of audio and visual slides to enable learners to explore
the delivery of compassionate person centred maternity care through fictionalised drama (in
collaboration with Forum Interactive Ltd.).
- A virtual learning environment (VLE) which supports learners to understand person-centred
approaches to maternity care, with a particular focus on smoking cessation (in collaboration
with Digital Design Studio).

¹ Ecogson and NHS Education for Scotland. (2012). Learning Needs Analysis to support the
A pilot of the Compassionate Connections workforce development programme began in September 2013. It engaged six NHS boards across Scotland which had identified themselves as early implementer sites and the three higher education institutions (HEIs) in Scotland which provide pre-registration midwifery programmes.

Support for implementation was provided by four (3 FTE\(^2\)) regional Practice Education (PE) posts employed by NES on a fixed term basis from August 2013 to March 2014.

Implementation centred on the delivery of events (meetings, workshops, lectures – collectively referred to as ‘sessions’) designed to introduce and pilot the programme:

- Awareness-raising sessions, designed to introduce the programme resources to a very wide range of strategic and operational stakeholders. These sessions often opportunistically ‘piggy-backed’ onto existing and/or scheduled meetings and events to make the best use of time.
- Introductory sessions, designed to introduce the programme to staff who had the potential to run Story Worlds learning sessions with their own clinical teams or colleagues (‘introductory’ ‘facilitators’ or ‘train-the-trainees’ sessions).
- Story Worlds learning sessions, designed to use the Compassionate Connections resources within a learning context with relevant staff or students (SW1). These sessions were followed up with a Story Worlds reflection session (SW2), to engage learners in reflecting on how they had made use of their learning in practice, since attending the Story Worlds session.
- Virtual Learning Environment (VLE) learning sessions, designed for individuals or groups to access and learn through the VLE.

The NES Compassionate Connections implementation team far exceeded their aims in delivering the pilot programme, in particular in relation to the delivery of Story Worlds introductory sessions and SW1 learning sessions. Between 25\(^{th}\) September 2013 and 5\(^{th}\) February 2014, 107 sessions were provided, reaching 1215 people.

2 The evaluation

The evaluation of the Compassionate Connections workforce development pilot programme was designed to assess:

- The extent to which the educational outputs of the Compassionate Connections Project is meeting the project aims and learning outcomes.
- The perceptions and experiences of key stakeholders across Scotland, of the project in terms of its relevance to and impact on the current policy landscape.
- The role of the Practice Educator in building capacity and capability for ongoing dissemination of the resources.

In particular, the evaluation was designed to address the following objectives and indicative research questions\(^3\):

1. To evaluate the educational resources.
2. To assess educational methods and media.

\(^2\) 2 x 1WTE plus 1 x 0.8WTE and 1 x 0.2WTE

\(^3\) Invitation to submit a competitive written quotation: Reference: C00106
3. To investigate user and stakeholder perceptions.
4. To explore the potential transferability of learning resources.
5. To assess the development and management of the project.
6. To assess the Practice Educator role in the project
7. To make recommendations for future development based on the evaluation

The evaluation approach was one of mixed methods to allow for triangulated analysis (i.e. using more than one method to check findings. The evaluation fieldwork ran in parallel with implementation, and was undertaken between September 2013 and March 2014.

3 Conclusions

3.1 The educational methods and media

The implementation of the Compassionate Connections pilot programme focused on the Story Worlds materials with fewer more targeted sessions focusing on the smoking cessation VLE.

The Story Worlds resource was considered by both stakeholders and learners to be:

- Best for discussion-based groups
- Realistic, relevant and non-judgemental
- Accessible and flexible
- High quality

The visual, story-based format worked well for participants’ learning. The literature on narrative pedagogy shows that this approach can be useful in developing critical thinking and reflection with health care staff, particularly around challenging, complex or sensitive areas of practice, providing a ‘safe environment’ to consider these issues. The use of digital approaches and multimedia have been reported as advantageous in terms of enhancing authenticity and fidelity. Technical problems were at times an issue in particular for the VLE.

Following the introductory sessions the vast majority of respondents were positive and supportive of the Compassionate Connections resources, with 95.3% agreeing that they really liked the resources and anticipated that staff would engage with and learn from them. Indeed, 39.5% respondents ‘strongly agreed’ with this statement, suggesting a high level of support, and anticipated impact on the staff who engage with the resources.

In terms of validity, almost all respondents (97.7%) considered the resources to accurately reflect real life scenarios (43% strongly agreed), and most (96.5%) agreed that they would help staff connect a deeper insight and understanding of compassionate person centred care (more than a third of respondents strongly agreed with this statement).

When asked to consider whether the reflective approach used during the story world resource was appropriate to meet the learning objectives, almost all respondents (96.5%) agreed. Respondents were highly positive regarding the use of stories as an educational method within this context: 96.5% respondents agreed that the use of stories was a useful learning approach, of which more than half (52.3%) strongly agreed.
3.2 Extent to which the learning materials have enabled the learners to achieve the learning outcomes

Most sessions provided outwith HEIs were facilitated by the Compassionate Connection Practice Educators. Learning sessions were delivered in relation to both the SW and the VLE resources: specific learning outcomes for sessions were developed by the PEs as appropriate to their target participants.

The learning outcomes were not assessed in any formal way – with the SW2 (reflection) session providing an informal opportunity to reflect on the achievement of learning outcomes. The session participant survey provided an opportunity to elicit individual perspectives on their achievement of the learning outcomes.

Participants in Story Worlds learning sessions generally perceived that their ability in relation to the SW learning outcomes had improved as a result of the learning session. This was most noticeable in relation to:

- Understanding the principles of compassionate person centred care, in particular in how it relates to practitioners’ own roles within maternity care services
- Identifying opportunities to use strengths-based approaches in the delivery of maternity care
- The delivery of inequalities sensitive maternity care
- Identifying opportunities to support health behaviour change in the delivery of maternity care

Participants in VLE learning sessions considered that their ability in relation to the VLE learning outcomes had improved in relation to:

- Using an assets-based approach to improve health outcomes
- Using available collective resources that promote the coping/decision-making abilities of women
- Using available collective resources that promote the self-esteem of women.

3.3 Extent to which participants feel able to apply the outcomes to practice

The timescales for the evaluation of the pilot programme made it impossible to make any effective evaluation of the extent to which participant felt able to apply the learning outcomes of the Compassionate Connections resources in practice. Nevertheless, almost all (90%) participants in Story Worlds learning sessions expected that it would improve their practice in terms of care and compassion towards women and families.

Similarly, almost all (92%) participants in a VLE learning session expected it to improve their practice in terms of providing compassionate care for patients.

The evaluation of the pilot programme provides the potential to develop more longitudinal evaluation of impacts on practice, for example by following up case studies and/or individuals who participated in the learning sessions.
3.4 User and stakeholder perceptions

Users and stakeholders were optimistic about the potential positive impact on practitioners’ ability in relation to Compassionate Connections learning outcomes, whilst recognising that it was too early to see the impact.

Following awareness sessions the majority of respondents (85%) really liked the resources, and anticipated that staff would both engage with them and learn from them. Further, 91% respondents thought that the resources accurately represented real life scenarios.

The vast majority of respondents thought the resources would have a positive impact on staff and practice. Most respondents (86%) thought that the resources would positively affirm the work that maternity care staff do in practice already, and 81% agreed that the resources would connect staff with a greater insight and understanding into compassionate patient-centred care. In addition, the majority of respondents (82%) thought that the resources would have a positive impact in terms of helping the maternity care workforce make effective cross-sector links, and 87% of respondents agreed that they would help translate strategic policy aspirations into real and meaningful practice.

3.5 Potential transferability of learning resources

The literature on narrative pedagogy shows that the use of narrative and stories has been successful across a range of contexts, in particular in relation to health promotion (across diverse groups). Within health professions education, the use of narrative is often focused towards developing individuals’ knowledge or competence with regard to ‘sensitive’ areas of practice, including compassionate care, emotionally challenging practice, and developing empathy.

Stakeholders interviewed pointed to the relevance of the Compassionate Connections programme to wider health and social care workforce groups, and to national programmes/initiatives, notably:
- GIRFEC
- The Early Years Collaborative
- The implementation of the new Baby Friendly Initiative standards.

Following introductory sessions Ninety-five 95% of respondents thought that the resources would be useful beyond the maternity care workforce noting the importance of explicating the relevance of the Compassionate Connections programme to other staff groups, programmes and initiatives.

3.6 Development and management of the pilot programme

The pilot programme was implemented by a NES team of Practice Educators (PEs) in partnership with early implementer Boards and the three HEIs delivering pre-registration midwifery education in Scotland. It centred on the promotion of the Compassionate Connections resources through ‘sessions’ of three types: awareness raising sessions, ‘train-the-trainers’ sessions, and learning sessions.

The NES Compassionate Connections team went to significant effort to engage as many stakeholders as possible. This succeeded in reaching strategic and senior staff in awareness-raising sessions; and in engaging relevant staff (i.e. those with an education remit) in introductory sessions.
Midwifery and maternity-related staff were well represented in Story Worlds learning sessions, with pre-registration students being best able to attend reflection (SW2) sessions. The VLE resource was not promoted as strongly as the SW resource, and was delivered mainly to students and/or through individual sessions.

Strategic stakeholders considered that the provision of strong, skilled facilitators was a key factor in the successful implementation of the Compassionate Connections programme – in particular to make the links/connections with other relevant policies, initiatives and workforce development frameworks: some considered that this should be at a national level and independent of the territorial NHS Boards, others considered that this should be retained at local levels.

The NES PE team was seen as playing a key role in promoting/marketing the Compassionate Connections resources, with some stakeholders considering that the NES focus was too much on promotion and less on effective delivery.

### 3.7 The Practice Educator role

The key role of the Compassionate Connections PEs, was seen by stakeholders and PEs themselves as the promotion of the Compassionate Connections resources. From the outset the Practice Educator team felt confident in the quality of the resource and its intended messages. Successful promotion of the resources was perceived as requiring three main attributes:

- **Belief** in the ‘message’ of the resources
- **Skills** in stakeholder management and brokerage. This was facilitated by:
  - Having identified ‘champions’ at Board level
  - Being able to access relevant networks
  - Being able to explicate the relevance of the resources and the links that they have with key national frameworks – such as the KSF – and other key resources and initiatives.
  - Being able to demonstrate the relevance of the resources
  - Fitting in with what’s already there
- **Facilitation** of many different and complex groups to address the same issues. This required:
  - Clarity of the purpose
  - Significant knowledge in addition to midwifery clinical practice
  - The development of an approach to assure the integrity of the Compassionate Connections message

### 3.8 The 2012 learning needs analysis

The 2012 learning needs analysis identified a range of core competencies required to support implementation of the Refreshed Framework, which were mapped to those developed through other relevant training programmes, including the Family Nurse Partnership (FNP) training programme and GIRFEC multi-agency training. It recommended that NES consider the development of training and development related to the Continuous Learning Framework for Social Services and the FNP programme; both of which demonstrated a good fit with the core competencies required to implement the Refreshed Framework.

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4 Detailed findings in relation to this aspect of the evaluation have been provided to NES as a separate confidential appendix. This is because the PE team is very small, and easily identifiable. It is not appropriate to provide such personalised data in an evaluation report such as this.
The learning needs analysis also identified a number of factors that contribute to effective training for the maternity care workforce, recommending that training activities and resources must be flexible, accessible, and meeting the following core components:

- Using a blended approach (i.e. interactive group based learning, supplemented with online resources, opportunities to continue/take forward learning (e.g. resource pack to take away and share with colleagues), a range of tools (e.g. DVD resources, scenarios, tutor led discussion, group work and reflection)
- Multi-disciplinary training (i.e. include profession specific elements so that the training feels relevant, develop shared understanding of the roles and remit of different groups in the workforce)
- A staged approach (i.e. provision of background information)
- Self-assessment of learning needs (i.e. benchmarking of knowledge, skills, values and attributes, training sessions, reflection – mentoring, coaching and reflective logs, follow up)
- Quality (i.e. high quality resources, skilled facilitators, relevance to practice)

The Compassionate Connections workforce development pilot programme was purposefully structured around generic learning outcomes – rather than competencies. This evaluation indicates that the generic nature of the content of the resources was both strength and a weakness:

- A strength because it provides strong complementary content/learning to other person-centred workforce initiatives- such as GIRFEC.
- A weakness because without a clear locus its message could be lost; this needs to be explicated at national and local levels to ensure that the programme has relevance.

The pilot programme used a blended approach to deliver multi-disciplinary training – with some tailoring to specific target audiences (eg in relation to GIRFEC). It offered resources that were regarded as very high quality – but which needed to be delivered through highly skilled, knowledgeable and consistent facilitation. It was designed to facilitate reflective learning and practice, but provided no benchmarking of knowledge, skills, values and attributes – for example in relation to the KSF or the Continuous Learning Framework for Social Services.

4 Recommendations

The implementation of the pilot programme has succeeded in significantly raising awareness of the Compassionate Connections resources. The positive response to this will support further implementation – and it may also necessitate some demand management. The pilot programme has also enabled the implementation team to ‘test’ the resources in a wide variety of different contexts, and with a wide range of stakeholders and learners. The evaluation findings show that the resources are valued, and that there is an anticipated impact on practice. In order to maximise that anticipated impact, we propose the following recommendations:

1. **Focusing implementation** ...
   ... by doing less awareness-raising; and more capacity building (i.e. through training-the trainers) at Board level.

2. **Making the connections** with Compassionate Connections explicit; notably in relation to:
   a. Other programmes/initiatives/resources at local and national levels
   b. Career development

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structures and frameworks
This will demonstrate the relevance of the programme, and help to:
• Sharpen learning outcomes
• Secure strategic/management support/buy-in to the programme by showing how it can support the achievement of strategic outcomes.

3. Supporting facilitation...
...provide examples to show potential users of the resource how it can be used to support teaching and learning. The resource was designed to be as flexible as possible and as the evaluation showed, this is both an advantage and a disadvantage with potential users left uncertain about how best to use it for their own purposes. This point could be addressed by the provision of additional exemplar material and by supporting users in the development of facilitation skills relevant to this type of material.

4. Addressing the use of the VLE:
Significant investment has already gone into this resource. The pilot programme did not strongly promote it; nevertheless, the evaluation has indicated that learners like it – particularly in terms of the quality of its information.

5. Demonstrating impacts on practice...
...by building capacity for ongoing self-evaluation; and light touch external evaluation to support self-evaluation and provide programme level independent evaluation. Findings should be disseminated so as to provide ongoing feedback to Boards on impacts, which in turn will support the sustainability of the programme.
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1 Introduction and Background

Compassionate Connections is a collaborative programme run by NHS Education for Scotland and NHS Health Scotland. It was initiated to support implementation of the Refreshed Framework for Maternity Care in Scotland and Improving Maternal and Infant Nutrition – a Framework for Action.

The programme began in early 2011 following the launch of the frameworks and associated policy guidance. In November 2011 a learning needs analysis was commissioned to support the project. This was completed in March 2012 and in response to the findings of this report a flexible set of interactive educational resources was developed through extensive stakeholder engagement and consultation.

This chapter provides the strategic context and background of the Compassionate Connections programme.

1.1 The Strategic Context

The need to ensure the best quality care for NHS patients in Scotland has been the focus of health and social policy for many years. In December 2007 the Scottish Government published an ambitious action plan ‘Better Health Better Care’, which focused on health improvement strategies for disadvantaged communities, including the need for improved access to services. Within the Better Health Better Care plan, the Scottish Government reiterated its ongoing commitment to the provision of women and family-centred maternity services within a network of care offered as locally as possible, by clinically competent professionals.

1.1.1 Putting patients at the heart of healthcare

Building on the momentum of this work, the Healthcare Quality Strategy for Scotland was published in 2010, emphasising the need to put patients at the heart of healthcare in Scotland. Its focus was to make measurable improvements in the aspects of quality of care that patients, and their families and carers see as important. It aimed for patients to be partners in their own care and for them to experience improvements in the areas of care that matter to them, including caring and compassionate treatment, clear communication and explanation, and effective collaboration with health professionals.

The vision for improved maternity care in NHS Scotland is embedded within the Quality Strategy, with priorities identified as the development of mutually beneficial partnerships between patients, their families and professionals providing maternity services (including shared decision making),

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reducing the number of healthcare acquired infections in maternity care and reducing inequalities in access to and quality of maternity services. The publication of this strategy was concurrent with a number of other strong social and political drivers in the UK, as a number of high profile public inquiries of poor quality care emerged, such as the Mid-Staffordshire NHS Foundation Trust Inquiry and subsequent Francis Report.4

Concerns regarding the standards of healthcare in the UK have continued to grow in recent years, and the need for compassionate, safe care within the NHS is one of the highest priorities and socio-political drivers today.

1.1.2 The Refreshed Framework for Maternity Care in Scotland

Strategies to implement these priorities across Scotland are described in the Refreshed Framework for Maternity Care in Scotland5 and Improving Maternal and Infant Nutrition – A Framework for Action.6 The Refreshed Framework for Maternity Care in Scotland also integrates with the principles of the Getting it Right for Every Child7 approach, the Early Years Framework8 and Equally Well.9 It makes explicit the pivotal role of maternity services to the long term health and well-being of women, their children and families. The framework is designed to address all aspects of care from conception, throughout pregnancy and during the postnatal phase. It recognises that all staff will need learning and development support to continue to develop the knowledge and skills they need to deliver tailored maternity care of consistently high quality for all women. This includes the need for staff to have the skills to work with women and their families using health asset or strengths based approaches, which start with and harness the high levels of motivation women have to do what’s best for their babies.

For NHS staff, the move to delivering more personalised, outcomes focused services creates opportunities for new ways of working, but there are also significant challenges for service providers in adapting culture, workforce and systems and managing these transitions. Stakeholders have highlighted workforce development as one of three specific areas that will benefit from national support via an implementation support group, to ensure that the framework is effectively implemented at Board level and meets the needs of local communities.

1.1.3 The move towards person-centred care and personal outcomes

The Scottish Government’s continued drive for safe and effective person-centred care is reflected in the Maternity Care Quality Improvement Collaborative, launched in March 2013. The Collaborative facilitates the coming together of healthcare professionals working within maternity, neonatal and paediatric services. It aims to support the continued drive for safe and effective person-centred care, improving outcomes and reducing inequalities in outcomes as a result. The key aims for the Collaborative are to increase the percentage of women satisfied with their experience of maternity care to 95% by 2015, and reduce avoidable harm in women and babies by 30% by 2015. As part of the Collaborative, the Scottish Government has funded Midwifery Champions for every NHS Board, with a unique role for implementing quality improvement for mothers and their babies.

Over recent years, a significant amount of work has gone into establishing outcomes for health and community/social care in Scotland. The Scottish Government, in consultation with COSLA and other key stakeholders, has proposed seven Health and Social Care Quality Outcomes.10 These are high-level statements of what health and social care partners are attempting to achieve through the integration of health and social care, and ultimately through the pursuit of quality improvement across health and social care. They will apply to all care groups in all settings. The outcomes are currently being refined and a suite of indicators and measures for integration of adult health and social care are under development. The development of outcomes and measures will continue over time as integration takes effect across health and social care.

A workforce priority with the personal outcomes approach is to ensure that support is available for partnerships to embed outcomes in practice so that the broader benefits can be realised. It is recognised that an outcomes based approach to performance can help to provide a common language and shared purpose between services, and with people using services and support. Through engagement at assessment and review, the approach ensures that care and support are appropriate and effective, avoiding service use that does not make the difference required.

1.1.4 Leadership in Compassionate Care

The leadership in Compassionate Care programme11 is a collaborative venture between Edinburgh Napier University and NHS Lothian. It was initiated in response to a growing awareness by nursing academics and staff at the University that person-centred, compassionate caring had been lost within practice, and was not always made explicit within pre-registration nursing and midwifery programmes.12 The aim of the 3 year programme was to ensure compassionate, person-centred nursing practice is at the heart of nursing practice within NHS Lothian and within the University’s undergraduate nursing programme. The programme fulfilled a variety of roles, from promoting the principles of compassionate care within the curriculum, to helping graduates practice compassionate care in their first year as qualified nurses. Centres of excellence, known as Beacon Wards, were also

10 http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes
established at several NHS Lothian sites, to consistently support the development of leadership skills in compassionate care. The programme team concluded that engaging in caring conversations, providing the opportunity to stop and reflect about how care is provided, and understanding differing perspectives are critical to developments in practice and education. The framework for compassionate care developed from this research provides a basis for continuing development in practice and measurement of compassionate caring.

1.1.5 The Public Health Role of the Midwife

The potential public health role in midwifery has been well documented and the Midwifery 2020 programme\textsuperscript{13}, which was published in 2010 by the Chief Nursing officers for England, Wales, Northern Ireland and Scotland sought to clarify this role. The report underpins the vision of how midwives can lead and deliver care in a changing health care environment, reflecting policy and service direction. It also identifies the changes required to the way that midwives work, their role, and their education and/or professional development to meet this vision. It notes that systematic measurement of the quality of midwifery care is vital to drive improvements, and that quality indicators should take account of safety, person-centredness, equity, timeliness, efficiency and satisfaction with care. Whilst many outcomes are already measured by existing datasets, it is more difficult to measure the care that women actually receive. The strongest indicators of a woman’s positive experience of midwifery care are related to interaction with staff and include communication, explanations and support, and being treated with respect, dignity and kindness.\textsuperscript{14}

On this basis, the report concludes that it is vital that interpersonal skills are given equal priority with academic qualifications in selecting student midwives and that midwifery education enhances the emotional intelligence of midwives, emphasising the development of skills and knowledge to sustain authentic, empathetic behaviours and compassionate caring.

A recent public health and midwifery scoping project, undertaken by Queens University Belfast on behalf of NHS Education for Scotland builds on the work of the Midwifery 2020 public health work stream. This project scoped the current provision of pre and post registration midwifery education in relation to public health and inequalities. The project report\textsuperscript{15} highlighted that whilst key public health issues were generally included in educational programmes, theory was not well translated into practice. A gap was also evident around perceptions relating to the confidence and ability of midwives to discuss public health issues with women effectively, indicating the need for further training in this area. However, the key issue emerging from the project was the lack of clarity and understanding about the meaning of public health and the recommended priority for future work was to develop a training tool with the aim of improving the visibility and ethos of public health amongst midwives.

1.1.6 Women’s perceptions of maternity care in Scotland

In January 2014, the results of the first Scottish Maternity Care survey\textsuperscript{16} for over 15 years were released. This national report presents findings for Scotland at each stage of women’s maternity care, which will provide a benchmark that will be used for local and national targeting of healthcare improvements and to inform future maternity policy directions. The survey highlighted many areas of good practice and examples where the aspirations/recommendations of maternity care policy are being achieved. However, a concerning finding was that during postnatal care in hospital one third of women felt that they were not always treated with kindness and understanding. Key to improving women’s experience of care is effective communication, listening and support; however postnatal care in hospital is often provided in a context of time and workload pressure and this may not enable staff to always provide women centred care. The report recommends that postnatal hospital care must be given a higher priority and staffing resource if women’s experience is to be improved.

1.2 The Compassionate Connections workforce development programme

Compassionate Connections is the overarching project title for work undertaken by NHS Education for Scotland (NES) and NHS Health Scotland to support the implementation of the Refreshed Framework for Maternity Care in Scotland and Improving Maternal and Infant Nutrition. The aims of the workforce development activities (undertaken by NES) of Compassionate Connections are to:

- Increase understanding of the impact of health and social circumstance on engagement with services and clinical outcomes
- Enable staff to maximise their contributions towards improving maternal, newborn and infant health and well-being.
- Build on existing staff knowledge and skills with new insights, experiences and understanding.

1.2.1 The Learning Needs analysis 2012

At the onset of the Compassionate Connections project a learning needs analysis was commissioned to identify the core competencies required to support the implementation of the Refreshed Framework for Maternity Care in Scotland.\textsuperscript{17} The work, which was completed in March 2012, also aimed to highlight specific approaches perceived to work well in the delivery of education and training, isolate the critical success factors associated with these approaches; and highlight any barriers and challenges associated with its workforce training and development recommendations.

The research concluded that whilst there was support for the principles of the Refreshed Framework among staff and stakeholders, there remained a lack of clarity for some around the drivers of change, the approaches promoted, and the roles of particular practitioners in embedding it in practice. The research identified a range of core competencies required to support implementation


of the Refreshed Framework, and mapped these core competencies with those developed through other relevant training programmes, including the Family Nurse Partnership (FNP) training programme and GIRFEC multi-agency training. They recommended that NES may wish to look to training and development activity related to the Continuous Learning Framework for Social Services and the FNP programme; both of which demonstrate a good fit with the core competencies required to implement the Refreshed Framework. In addition, the team identified a need to develop core competencies required to understand and implement the GIRFEC practice model.

The research team also identified a number of factors that contribute to effective training for the maternity care workforce, recommending that training activities and resources must be flexible, accessible, and meeting the following core components:

- Using a blended approach (i.e. interactive group based learning, supplemented with online resources, opportunities to continue/take forward learning (e.g. resource pack to take away and share with colleagues), a range of tools (e.g. DVD resources, scenarios, tutor led discussion, group work and reflection)
- Multi-disciplinary training (i.e. include profession specific elements so that the training feels relevant, develop shared understanding of the roles and remit of different groups in the workforce)
- A staged approach (i.e. provision of background information)
- Self-assessment of learning needs (i.e. benchmarking of knowledge, skills, values and attributes, training sessions, reflection – mentoring, coaching and reflective logs, follow up)
- Quality (i.e. high quality resources, skilled facilitators, relevance to practice)

1.2.2 The Compassionate Connections workforce development programme

In response to the findings of this study, NES has developed educational resources, designed to complement relevant existing resources, to support the implementation of a workforce development programme aiming to:

- Increase understanding of the impact of health and social circumstance on engagement with services and clinical outcomes
- Enable staff to make the most of their individual and collective contributions towards improving maternal, newborn and infant health and well-being.
- build on the existing knowledge and skills staff currently have and connect them with new insights, experiences and understanding

The resources comprised:

- Two Story Worlds which use a mixture of audio and visual slides to enable learners to explore the delivery of compassionate person centred maternity care through fictionalised drama (in collaboration with Forum Interactive Ltd.).
- A virtual learning environment (VLE) which supports learners to understand person-centred approaches to maternity care, with a particular focus on smoking cessation (in collaboration with Digital Design Studio).
These resources were developed through extensive stakeholder engagement and consultation. A steering group of key stakeholders was convened (chaired by the Senior Medical Officer, Women and Children's Health Scottish Government) in December 2011: this group oversaw the work of several project sub groups which addressed specific aspects. In total 52 senior stakeholders were engaged in the development of the resources up to their piloting from September 2014, see table 1.

**Table 1: Organisations engaged in development of Compassionate Connections**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of individuals engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Government Health Directorate</td>
<td>7</td>
</tr>
<tr>
<td>NES</td>
<td>10</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>8</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>3</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>3</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>3</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>2</td>
</tr>
<tr>
<td>NHS GG&amp;C</td>
<td>2</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>1</td>
</tr>
<tr>
<td>NHS healthcare Improvement Scotland</td>
<td>1</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>1</td>
</tr>
<tr>
<td>Royal College of Midwives</td>
<td>1</td>
</tr>
<tr>
<td>Scotland’s Colleges</td>
<td>1</td>
</tr>
<tr>
<td>Scottish Social Services Council</td>
<td>1</td>
</tr>
<tr>
<td>Edinburgh Napier University</td>
<td>2</td>
</tr>
<tr>
<td>Dundee University</td>
<td>1</td>
</tr>
<tr>
<td>UWS</td>
<td>1</td>
</tr>
<tr>
<td>RGU</td>
<td>1</td>
</tr>
<tr>
<td>Local Supervising Authority Midwifery Officers</td>
<td>1</td>
</tr>
<tr>
<td>Other, incl 3rd sector</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total individuals</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

*Source: SMCIA PCA analysis of programme documentation*

A pilot of the Compassionate Connections workforce development programme began in September 2013. It engaged six NHS boards across Scotland which had identified themselves as early implementer sites and the three higher education institutions (HEIs) in Scotland which provide pre-registration midwifery programmes:

- University of the West of Scotland
- Edinburgh Napier University
- Robert Gordon University
- NHS Fife
- NHS Greater Glasgow & Clyde
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Tayside
Support for implementation was provided by four (3 FTE\textsuperscript{18}) regional Practice Education (PE) posts employed by NES on a fixed term basis from August 2013 to March 2014.

\textsuperscript{18} 2 x 1WTE plus 1 x 0.8WTE and 1 x 0.2WTE
2 The evaluation approach

The evaluation of the Compassionate Connections workforce development pilot programme was designed to assess:

- The extent to which the educational outputs of the Compassionate Connections Project is meeting the project aims and learning outcomes, i.e. to:
  - Demonstrate knowledge of the impact of health and social circumstances on engagement with services and on clinical outcomes.
  - Work collaboratively with women, their families, colleagues and other health and social care agencies.
  - Identify opportunities to support health behaviour change and use strengths based approaches in the delivery of inequalities sensitive maternity care.
  - Understand the importance of flexible person centred risk-management to improving health and clinical outcomes.
  - Understand the principles of compassionate person centred care and how these relate to your own role within maternity care services.
  - Critically reflect on the issues raised in the Compassionate Connections resource and how these impact on your own contribution to improving maternal, newborn and infant health and well-being.
- The perceptions and experiences of key stakeholders across Scotland, of the project in terms of its relevance to and impact on the current policy landscape.
- The role of the Practice Educator in building capacity and capability for ongoing dissemination of the resources.

In particular, the evaluation was designed to address the following objectives and indicative research questions:

1. To evaluate the educational resources:
   a. What is the reaction to the learning materials?
   b. To what extent have the materials enabled the learners to achieve the learning outcomes?
   c. To what extent do participants feel able to apply the outcomes to practice?

2. To assess educational methods and media:
   a. What are the strengths and weaknesses of the educational methods and media chosen for delivery of the project aims?

3. To investigate user and stakeholder perceptions:
   a. What are the experiences of those using the educational resources, including measurement of engagement and impact on knowledge, skills, attitudes and capabilities?
   b. What are the perceptions and experiences of key strategic stakeholders of the project, its outputs and their wider implications, including members of the Scottish Government responsible for funding the project, senior managers and leaders of maternity services across the early implementer sites?

4. To explore the potential transferability of learning resources:
   a. What is the potential to transfer the resources to a wider range of learning and development priorities and work streams, for example child protection training, substance

19 Invitation to submit a competitive written quotation: Reference: C001068: July 2013
misuse or gender based violence domestic abuse, the Getting it Right for Every Child Approach and the work of the Early Years and Maternity Care collaborative?

5. To assess the development and management of the project:
   a. What were the successes and challenges experienced by the national project team and local health board teams in development and dissemination of the educational resources including analysis of organisational barriers and enablers?

6. To assess the Practice Educator role in the project:
   a. What are the strengths of the Practice Educator role in building capacity and capability to use the resources and areas for improvement?

7. To make recommendations for future development based on the evaluation:
   a. What recommendations can be drawn from the evaluation for future educational, practice development and research activities that will support the ongoing impact of this project?
   b. To evaluate the match of the learning resources to the learning needs analysis which informed it?
   c. To what extent did the learning resources project meet the recommendations of the learning needs analysis?

2.1 The evaluation methods

The evaluation was designed to run in parallel with the implementation of the pilot workforce development programme. A mixed methods approach was used in order to gather qualitative and quantitative data regarding the implementation process, perceived effectiveness and immediate impact of the resources on users and other stakeholders. This was an iterative process, involving:

1. Quantitative analysis of the perceptions and experiences of participants in the Story Worlds and VLE learning sessions, using web-based questionnaires (Qs) (see appendix A) agreed with the NES implementation team:
   a. Compassionate Connections introductory/facilitators/train-the-trainers’ session.
   b. Story Worlds learning session (SW1)
      i. Pre-session questionnaire
      ii. Post-session questionnaire
      iii. Story Worlds follow-up/reflection session (SW2)
   c. VLE post-session.
      i. Pre-session questionnaire ii. Post-session questionnaire

2. The development of case studies (see appendix B for template). Case studies were selected from session participants who had:
   a. Attended a SW 1 and 2 session and completed at least the post Q for SW 1
   b. Attended a SW introductory/train-the-trainers session and one other session (SW 1 or 2 or VLE) AND completed at least the post-Q for the introductory session
   c. Attended a VLE session and completed a VLE pre- and post- Q
3. A web-based questionnaire survey of wider stakeholders and participants at awareness sessions to explore their perceptions of the Compassionate Connections resources (see appendix A for questionnaire).

4. Interviews with 18 key stakeholders (identified in collaboration with the NES implementation team and in the light of stakeholder analysis). The interview topic guide (appendix C) was agreed with the NES implementation team. See appendix D for details of interviewees.

5. Interviews with the Practice Educators 20.

6. Analysis of session and other documentary information (see appendix E for details of session information analysed).

The National Workshop on 25th February 2014 provided a valuable forum for running facilitated focus group discussion groups to inform the evaluation (see appendix F for groupwork guidance, event programme and participant list).

Additionally a rapid, focused review of the recent literature (since 2004) discussing narrative pedagogy was reviewed, and key papers reporting areas such as the educational impact of narrative as a learning tool, and where possible established links with compassionate care education and reflection of the learning, were identified.

See table 2 for summary of how the evaluation methods related to the specified objectives.

Ethical approval was granted by the three HEIs involved in the programme, to allow students to engage in the SW and VLE sessions and related evaluation activities. Informed consent was obtained for all student participants, with consent forms being held by the HEI.

Table 2: Approach and Methodology for the Evaluation of Compassionate Connections project

<table>
<thead>
<tr>
<th>Objective</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) To evaluate the educational resources:</td>
<td>• A suite of pre-, post- and follow-up questionnaires were designed for sessions. These were designed to enable participants to identify expectations, current perspectives on practice etc. in advance of the training session; to identify early thoughts on learning materials, e.g. likelihood to change practice as a result of session, potential impact on practice; and follow up electronic questionnaire (all participants) at ideally 6-8 weeks post training to identify impact on practice etc.</td>
</tr>
<tr>
<td>• What is the reaction to the learning materials?</td>
<td>• Follow up telephone interviews with a sample of participants to explore impact of educational resources, longer term perspectives once implemented, perceived effectiveness etc. (case studies)</td>
</tr>
<tr>
<td>• To what extent have the materials enabled the learners to achieve the learning outcomes?</td>
<td></td>
</tr>
<tr>
<td>• To what extent do participants feel able to apply the outcomes to practice?</td>
<td></td>
</tr>
</tbody>
</table>

20 Detailed findings in relation to this aspect of the evaluation have been provided to NES as a separate confidential appendix. This is because the PE team is very small, and easily identifiable. It is not appropriate to provide such personalised data in an evaluation report such as this.
(ii) To assess educational methods and media:
• What are the strengths and weaknesses of the educational methods and media chosen for delivery of the project aims?
• Rapid review of the evidence around narrative pedagogy.
• Sections within post session questionnaires and telephone interviews around access to resources, ease of use, validity / reality of scenarios, stories etc, strengths, weaknesses etc
• Explore wider problems such as ability to keep scenarios current, coverage of learning outcomes, technical support (including interviews with PEs).

(iii) To investigate user and stakeholder perceptions:
• Experiences of users, engagement and impact on knowledge, skills, attitudes and capabilities
• Perceptions and experiences of key strategic stakeholders
• Questions included in the pre- and post-questionnaires, telephone interviews etc.
• Case studies also focus on these issues
• Interviews with key strategic stakeholders

(iv) To explore the potential transferability of resources:
• Rapid review of evidence regarding narrative pedagogy
• Questionnaire survey of wider stakeholders including those who attended awareness-raising sessions.

(v) To assess the development and management of the project
• Successes and challenges experienced by national project team, NHS Boards, including organisational barriers and enablers
• Interviews with strategic stakeholders
• Interviews and discussions with project team members especially Practice Educators.

(vi) To assess Practice Educator role in the project
• Interviews with strategic stakeholders
• Interviews and discussions with project team members especially Practice Educators.

(vii) to make recommendations for future development based on the evaluation
• Desk research: Full analysis

(viii) to evaluate the concordance between the learning resources and the needs analysis which informed it
• Desk research: mapping across the needs analysis and comparing the evaluation results in terms of which issues had been (or had not been) successful
• Further mapping against recommendations (vii) to identify where gaps can be addressed.

Quotations from interviews and the questionnaire response are included indicatively to provide examples of stakeholders’ perspectives. Quotations are indicated in italics.

2.2 Data/method limitations

2.2.1 Session participation

Analysis of session participation made use of data provided to the evaluation team by the PEs. No data confirming actual attendance were available, and the evaluation team know anecdotally through some responses to the invitation to complete a session questionnaire which stated ‘I did not
attend’. Consequently the data provide information about intent to attend a session and/or PE anticipation of session participants.

2.2.2 Web-Based Questionnaires

In order to maximise response rates, web-based questionnaires were tightly focused to ensure that participants’ time spent completing them was kept to a minimum, around 5-10 minutes. Fluidsurveys™ software (Ottawa, Canada) was used to implement the surveys and analyse the data. A number of limitations were encountered during the implementation of the questionnaires, mostly as a consequence of logistical difficulties associated with widespread implementation across a large number of stakeholders. Whilst these were mostly unavoidable, these issues will undoubtedly have had an impact on response rates achieved.

One limitation was the ad hoc nature of the arranged sessions, due to the limited time available for the PE’s to organise the events and late changes to schedules beyond their control. As the timing for invitations (with the link to the questionnaire) to be emailed to participants registered for the sessions needed to be precise (e.g. in order to establish responses to the pre-session questionnaire in advance of the other session), any changes to participants either registered for the event, or those actually attending could not be addressed retrospectively. In many cases, the list of participants registered for the sessions (provided to us via the PE’s) were not the same as the actual list of individuals attending the session (due to sickness absence, competing priorities and opportunistic attendees for example). As such, the response rate, particularly of the pre-session questionnaires, was negatively affected.

Other challenges were associated with the use of email to invite participants to complete the web questionnaire. A number of email addresses were ‘undeliverable’, and it became apparent that not all staff members regularly access their work email account, therefore did not become aware of the evaluation questionnaires until it was too late.

A further limitation was the need for invitations to be sent to student participants at one of the HEI’s through a third party (a requirement of HEI ethical approval). As such, these individuals could not be sent personal reminders to complete the questionnaires.

Although some ‘incomplete’ responses were received, these were a minority. Where this occurred, any data available was used for analysis, and acknowledged within percentage calculations. The aim of using pre-, post- and follow-up questionnaires was to attempt to evaluate any changes in stakeholders’ perceptions of the Compassionate Connections resources as a result of attending the sessions. However, as very few participants completed all three sequential questionnaires, this analysis was unfortunately not possible.
3 Literature Review

3.1 Introduction

Due to the vast body of literature around the broader concepts of compassion, professionalism, e-learning, reflection etc., the project team at NES requested a focused, rapid evidence review of the literature. The recent literature (since 2004) discussing narrative pedagogy was reviewed, and key papers reporting areas such as the educational impact of narrative as a learning tool, and where possible established links with compassionate care education and reflection of the learning, were identified. Following review of these papers, additional references were also retrieved where relevant.

3.2 Storytelling and the Use of Narrative

The use of stories to communicate, learn and establish meaning is accepted as one of the foundations of human development. For generations, stories – whether historical accounts, acted performance, folklore or legend – have been used by people across cultures and contexts to enrich the human experience (Hunter and Hunter, 2006; Haigh & Hardy, 2011).

Within the context of healthcare, the benefits of storytelling are wide ranging and a number of salutary effects have been reported. Patients suffering from serious or life threatening illnesses have been supported through the use of stories, developing coping strategies and helping them (and their families) come to terms with or find meaning in their experience (Hunter & Hunter, 2006; Heiney, 1995). In a study by Chelf, 97% cancer patients reported the use of storytelling as a helpful way to deal with cancer, and 85% agreed that hearing others’ stories gave them hope (Chelf, 2000). Similar benefits of empowerment have been experienced by breast cancer patients through stories expressed online (Hoybye, 2005) and by a range of patients participating in the UK Patient Voices Programme, following creation of their personal stories using digital media (Haigh & Hardy, 2011). Storytelling has also proven useful within the area of health promotion, particularly when reaching across culturally diverse and / or isolated groups (Hunter & Hunter, 2006; Haigh & Hardy, 2011). African women reported enhanced learning and validated personal experiences as a result of listening to others’ experiences, and the use of traditional Native American stories for health promotion in this cultural setting was effective (Hunter & Hunter, 2011).

Within the context of education, storytelling has also been reported as being effective in developing and supporting children in a culturally diverse school in New Zealand (Baskerville, 2011), ‘fostering empathy, compassion, tolerance and respect for difference’. Further, storytelling is becoming increasingly used in the classroom in association with modern learning technologies, with students being involved in the generation of digital stories from concept to recording (Yang & Wu, 2012). Storytelling is being increasingly recognised as a mechanism to enhance learning in the context of Health Professions Education, particularly around sensitive topic areas. In many instances, the learners (e.g. nursing / midwifery students or newly qualified nurses) are involved in the identification, development and telling of their own personal stories, enabling them to learn within a safe environment, and share experiences and reflect upon initial work experiences and the ‘reality
shock’ that this can present (Stacey & Hardy, 2011; Haigh & Hardy, 2011). Narrative pedagogy has also been implemented within nurse education using stories developed by faculty to highlight specific areas, or by patients themselves, to help prepare students for the professional and emotional demands of ‘real’ nursing practice, facilitating the development of coping strategies in advance (Walsh, 2011). Hunter and Hunter (2006) describe the successful use of purposive storytelling as a creative teaching strategy for midwifery students in the USA.

Within the literature, the terms ‘storytelling’ and ‘narrative’ tend to be used interchangeably. However, Haigh and Hardy (2011) make a distinction between the two, stating that ‘although some authors use the word ‘narrative’ as a synonym for ‘story’, narrative can be defined as predominantly factual, whereas stories are reflective, creative and value laden, usually revealing something about the human condition’.

3.3 Pedagogy

The use of storytelling within learning and teaching is supported by social learning theories and the principles of social constructivism (Rositer, 2002; Jarvis, 2005; Yang & Wu, 2012). Learning and the synthesis of knowledge networks (schema) is supported by student activities such as participating in group discussion, where ideas can be tested and generalisation can take place. Learning activities within an authentic environment or context is important for both development and knowledge transfer. In terms of health professions education, narrative pedagogy and storytelling have been suggested as being a powerful way to complement the focus on competency-based education and evidence-based practice, and particularly relevant in the development of critical thinking and reflection on practice (Hunter & Hunter, 2006; Haigh & Hardy, 2011). However, although this is a convincing argument, research evidence to support this approach is limited (Brown et al, 2008; Walsh, 2011).

The connections between narrative pedagogy and critical thinking have been reported by a number of authors (Hunter & Hunter, 2006; Walsh, 2011; Yang & Wu, 2012). Using the key aspects of critical thinking described by Rubenfield and Scheffer (2005), i.e. ‘Analysing’, ‘Applying standards’, ‘Discriminating’, ‘Information seeking’, ‘Logical Reasoning’, ‘Predicting’ and ‘Transforming knowledge’, Walsh (2011) discusses the associated links with processes involved in narrative pedagogy, for example the interpretation of a story and deriving information from the story constitutes the ‘analysis’ aspect of critical thinking, and so forth. The author concludes that ‘narrative pedagogy therefore offers a way of expanding conventional pedagogical approaches of content and competency to accommodate the complexity of context and the patient as a human being’.

A number of benefits to professional development have been described with regard to the use of storytelling in education. The promotion of reflection by learners has been described in studies relating to nurse education (Hardy, 2007; Haigh & Hardy, 2011), midwife education (Hunter & Hunter, 2006), and within an initiative to ease the transition of newly qualified nurses into practice (Stacey & Hardy, 2011). Storytelling has also been suggested as a mechanism to enhance the empathy and compassion of health professionals, the basis of which underpins the Compassionate Connections resources. The development of empathy through the use of storytelling has been
reported with care professionals (Fairbairn, 2002), and midwifery students reported having ‘learned to feel more compassion and empathy for others’ (Hunter & Hunter, 2006). The power of stories in being able to stimulate an empathic response has been explained by the ‘learner involvement factor’, i.e. the ability of individuals to be able to engage with a story capturing the full experience, and as such the response is more than that which would arise as a result of facts alone (Rossiter, 2002). It has also been suggested that the use of stories may promote the delivery of compassionate, person-centred care indirectly, through the support of the transition of nurses into practice (Stacey & Hardy, 2011).

3.4 Impact

There is little or no research evidence demonstrating the impact of narrative pedagogy on professional development (Brown et al, 2008) or the quality of patient care (Walsh, 2011). However, this is most likely as a result of the difficulties in establishing causality within educational research where the control of other variables is a challenge. A direct impact on the achievement, critical thinking and learning motivation of senior high school students learning English as a foreign language in Taiwan was demonstrated in a one year longitudinal study by Yang and Wu (2012), which involved a pre and post-test quasi-experimental design.

A number of studies however have obtained process evaluation data, and report the impact of storytelling / narrative pedagogy on individual learners and teachers. The majority of studies reported positive experiences of teachers and learners (McAllister et al, 2009; Walsh, 2011). Students described the type of ‘thinking’ they did during narrative pedagogy as being different to that done in more traditional approaches to education, i.e. with ‘thinking’ involving more interpretation rather than simply being a means to an end in itself (Ironside, 2006; Walsh, 2011). Storytelling by students themselves has been reported as facilitating ‘meaningful connections among classmates’, and upon evaluation of the educational programme students commented that they were reassured and comforted to know that fellow students were having similar clinical and emotional experiences. Faculty evaluations of the same programme involving storytelling, described a feeling that they had achieved a better rapport with the students (Hunter & Hunter, 2006).

3.5 Implementation

Different sources for the stories are evident, with many studies published in the literature describing stories being derived from the students / professionals themselves. This approach to education was particularly effective for digital storytelling, where the activity of identifying, developing and recording digital stories had a significant impact on the learning, critical thinking and motivation of students (Yang & Wu, 2012). Alternatively, the potential for patient narratives to provide a richer source for education has been discussed, and a number of initiatives in the UK have been established to involve patients in the education of health professionals (Haigh & Hardy, 2011). Narrative pedagogy has been implemented using a range of media, including personal, written, digital and virtual (Walsh, 2011; Haigh & Hardy, 2011). The advantages of digital approaches to storytelling have been described, and it has even been suggested that when considering sensitive topics the distance (in terms of space and time) viewing stories on video / online is helpful, giving the
learner a sense of safety and freedom to explore the issues without the need to interact with a patient directly (Hardy, 2007; Haigh & Hardy, 2011). Walsh (2011) describes the use of multimedia resources for narrative pedagogy, with real actors and settings, as having a number of advantages, including increased reality, authenticity and fidelity. In contrast, the use of virtual simulation has been criticised as being ‘too unrealistic, and fail to capture the true complexities of how communities function’. Avatars have been described as being ‘no substitute for human actors’, as a result of the communication between humans being subtle and non-verbal in nature, such as facial expression (Walsh, 2011).

3.6 Summary

Recognising the limitations of the scope of this rapid review, a number of key messages can be drawn from the literature analysed:

The strengths and weaknesses of narrative pedagogy
A number of advantages of using narrative / stories have been reported in the literature. In terms of health professions education, this approach has been linked to the processes involved in critical thinking – a skill established as important for competent clinical practice. Narrative has also been reported as being useful to foster reflection within practitioners, particularly around challenging, complex or sensitive areas of practice, providing a ‘safe environment’ to consider these issues.

Various media have been used to implement health professions education using narrative / stories, and it is likely that the optimal method is dependent on the context for which it is being used. The use of digital approaches and multimedia have been reported as advantageous in terms of enhancing authenticity and fidelity. However, it has been suggested that VLE and / or avatars lack authenticity in some instances.

Transferability of this approach (use of narrative) across contexts
The use of narrative and stories has been successful across a range of contexts. In terms of the aims of using this approach, positive results have been observed when narrative has been used for health / patient care (particularly the emotional support of patients), in health promotion (particularly reaching across diverse groups), within education (of children in schools) and health profession education (pre-registration and postgraduate / continuing professional development).

Within health professions education, the use of narrative is often focused towards developing individuals’ knowledge or competence with regard to ‘sensitive’ areas of practice, including compassionate care, emotionally challenging practice, and developing empathy. Stories have been used in the education and development of different health professions, including nurses, midwives and care professionals.
3.7 References


4 Engagement with the Compassionate Connections pilot programme

4.1 Introduction

Implementation of the Compassionate Connections pilot workforce development programme began with a national event on 3rd September. The evaluation team supported the implementation team by providing workshop materials for use in the event to develop implementation plans (see appendix G for groupwork guidance). Following this event, the PEs worked closely with the early implementer NHS Boards and the three HEIs to negotiate and facilitate implementation plans with each. These plans centred on the delivery of events (meetings, workshops, lectures – collectively referred to as ‘sessions’) designed to introduce and pilot the programme:

- **Awareness-raising sessions**, designed to introduce the programme resources to a very wide range of strategic and operational stakeholders. These sessions often opportunistically ‘piggy-backed’ onto existing and/or scheduled meetings and events to make the best use of time.
- **Introductory sessions**, designed to introduce the programme to staff who had the potential to run Story Worlds learning sessions with their own clinical teams or colleagues (‘introductory’ ‘facilitators’ or ‘train-the-trainers’ sessions).
- **Story Worlds learning sessions**, designed to use the Compassionate Connections resources within a learning context with relevant staff or students (SW1). These sessions were followed up with a Story Worlds reflection session (SW2), to engage learners in reflecting on how they had made use of their learning in practice, since attending the Story Worlds session.
- **Virtual Learning Environment (VLE) learning sessions**, designed for individuals or groups to access and learn through the VLE. This focused on smoking cessation.

The implementation team aimed to provide – by March 2014:

- Nine Introductory sessions
- Nine Story Worlds 1 sessions
- Nine Story Worlds 2 sessions
- Two one-to-one VLE sessions in each (early implementer) NHS Board are (12 sessions in total)
- One group VLE session in each HEI (3 sessions in total)

The implementation team also aimed to opportunistically raise awareness of the Compassionate Connections resources.

The first session was on 25th September 2013, with sessions running until March 2014: the evaluation covered the most intense period of implementation, including analysis of sessions up to 5th February 2014.
4.2 Session participation

Between 25th September 2013 and 5th February 2014 107 sessions were provided, reaching 1215 people. The majority of individuals (67%) were reached through awareness-raising sessions, with the fewest through VLE sessions, see table 3. See appendix E for details of targeted groups.

Table 3: Session participation: by type and participant numbers

<table>
<thead>
<tr>
<th>Session type</th>
<th>Total sessions</th>
<th>total participants</th>
<th>average participation no’s in each session</th>
<th>% all sessions</th>
<th>% all participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>59</td>
<td>810</td>
<td>14</td>
<td>56%</td>
<td>67%</td>
</tr>
<tr>
<td>SW Intro</td>
<td>14</td>
<td>138</td>
<td>10</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>SW 1</td>
<td>13</td>
<td>129</td>
<td>10</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>SW2</td>
<td>6</td>
<td>46</td>
<td>7</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>VLE</td>
<td>15</td>
<td>92</td>
<td>6</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Totals</td>
<td>107</td>
<td>1215</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SMCIA analysis of participation data.
Percentages total more than 100% because of rounding

The majority of participants were midwives (40%), with significant participation by students (17%) and educators (13%), see figure 1. Most ‘educators’ were practice based (68%), with 73% (104) attending awareness session, with a quarter (26%) engaging in introductory/train-the-trainers sessions (see table 4). Here it is important to note that many practitioners who describe themselves as ‘midwives’ may, in fact, have a significant educational and/or managerial aspect to their role.

‘Maternity related’ participants included health visitors, obstetricians, staff working within paediatrics, neonatal care staff, antenatal care staff, and breast feeding practitioners. ‘Other’ participants included smoking cessation practitioners (10), health care support workers (5), staff working with the management of aggression workers (4), infection control practitioners (4), gender based violence advisors (4), child protection advisors (3), and addiction workers (2).

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21 Analysis of session participation was from information provided to the evaluation team by the PEs.
Strategic managers, maternity related medical consultants and health improvement staff represented the majority of participants in awareness-raising sessions (see table 5). This indicates successful targeting of awareness sessions to strategic and senior staff. Educators and maternity related staff represented the majority of participants in introductory/train-the-trainer sessions; this indicates that there was effective targeting of introductory/train-the-trainer sessions to educators.

Midwives, maternity related staff and public health staff represented the majority of participants in SW1 sessions. The majority of participants in SW2 sessions were students, suggesting perhaps that students find it easier than staff (or may have different motivations) to attend SW2 (reflection/follow-up) sessions.

The VLE sessions took the form of individuals working through the resource alone or classroom based teaching session. Three of the VLE sessions involved a large number of student midwives in a classroom setting. This meant that, although the majority of VLE sessions were individual sessions, with one or two participants selected as being ‘experts’ in the field of smoking, the vast majority of participants in VLE sessions were students. See table 5.
### Table 5: Session participation by job type

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Total</th>
<th>Awareness</th>
<th>Intro</th>
<th>SW1</th>
<th>SW2</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Midwife</td>
<td>419</td>
<td>40%</td>
<td>302</td>
<td>45%</td>
<td>50</td>
<td>38%</td>
</tr>
<tr>
<td>Student</td>
<td>181</td>
<td>17%</td>
<td>32</td>
<td>5%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>146</td>
<td>14%</td>
<td>111</td>
<td>16%</td>
<td>27</td>
<td>21%</td>
</tr>
<tr>
<td>Educator</td>
<td>142</td>
<td>13%</td>
<td>104</td>
<td>15%</td>
<td>37</td>
<td>28%</td>
</tr>
<tr>
<td>Maternity related</td>
<td>53</td>
<td>5%</td>
<td>30</td>
<td>4%</td>
<td>11</td>
<td>8%</td>
</tr>
<tr>
<td>Public health</td>
<td>29</td>
<td>3%</td>
<td>16</td>
<td>2%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Consultant medic (maternity related)</td>
<td>28</td>
<td>3%</td>
<td>24</td>
<td>4%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Health improvement</td>
<td>25</td>
<td>2%</td>
<td>23</td>
<td>3%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Administrator</td>
<td>19</td>
<td>2%</td>
<td>19</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Strategic Manager</td>
<td>14</td>
<td>1%</td>
<td>14</td>
<td>2%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>1056</td>
<td></td>
<td>675</td>
<td></td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of participation data

No job title data were available for 12% (146) total participants.

NB total numbers differ from those in Table 3: Session participation: by type and participant numbers because some participants attended more than one session – see section 5.

### 4.3 Summary

The NES Compassionate Connections implementation team far exceeded their aims in delivering the pilot programme, in particular in relation to the delivery of Story Worlds introductory sessions and Story Worlds 1 learning sessions, see table 6. There were challenges in attracting participation in SW2 (reflection) sessions – see later sections for exploration of this.

### Table 6: Story Worlds sessions: aim and actual numbers

<table>
<thead>
<tr>
<th>Session Type</th>
<th>Aim</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Worlds introductory sessions</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Story Worlds 1 sessions</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Story Worlds 2 sessions</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of participation data

The implementation team went to significant efforts to engage as many stakeholders as possible. This resulted in success reaching strategic and senior staff in awareness-raising sessions; and in engaging relevant staff (i.e. those with an education remit) in introductory / train-the-trainers sessions.

Midwifery and maternity-related staff were well represented in Story Worlds learning sessions, with pre-registration students being best able to attend reflections sessions.

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22 None of the individuals who did SW2 and provided job title had done SW1
23 Here it is important to note that many practitioners who describe themselves as ‘midwives’ may, in fact, have a significant educational and/or managerial aspect to their role.
24 All of these individuals were involved in smoking cessation
5 The Compassionate Connections sessions

5.1 Introduction

This chapter provides evaluation findings in relation to:

- Analysis of session learning outcomes for both the Story Worlds and the VLE resources.
- The perceived impacts of the Compassionate Connections sessions: including learning sessions, introductory sessions and awareness raising sessions.
- Detailed case studies of individual participants in relation to both the nature of the resource and perceived impacts on practice.

5.2 Session learning outcomes

5.2.1 Story Worlds

The defined learning outcomes of the Story Worlds (SW) resource are:

“On completion of this resource and appropriate additional practice-based development you will:

1. Demonstrate knowledge of the impact of health and social circumstances on engagement with services and on clinical outcomes.
2. Work collaboratively with women, their families, colleagues and other health and social care agencies.
3. Identify opportunities to support health behaviour change and use strengths based approaches in the delivery of inequalities sensitive maternity care.
4. Understand the importance of flexible person centred risk-management to improving health and clinical outcomes.
5. Understand the principles of compassionate person centred care and how these relate to your own role within maternity care services.
6. Critically reflect on the issues raised in the Compassionate Connections resource and how these impact on your own contribution to improving maternal, newborn and infant health and well-being.”

Most sessions provided outwith HEIs were facilitated by the Compassionate Connection Practice Educators. Specific learning outcomes for sessions were developed by the PEs as appropriate to their target participants. An example of learning objectives developed for the introductory sessions was:

- To inform you of the background, aims & objectives of this resource.
- To let you experience how it works
- To help you identify its strengths and potential value as a learning tool
- To encourage you to use it in your own work
- To encourage you to spread the word to other colleagues.

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Compassionate Connections: Story Worlds learning resource
PEs adopted various SW learning outcomes for the learning sessions, with collaborative working being made most use of, and support health behaviour change and using strengths based approaches in the delivery of inequalities sensitive maternity care least frequently used.

Table 7: Story Worlds learning outcomes adopted for sessions

<table>
<thead>
<tr>
<th>Sessions for which learning outcomes were available</th>
<th>SW1</th>
<th>SW2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate knowledge of the impact of health and social circumstances on engagement with services and on clinical outcomes.</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Work collaboratively with women, their families, colleagues and other health and social care agencies.</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Identify opportunities to support health behaviour change and use strengths based approaches in the delivery of inequalities sensitive maternity care.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Understand the importance of flexible person centred risk-management to improving health and clinical outcomes.</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Understand the principles of compassionate person centred care and how these relate to your own role within maternity care services.</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Critically reflect on the issues raised in the Compassionate Connections resource and how these impact on your own contribution to improving maternal, newborn and infant health and well-being.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other outcomes</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of session data

5.2.2 The VLE

Most of the VLE sessions were not facilitated, with participants working through the resource alone. This, together with the very specific nature of the VLE resource meant that the learning outcomes set matched those of the resource:
- Develop motivational communication skills that guide women to self-reflection and empower positive behaviour change.
- Identify the protective factors that support health and wellbeing with a focus on the collective resources available that promote self-esteem and coping/decision-making abilities of women.
- Explore the concept of person-centeredness in relation to working practices and attitudes.
- Use an asset-based approach to improve health outcomes.
- Demonstrate detailed knowledge and understanding of smoking cessation in pregnancy

5.3 Session impacts

5.3.1 Introduction

Questionnaires were designed and implemented to attempt to address both the process and outcomes / impact of the sessions. Whilst acknowledging the challenge of questionnaire implementation and achieving good response rates (see data/method limitations – section 2.2), an inclusive approach was taken and attempts made to measure differences in perceptions at different time points during the pilot. Although the same cohorts of individuals responding to different
questionnaires could not be guaranteed, it was hoped that sufficient commitment from respondents would allow patterns in the data to emerge.

Evaluation questionnaires were designed for each of the different approaches to implementation as follows:

- **Compassionate Connections Session**
  - Awareness raising sessions: Stakeholder evaluation questionnaire
  - Introductory Sessions: Introductory session questionnaire
  - Story Worlds learning sessions: Pre-evaluation questionnaire (prior to SW session 1), Post-evaluation questionnaire (after SW session 1), Follow-up evaluation questionnaire (SW session 2)
  - VLE Resource: Pre-evaluation questionnaire (prior to seeing the resource), Post-evaluation questionnaire (after using the resource)

Each of the questionnaires contained a demographics section (where more than one questionnaire was implemented for a session, only the pre-session questionnaire included demographics questions), and a section asking respondents to rate their agreement with a range of statements regarding the resources, and/or rate their own ability in the competencies that the resources were targeting.

The questionnaires were developed and approved by the NES Compassionate Connections team prior to implementation. Each of the questionnaires was implemented electronically (Fluidsurveys™ software), with invitations being sent via email. Where possible, a reminder was sent via email to those who had not responded within approximately 1 week.

The questionnaires are included in PDF format in Appendix A.

### 5.3.2 Response rates

Whilst we are unable to calculate accurate response rates due to some invitations being sent out to participants by a third party (at some Higher Education Institutions), we have calculated approximate response rates for each questionnaire based on the invitations sent to participants that we have a record of. Where invitations were also sent out by a third party these figures may indicate response rates slightly higher than the actual rate. Further, in some instances the participants’ contact details provided (and hence invitations sent) were not representative of the actual participants at the event. As such, the response rates should be considered as an approximate indication of engagement. The response rates are indicated in Table 8.

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26 See section 2 for method limitations
27 Due to HEI ethics committee requirements
Table 8: Session questionnaire response rates

<table>
<thead>
<tr>
<th>Questionnaire*</th>
<th>Invitations sent</th>
<th>Responses received</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness raising sessions</td>
<td>714</td>
<td>99</td>
<td>13.9%</td>
</tr>
<tr>
<td>Introductory Session</td>
<td>124</td>
<td>86</td>
<td>69.4%</td>
</tr>
<tr>
<td>Story Worlds Pre-Session</td>
<td>80</td>
<td>49</td>
<td>61.3%</td>
</tr>
<tr>
<td>Story Worlds Post-Session</td>
<td>152</td>
<td>51</td>
<td>33.6%</td>
</tr>
<tr>
<td>Story Worlds Follow-up</td>
<td>91</td>
<td>24</td>
<td>26.4%</td>
</tr>
<tr>
<td>VLE Pre-Session</td>
<td>70</td>
<td>36</td>
<td>51.4%</td>
</tr>
<tr>
<td>VLE Post-Session</td>
<td>70</td>
<td>27</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

* Source: SMCIA PCA analysis of evaluation data

There are a number of reasons why the number of responses to pre-, post- and follow-up questionnaires for the Story Worlds sessions were so variable, including:

- Participant lists were not always available prior to the event taking place.
- Participant contact information was not always accurate, with a number of email addresses undeliverable (see section 2.2).
- Where updated participant information was provided after the session had taken place, this was frequently different to that provided in advance of the session (where individuals were unable to attend etc.).
- Some Story Worlds follow-up (reflection) sessions were held outwith the evaluation period and therefore not included in the evaluation.

5.3.3 Awareness raising sessions

The stakeholder questionnaire was implemented with participants from the awareness raising sessions in order to evaluate their opinions regarding the potential relevance, impact and implementation of the Compassionate Connections resources. This questionnaire was anonymous; participants were not required to provide their name.

5.3.3.1 Response

A total of 99 responses were received, from a range of individuals representing each of the early implementer sites for the study.

The majority of respondents were Midwives (n=63), with further responses from individuals in Nursing (11), education and training (10), and Public Health (8) roles (see figure 2). The low number of respondents in management roles may be misleading, as a number of the respondents may hold leadership positions in addition to their clinical role, e.g. be a midwife but in a leadership or management position within that area.
In terms of how the respondents had learned about the Compassionate Connections resources, the majority (83%) had attended a routine meeting where the resources had been presented to them as part of the agenda. Others had attended a meeting specifically arranged to discuss the resources (23%), or had been involved in the development of the resources (4%).

**5.3.3.2 Perceptions of the learning resources and their perceived impact on learning and practice**

Respondents were asked to rate their level of agreement (or otherwise) with a range of statements corresponding to the Compassionate Connections resources. The results were consistently positive across the range of statements, indicating that stakeholders perceived the resources to be helpful and suggesting strong support for them (table 9).

To summarise, the majority of respondents (85%) really liked the resources, and anticipated that staff would both engage with them and learn from them. Further, 91% respondents thought that the resources accurately represented real life scenarios.

Regarding impact, the vast majority of respondents thought the resources would have a positive impact on staff and practice. Most respondents (86%) thought that the resources would positively affirm the work that maternity care staff do in practice already, and 81% agreed that the resources would connect staff with a greater insight and understanding into compassionate patient-centred care. In addition, the majority of respondents (82%) thought that the resources would have a positive impact in terms of helping the maternity care workforce make effective cross-sector links, and also 87% respondents agreed that they would help translate strategic policy aspirations into real and meaningful practice.
Table 9: Stakeholder perceptions of the resources

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>I really like the Compassionate Connections resources and anticipate that staff will engage with and learn from them</td>
<td>3 (3%)</td>
<td>11 (11%)</td>
<td>56 (57%)</td>
<td>28 (28%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>I don’t think that digital / virtual resources are helpful in developing staff understanding and knowledge</td>
<td>27 (27%)</td>
<td>50 (51%)</td>
<td>11 (11%)</td>
<td>10 (10%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>I think that the story worlds accurately reflect real life scenarios</td>
<td>2 (2%)</td>
<td>7 (7%)</td>
<td>63 (64%)</td>
<td>27 (27%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>I think that the reflective process used in the resources is appropriate to meet the learning outcomes</td>
<td>0 (0%)</td>
<td>6 (6%)</td>
<td>68 (69%)</td>
<td>24 (24%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>I think the story worlds will positively affirm the work that maternity care staff already do in practice</td>
<td>1 (1%)</td>
<td>8 (8%)</td>
<td>56 (57%)</td>
<td>29 (29%)</td>
<td>5 (5%)</td>
</tr>
<tr>
<td>I think that the use of stories is a useful learning approach</td>
<td>1 (1%)</td>
<td>2 (2%)</td>
<td>44 (44%)</td>
<td>51 (52%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>I think that the story worlds will connect staff with a deeper insight and understanding of compassionate person-centred care</td>
<td>0 (0%)</td>
<td>15 (15%)</td>
<td>48 (48%)</td>
<td>33 (33%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>I think that the story worlds will help the maternity care workforce to make effective cross sector links</td>
<td>0 (0%)</td>
<td>14 (14%)</td>
<td>59 (60%)</td>
<td>22 (22%)</td>
<td>4 (4%)</td>
</tr>
<tr>
<td>I think that the story worlds are effective in translating strategic policy aspirations into real and meaningful practice.</td>
<td>0 (0%)</td>
<td>10 (10%)</td>
<td>59 (60%)</td>
<td>27 (27%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>I think the story worlds learning resource will be useful to disciplines beyond the maternity care workforce</td>
<td>0 (0%)</td>
<td>6 (6%)</td>
<td>59 (60%)</td>
<td>34 (34%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>I believe that practitioners / students should have ‘protected’ time built into their work schedule / timetable to use these resources</td>
<td>2 (2%)</td>
<td>9 (9%)</td>
<td>51 (52%)</td>
<td>34 (34%)</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>I don’t feel there will be much organisational support for the story worlds resources</td>
<td>10 (10%)</td>
<td>55 (56%)</td>
<td>26 (26%)</td>
<td>4 (4%)</td>
<td>4 (4%)</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

5.3.3.2.1 Educational methods and media

In terms of this type of educational methods and media, the results were positive. Despite concerns to the contrary, the majority of respondents (78%) thought that digital / virtual resources are helpful in developing staff understanding and knowledge. Further, almost all respondents (96%) considered the use of stories to be a useful learning approach (more than half of respondents - 51% - strongly agreed with this statement), and 93% respondents agreed that the reflective process used in the resources was appropriate to meet the learning outcomes (24% strongly agreed with this statement, and no respondents strongly disagreed).
5.3.3.2 Implementation and potential transferability of the resources

Perceptions regarding implementation of the resources were also positive. Ninety-four percent of respondents thought that the resources would be useful beyond the maternity care workforce, and 86% respondents thought that staff/students should have protected time for this type of learning. Whilst around a third (30%) of respondents agreed with the statement ‘I don’t feel there will be much organisational support for the Story Worlds resources’, the majority (66%) thought there would be organisational support.

Around half of the respondents (53%) were not aware of any other formal educational sessions or CPD around compassionate person-centred care; however a third of respondents (33%) were familiar with a range of other resources that were available in this area. A wide range of examples were provided, including:

- Use of the NES Essential shared capabilities within the curriculum
- Caring Behaviours Assurance System (CBAS)
- Effective Practitioner, Flying Start resources
- Releasing Time to Care, Vitality and Caring Questionnaire
- There are learn-pro modules and study days pertaining to compassionate care
- Gender Based Violence training

With regard to respondents being aware of alternative feedback mechanisms for staff in relation to the delivery of compassionate person-centred care, 65% of respondents were unaware of any existing mechanisms in place. One in five respondents (20%) were aware of other feedback mechanisms in this area, including:

- Directly from clients (patient experience questionnaires), record keeping audits
- Better together questionnaires as part of leading better care / releasing time to care
- Supervision of midwifery, Personal Development Planning, eKSF, reflective reviews
- Midwives forums / meetings – the Maternity Care Quality Improvement Collaborative (MCQIC)

5.3.3.2.3 Perceived impacts on practice

Respondents were asked to rate the effectiveness of the Compassionate Connections resources in terms of having a potential positive impact on practitioners’ ability in relation to Compassionate Connections learning outcomes (0=no anticipated impact on practice / 10=substantial impact on practice). The average scores awarded across the 10 point scale are shown in figure 3.

Stakeholders were optimistic regarding the impact of the resources on practitioners, with average scores ranging from 6.5 to 7.1. The results were also positive in relation to the perceived impact of the resources impact on individuals’ understanding of the principles of compassionate care (7.1) and collaborative working with colleagues (6.9).

Respondents were invited to provide any additional comments about the Compassionate Connections resources. Several respondents provided comments to highlight further their strong support for the resource:
• Appears to be a useful, well-researched and thought out resource.
• These are an excellent resource in my opinion and would like to use them in the adult programme.
• Useful for students and newly qualified staff, or those returning to practice.
• Very useful resource which has been utilised in 2 of my modules with pre-registration midwifery students. I feel the earlier it is used in education the bigger impact it will have in developing understanding about the importance of person centred approach to care.
• Good resource, highly transferable and could easily be developed further to be even more relevant for many other staff groups
• This is an excellent learning resource which is easily accessible, user friendly and appropriate for various staff groups in maternity.
• I really enjoyed the session & tried out a couple of the scenarios at a training day I was involved in & it received a very positive response - it clarifies how much of an impact our communication has with patients & in both negative & positive ways. I hope it will be adopted throughout the health care professions

A number of respondents noted that in order to maximise the impact of a resource like Compassionate Connections, feasibility considerations and issues relating to the implementation, such as protected time for staff, would be important:
• I would like to see Lead Midwives and Clinical Managers facilitating protected time to allow practitioners to fully engage with this initiative.
• Resource is really good but feel staff will need time to work through resource in groups with facilitated discussion and reflection. Will be difficult to get study time for all staff
• I cannot see midwives being released for this training. The resource is good but needs to be linked to an established structure to enable it to be cascaded widely. In my opinion embedding the resources in already established motivational interviewing training and making this compulsory for all midwives would be the best way forward
• The success of this programme will be dependent on investing time to allow staff to learn and use the system. Staff under pressure find it difficult to be compassionate all the time and to consider all aspects of women’s background history as well as immediate pregnancy problems.
• Useful for a learn-pro module but might have time management issues in the clinical environment.
Respondents also provided feedback regarding other aspects of the implementation of the resources, such as the level of facilitation required in order to optimise the impact of the resource and approaches to training that involve reflection, and the format in which this takes place:

- **Thought it was really good to introduce Motivational Interviewing and strengths based approaches but you would definitely need a facilitator who knows about Health Behaviour Change as this is a skill which should not be underestimated.**
- **Reflection as a group and group discussion is quite dependant on the skill of the facilitator to draw meaningful dialogue from the group and to facilitate deeper understanding. It has been evident that facilitation skills are lacking at times when people have used the learning resources. Perhaps sessions on how to facilitate adult learning groups would be useful for “trainers” who intend to utilize the learning resources otherwise I fear that these resources will not be used to their full extent and not have the intended impact.**
• Think facilitation is crucial as there is potential risk that individuals using resource independently may interpret some of the behaviours and attitudes towards patients / women, as acceptable. Resource really needs to be clear re best practice and best approaches.

• I think that perhaps the presentation I received was too superficial. I found the story very basic and simplistic & not a true reflection of the complex cases we deal with on a daily basis in this demanding job.

• Presenting negative practice was not helpful in this resource particularly when the 'positive' scenarios have poor practice in terms of compassionate communication evident in them as well.

• A nice idea, well presented and produced. I did have a slight concern that the message was so positive about person centred care, that it almost had a slight feel of discouraging honest information sharing, and openly discussing concerns in very high risk situations. However this may have been a reflection of the discussion that was generated by the group who listened to an audio extract. Would be helpful in my opinion to balance the information slightly with the odd reminder of duties where there are child protection/ safety concerns.

Some stakeholders provided feedback on the educational media of the resources:

• I think the impact was lost when the story board was made "still". It was far more engaging when the actors were moving.

• I was looking forward to Compassionate Connections and its use of multi-media communication tools. I believe visual story resources are an excellent way of communicating learning and reinforcing development but unfortunately the content of Compassionate Connections was demonstrating nothing new to the staff I have spoken to.

A number of respondents (from both NHS Boards and Higher Education Institutions) commented that the resources may be particularly effective in the education of students:

• I think the resource is useful and certainly something we can use with students to support our own sessions and learning outcomes however for those in practice once they have looked at it, I don’t know how many would come back to it. I’m not sure how this would be implemented or if it’s a course that can be attended? I’m still not quite sure what some of the learning outcomes mean e.g. ‘flexible person centred risk management’.

• Feedback from some GP trainees was that the resource seemed to be aimed at a more junior level - e.g student level. I certainly think it would be useful for juniors.

Some respondents focused upon the need for training in compassionate person-centred care rather than the Compassionate Connections resources themselves, with a number of comments suggesting that problems in this area were caused by other factors such as workload / staffing rather than the need for training, or other initiatives:

• If Changing Childbirth had been implemented, we wouldn't have a problem connecting with women in a sensitive compassionate way. Women want to know their midwife, and they want them to be at their birth and support them at all stages during their childbirth journey, especially vulnerable women.

• I realise that Compassionate Connections is a tool to help the implementation of the 'refreshed framework', however I believe that a lot of midwives already offer compassionate care & are already well aware of health inequalities & the health implications these can lead to. Many work
away quietly, signposting family groups who can help with friendship and life-skills or national charities e.g. Gingerbread that can provide trained volunteers to help with more serious issues e.g. debt. Whilst I appreciate that up-skilling or revisiting communication skills can always help, I believe midwives know how to ask questions & if they feel they want to discuss a situation that occurred, they all have supervisors for reflection with.

- I think we’re able to treat women & families compassionately - money better spent on extra staff
- I think this was one of the worst initiatives I have ever seen. Staff know how to care for patients, they just don’t have the resources to do it correctly due to massive amounts of money being invested in the wrong area, and not enough clinical staff. This resource will not be used by health staff as they won’t have the time to access it.
- Work load and pressure to have patients out of beds and home asap directly impact on Compassionate Care, this needs to be addressed along with training

5.3.4 Introductory sessions

An evaluation questionnaire (appendix A) was sent to all participants following their attendance at a Compassionate Connections introductory session, in order to evaluate the perceptions of stakeholder to the Compassionate Connections resources in terms of their potential impact on learning and practice, the methods and media used and implementation

5.3.4.1 Response

A total of 86 responses were received to this questionnaire, representing a range of NHS Boards and Higher Education Institutions. The majority of respondents were midwives (47) and nurses (15); and in Agenda for Change bands 6-8

![Figure 4: Role distribution of respondents (introductory sessions)](source: SMCIA PCA analysis of evaluation data)

NB: many of the Midwives identified in Fig 6 may also be managers / educators for the purpose of this project
5.3.4.2 Perceptions of the learning resources and potential impact on learning and practice

Respondents were asked to rate the level of agreement (or otherwise) with a range of statements corresponding to the Compassionate Connections resources. The results are shown in table 10.

The vast majority of respondents were positive and supportive of the Compassionate Connections resources, with 95.3% agreeing that they really liked the resources and anticipated that staff would engage with and learn from them. Indeed, 39.5% respondents ‘strongly agreed’ with this statement, suggesting a high level of support, and anticipated impact on the staff who engage with the resources.

In terms of validity, almost all respondents (97.7%) considered the resources to accurately reflect real life scenarios (43% strongly agreed), and most (96.5%) agreed that they would help staff connect a deeper insight and understanding of compassionate person centred care (more than a third of respondents strongly agreed with this statement).

In terms of perceived educational impact, the support was equally strong with the majority of respondents indicating that they anticipated the resources would have a positive educational impact on staff / students in a number of areas. When asked to consider whether the resources would positively affirm the work that maternity care staff already do in practice, almost all respondents agreed (94.1%) with almost a quarter of respondents strongly agreeing (no respondents strongly disagreed). Further, 89.5% respondents agreed that the resource would help the maternity care workforce make effective cross sector links (22.4% strongly agreed), and 91.9% thought that the story worlds are effective in translating strategic policy aspirations into real and meaningful practice.

5.3.4.2.1 Educational Methods and Media

In terms of the educational methods and media underpinning the resources, there was strong support from the respondents responding to the survey, with almost all indicating that they felt the approach used was appropriate and useful. When asked to consider whether the reflective approach used during the story world resource was appropriate to meet the learning objectives, almost all respondents (96.5%) agreed, with more than a quarter of individuals strongly agreeing with the statement. Further, respondents were highly positive regarding the use of stories as an educational method within this context: 96.5% respondents agreed that the use of stories was a useful learning approach, of which more than half (52.3%) strongly agreed (table 10).
Table 10: Introductory Session participants’ perceptions of the Compassionate Connections resources

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I really like the Story Worlds resource and anticipate that staff will engage with and learn from it</td>
<td>2 (2.3%)</td>
<td>2 (2.3%)</td>
<td>48 (55.8%)</td>
<td>34 (39.5%)</td>
</tr>
<tr>
<td>I don’t think that digital/virtual resources are helpful in developing staff understanding and knowledge</td>
<td>33 (38.4%)</td>
<td>45 (52.3%)</td>
<td>6 (7.0%)</td>
<td>2 (2.3%)</td>
</tr>
<tr>
<td>I think the story worlds accurately reflect real life scenarios</td>
<td>1 (1.2%)</td>
<td>1 (1.2%)</td>
<td>47 (54.7%)</td>
<td>37 (43.0%)</td>
</tr>
<tr>
<td>I think that the reflective process used in the resource is appropriate to meet the learning outcomes</td>
<td>2 (2.3%)</td>
<td>1 (1.2%)</td>
<td>61 (70.9%)</td>
<td>22 (25.6%)</td>
</tr>
<tr>
<td>I think the story worlds will positively affirm the work that maternity care staff already does in practice</td>
<td>0 (0.0%)</td>
<td>5 (5.9%)</td>
<td>59 (69.4%)</td>
<td>21 (24.7%)</td>
</tr>
<tr>
<td>I think that the use of stories is a useful learning approach</td>
<td>1 (1.2%)</td>
<td>2 (2.3%)</td>
<td>38 (44.2%)</td>
<td>45 (52.3%)</td>
</tr>
<tr>
<td>I think that the story worlds will connect staff with a deeper insight and understanding of compassionate person centred care.</td>
<td>1 (1.2%)</td>
<td>2 (2.3%)</td>
<td>54 (62.8%)</td>
<td>29 (33.7%)</td>
</tr>
<tr>
<td>I think that the story worlds will help the maternity care workforce to make effective cross sector links</td>
<td>2 (2.4%)</td>
<td>7 (8.2%)</td>
<td>57 (67.1%)</td>
<td>19 (22.4%)</td>
</tr>
<tr>
<td>I think that the story worlds are effective in translating strategic policy aspirations into real and meaningful practice</td>
<td>2 (2.3%)</td>
<td>5 (5.8%)</td>
<td>57 (66.3%)</td>
<td>22 (25.6%)</td>
</tr>
<tr>
<td>I think the story worlds learning resource will be useful to disciplines beyond the maternity care workforce</td>
<td>1 (1.2%)</td>
<td>3 (3.5%)</td>
<td>42 (48.8%)</td>
<td>40 (46.5%)</td>
</tr>
<tr>
<td>I believe practitioners / students should have ‘protected’ time built into their work schedule / timetable to use these resources</td>
<td>2 (2.3%)</td>
<td>4 (4.7%)</td>
<td>44 (51.2%)</td>
<td>36 (41.9%)</td>
</tr>
<tr>
<td>I don’t feel there will be much organisational support for the story world’s resource.</td>
<td>14 (16.3%)</td>
<td>48 (55.8%)</td>
<td>24 (27.9%)</td>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

5.3.4.2.2 Implementation and potential transferability

The high levels of support from stakeholders responding to the questionnaire continued when they were asked to consider issues around the potential of the story worlds to be transferable to other professionals. The vast majority of respondents (95.3%) thought the Story Worlds would be useful beyond the maternity care workforce, with almost half of these (46.5%) in strong agreement. Similarly, stakeholders recognised the need for effective implementation, with most respondents (93.1%) agreeing that there should be protected time for staff / students to complete the resources (41.9% strongly agreed that there should be protected time). When asked whether they thought that there would be organisational support for the implementation of the resources, results remained positive with the majority of respondents (72.1%) agreeing that organisational support for the resources would be evident. However, around a quarter of respondents disagreed with this statement (27.9%), suggesting that others were unsure in this regard (table 10).
Although more than half (54.3%) of the stakeholders responding to the questionnaire were unaware of any other formal educational sessions or CPD focusing on the delivery of compassionate person-centred care, around a third of respondents (34.6%) were aware of other resources or approaches and provided a range of examples, including:

- NES Masterclasses/Leadership in Compassionate Care programme
- Compassionate care course/delivering Better care
- Person centred care workshops in NHS Lothian and RCM
- Caring Behaviours Assurance System CBAS, Leading better care, releasing time to care
- I think it reflects the health behaviour change and motivational interviewing techniques

A similar proportion of respondents (25.9%) were aware of other feedback mechanisms in place for staff around the delivery of compassionate person-centred care (56.8% were unaware). Examples provided included the following:

- Client experience questionnaire
- Patient stories / feedback
- Supervisor of midwives
- Supervisory annual review / Personal Development Planning
- CBAS using a person centred care quality indicator

5.3.4.2.3 Perceived impacts on practice

Respondents were asked to rate the effectiveness of the Compassionate Connections resources in terms of having a potential positive impact on practitioners’ ability in relation to Compassionate Connections learning outcomes (0=no anticipated impact on practice / 10=substantial impact on practice). The average scores awarded across the 10 point scale are shown in figure 5.

Participants in the introductory sessions were positive across the range of issues, suggesting that they thought the resources would have a strong impact on practitioners’ abilities. Average scores were all in excess of 7 on the scale of 0 – 10, ranging from 7.15 to 7.79.

The perceived potential impact of the resources on practitioners’ abilities were consistently high with regard to ‘knowledge of the impact of health and social circumstances on engagement with services’ (7.2), and ‘on clinical outcomes’ (7.39), ‘working collaboratively with women and their families’ (7.61), ‘working collaboratively with colleagues’ (7.3), ‘working collaboratively with other health and social care agencies’ (7.15), ‘identifying opportunities to support health behaviour change in the delivery of maternity care’ (7.35), ‘identifying opportunities to use strengths based approaches’ (7.41), identifying opportunities to deliver inequalities sensitive maternity care’ (7.32), ‘understanding the importance of flexible person-centred risk management’ (7.35), ‘understanding the principles of compassionate care’ (7.79), and ‘how these relate to their role within maternity care services’ (7.63), and being able to ‘critically reflect on practice issues’ (7.58).
### Figure 5: Introductory sessions: Perceived potential impact on practitioners abilities

<table>
<thead>
<tr>
<th>Area</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the impact of health and social circumstances on engagement with services</td>
<td>7.20</td>
</tr>
<tr>
<td>Knowledge of the impact of health and social circumstances on clinical outcomes</td>
<td>7.39</td>
</tr>
<tr>
<td>Working collaboratively with women and their families</td>
<td>7.61</td>
</tr>
<tr>
<td>Working collaboratively with colleagues</td>
<td>7.30</td>
</tr>
<tr>
<td>Working collaboratively with other health and social care agencies</td>
<td>7.15</td>
</tr>
<tr>
<td>Identifying opportunities to support health behaviour change in the delivery of maternity care</td>
<td>7.35</td>
</tr>
<tr>
<td>Identifying opportunities to use strengths based approaches in the delivery of maternity care</td>
<td>7.41</td>
</tr>
<tr>
<td>Identifying opportunities to deliver inequalities sensitive maternity care</td>
<td>7.32</td>
</tr>
<tr>
<td>Understanding the importance of flexible person centred risk-management to improving health and clinical outcomes</td>
<td>7.35</td>
</tr>
<tr>
<td>Understanding the principles of compassionate person centred care</td>
<td>7.79</td>
</tr>
<tr>
<td>Understand the principles of compassionate person centred care and how these relate to your own role within maternity care services</td>
<td>7.63</td>
</tr>
<tr>
<td>Critically reflect on practice issues</td>
<td>7.58</td>
</tr>
</tbody>
</table>

*Source: SMCIA PCA analysis of evaluation data*

*Analysis was using a ten point scale where 0 = Very Poor and 10 = Excellent*
5.3.5  Story Worlds learning sessions

The Story Worlds learning sessions were evaluated at three time points: prior to attending the first session (pre-questionnaire evaluation), immediately after the first session (post-session evaluation questionnaire), and a follow-up evaluation at the time of the follow-up (reflective) session (follow-up evaluation questionnaire). The aim of the questionnaires was to evaluate participants’ perceptions of the resources, in terms of perceived impact on learning and practice, and the educational methods and media.

To allow a more general comparison of data across the three questionnaires and any changing views during the implementation of the Story Worlds resources, the results are presented for each in parallel below.

5.3.5.1  Response

Respondents to the Story Worlds pre-session evaluation questionnaire were employed or studying across a range of NHS Boards or HEIs.

In terms of the roles of individuals responding to the pre-session evaluation questionnaire, the majority (n=41 / 85.4%) were midwives, with the others being Nurses (n=2), Public Health Nurses (n=2), Public Health professionals (n=2) or Health Visitors (n=1). It should be noted however that many of the Midwives may also be managers / educators for the purpose of this project. From the respondents in employment, 8 were Agenda for Change band 5, 8 were band 6, and 4 were band 7.

5.3.5.2  Perceptions of the resource and potential impact on learning and practice

Acknowledging that for many, this may be a new and unique way of learning, respondents were asked to tell us about their expectations regarding the Story Worlds sessions across a range of issues by completing a pre-session evaluation questionnaire. Participants’ experiences with regard to similar issues were also evaluated after they had attended the session (post-session questionnaire). These results are shown in tables 11 and 12 below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am looking forward to this learning session</td>
<td>0%</td>
<td>10.2%</td>
<td>79.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>I expect this session to improve my practice in terms of care and compassion towards women and families.</td>
<td>0%</td>
<td>10.2%</td>
<td>59.2%</td>
<td>30.6%</td>
</tr>
<tr>
<td>I regularly use e-learning resources</td>
<td>0%</td>
<td>18.4%</td>
<td>67.3%</td>
<td>14.3%</td>
</tr>
<tr>
<td>I enjoy using reflection during learning sessions</td>
<td>0%</td>
<td>8.2%</td>
<td>73.5%</td>
<td>18.4%</td>
</tr>
<tr>
<td>I find group discussion a helpful way to learn</td>
<td>0%</td>
<td>8.2%</td>
<td>67.3%</td>
<td>24.5%</td>
</tr>
<tr>
<td>I hope the Story Worlds will accurately reflect real practice</td>
<td>0%</td>
<td>0%</td>
<td>55.1%</td>
<td>44.9%</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data
Table 12: Respondents’ experience of the Story Worlds learning session (post-session questionnaire)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoyed this learning session</td>
<td>0%</td>
<td>5.9%</td>
<td>62.7%</td>
<td>31.4%</td>
</tr>
<tr>
<td>As a result of this session that I intend to change my practice in terms</td>
<td>3.9%</td>
<td>17.6%</td>
<td>70.6%</td>
<td>7.8%</td>
</tr>
<tr>
<td>of care and compassion towards women and families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Story Worlds resource was easy to use</td>
<td>0%</td>
<td>0%</td>
<td>78.4%</td>
<td>21.6%</td>
</tr>
<tr>
<td>I feel comfortable using this resource</td>
<td>0%</td>
<td>7.8%</td>
<td>74.5%</td>
<td>17.6%</td>
</tr>
<tr>
<td>I was able to reflect on my own performance in practice during this</td>
<td>0%</td>
<td>7.8%</td>
<td>70.6%</td>
<td>21.6%</td>
</tr>
<tr>
<td>session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the group discussion a helpful way to learn</td>
<td>2%</td>
<td>5.9%</td>
<td>68.6%</td>
<td>23.5%</td>
</tr>
<tr>
<td>I think Story Worlds are an accurate reflection of real practice</td>
<td>2%</td>
<td>15.7%</td>
<td>68.6%</td>
<td>13.7%</td>
</tr>
<tr>
<td>I feel able to apply what I’ve learned in this session into practice</td>
<td>0%</td>
<td>9.8%</td>
<td>72.5%</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

The responses to both the pre and post session questionnaires were extremely positive. Most respondents (89.8%) reported that they were looking forward to the Story Worlds learning session, and that they expected the session to improve their practice in terms of care and compassion towards women (almost a third of respondents – 30.6% - strongly agreed with this statement). Although most respondents (81.6%) agreed in advance of the session that they regularly use e-learning resources, almost 1 in 5 individuals disagreed (18.4%) indicating that e-learning may have been relatively new to a proportion of the stakeholders involved in the pilot. However, the vast majority of respondents reported that they enjoyed using reflection during learning sessions (91.8%) and found group discussion helpful (91.8%) prior to attending the story world learning session.

The post session questionnaire elicited equally positive results, with the majority of respondents having enjoyed the story world session (94.1%), with almost a third of these strongly agreeing with the statement).

Although 89.8% respondents expected that the learning session would improve their practice in terms of care and compassion towards women and families (30.6% strongly agreed with this), after attending the session this reduced slightly to 78.4% respondents reporting an intention to change practice as a result of the session.

All respondents thought that the Story Worlds resource was easy to use. Further, the majority of respondents (92.2%) agreed that they were comfortable using the resource and had the opportunity to reflect when using the resource. In terms of validity, the majority of respondents agreed (81.3%) the resources were an accurate representation of real practice.

5.3.5.2.1 Educational methods and media

Approximately one third of respondents (32.7%) reported having experience of using stories as a learning tool previously. The majority of these respondents were in the younger age groups (37.5%
from age 16-25; and 43.8% from age 26-35). However, around a half of respondents (55.1%) reported having no previous experience using stories as a learning tool before. From these individuals, the distribution of age groups was relatively even as follows; 16-25years = 25.9%, 26-35years = 22.2%, 36-45years = 22.2%, 46-55years = 18.5% and 56-65years = 11.1%).

5.3.5.2.2 Perceived impacts on practice

Respondents were asked to rate their own abilities across the Story Worlds learning outcomes using a 10 point scale, where 0 = very poor and 10 = excellent, at three points:

- Before they participated in the SW1 session
- After they participated in the SW1 session
- When they participated in the SW2 (reflective session)

Although different individuals often responded to the pre- post- and follow-up- questionnaires, the results for each question is presented together (see figure 6) to enable any differences in the pattern of outcomes to be observed. It should also be acknowledged that stakeholders’ expectations may be influenced by the fact that the Story Worlds are a new and unique way of learning for some participants.

Although any formal comparison of the relationship between data collected at different time points (pre-session, post-session and follow-up) should be interpreted with caution as the respondents were representative of different cohorts, in most cases respondents reported an increase in their perceived ability regarding the areas within the statements is observed, suggesting that the story worlds had a positive impact on learning. This is perhaps most noticeable for:

- Understanding the principles of compassionate person centred care (average ratings increased from 7.7 to 8.6), in particular how these principles relate to practitioners’ own roles within maternity care services (increased average ratings from 7.1 to 8.5)
- Perceived ability in being able to identify opportunities to use strengths-based approaches in the delivery of maternity care (average ratings increased from 6.1 to 7.5)
- Perceived ability in the delivery of inequalities sensitive maternity care (average ratings increased from 6.3 to 7.7)
- Perceived ability in being able to identify opportunities to support health behaviour change in the delivery of maternity care (average ratings increased from 7 to 8)
- Perceived ability in being able to critically reflect on practice issues (average ratings increased from 7.3 to 8.3)
Respondents were asked in the pre-session questionnaire to name three things that they would like to learn during the Story Worlds learning session, and were asked in the post-session questionnaire to identify three things that they learned during the session. Table 13 shows the ten areas identified most frequently by participants prior to the Story Worlds session (in ranked order, with the areas identified most frequently at the top). Table 14 shows the ten areas identified most frequently by respondents as having been learned during the session.
Table 13: Areas identified by respondents that they anticipate learning during the Story Worlds session.

<table>
<thead>
<tr>
<th>Anticipated Learning Outcome</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of people I can contact in various situations / referral / multi agency working</td>
<td>7</td>
</tr>
<tr>
<td>Ways to provide effective compassionate care</td>
<td>6</td>
</tr>
<tr>
<td>Different ways to approach a sensitive / difficult situation that are not confrontational</td>
<td>6</td>
</tr>
<tr>
<td>Communication skills / Compassionate Communication</td>
<td>6</td>
</tr>
<tr>
<td>Compassionate care and the removal of assumptions and judgment in the care of women in</td>
<td>5</td>
</tr>
<tr>
<td>difficult socio-economic situations</td>
<td></td>
</tr>
<tr>
<td>Better tools for reflecting on practice</td>
<td>4</td>
</tr>
<tr>
<td>How story worlds can improve my practice</td>
<td>4</td>
</tr>
<tr>
<td>More co-ordinated approach to management of care within a multi-disciplinary team</td>
<td>4</td>
</tr>
<tr>
<td>How to use Compassionate Connections in my workplace</td>
<td>4</td>
</tr>
<tr>
<td>Increase my knowledge in this area</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

Table 14: Learning outcomes identified by respondents following the Story Worlds session

<table>
<thead>
<tr>
<th>Learning Outcome</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of communication, listening and patience</td>
<td>5</td>
</tr>
<tr>
<td>Reflecting and learning from experiences helps to improve my practice.</td>
<td>4</td>
</tr>
<tr>
<td>About recognising and responding to vulnerability</td>
<td>4</td>
</tr>
<tr>
<td>Body language and the way we are positioned when speaking to clients</td>
<td>3</td>
</tr>
<tr>
<td>Resources and guidelines available to guide compassionate care giving</td>
<td>3</td>
</tr>
<tr>
<td>How to better communicate in situations where social/clinical circumstances occur</td>
<td>3</td>
</tr>
<tr>
<td>Ensure that we are always compassionate, non-judgemental and approachable</td>
<td>3</td>
</tr>
<tr>
<td>the importance on drawing on the life experience of the client to understand their behaviour and influence change</td>
<td>3</td>
</tr>
<tr>
<td>How we as health professionals may be perceived by our patients</td>
<td>2</td>
</tr>
<tr>
<td>How to find a positive way forward in a difficult situation</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

Although the anticipated learning outcomes appeared to be more general than the reported learning outcomes, there was a good degree of overlap between the areas provided, suggesting that in many cases the expectations of participants were met.
5.3.6 VLE learning sessions

The VLE resource was evaluated using a pre-session questionnaire to understand respondents’ expectations and opinions regarding virtual learning resources in advance of the session, and after a period of reflection (whereby the individual had had time to use the resource) using a post-session questionnaire. The aim of the questionnaire was to evaluate stakeholders’ perceptions regarding the VLE, its potential impact on learning and practice, and effectiveness of educational methods and media used.

5.3.6.1 Response

When implemented within NHS Boards, NHS staff were often involved individually or in small groups. Where the VLE was implemented in HEIs this frequently involved larger numbers of students as this was timetables as part of their learning within a module. Two-thirds (66.7%) respondents to the VLE (pre-session) questionnaire were from HEIs, the majority (52.8%) being from the University of the West of Scotland, therefore this analysis reflects just two classroom based sessions with large numbers of participants. From the respondents providing their Agenda for Change payband (not relevant to students or other participants from outwith NHS), these were all bands 5-7, with 50% of those responding being a band 6 member of NHS staff.

5.3.6.2 Perceptions of the resource and potential impact on learning and practice

Respondents were asked to rate their level of agreement with a number of statements relating to their expectations of the resource (Pre-session questionnaire) and again following their experiences having used the VLE (post-session questionnaire). The results are shown together in order to enable comparison in table 15.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre / Post Qu’aïre</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am looking forward to using this resource</td>
<td>Pre</td>
<td>0%</td>
<td>11.1%</td>
<td>66.7%</td>
<td>22.2%</td>
</tr>
<tr>
<td>I enjoyed using this resource</td>
<td>Post</td>
<td>0%</td>
<td>11.1%</td>
<td>70.4%</td>
<td>18.5%</td>
</tr>
<tr>
<td>I expect this session to improve my practice, in terms of providing care and compassionate care towards patients</td>
<td>Pre</td>
<td>2.8%</td>
<td>5.6%</td>
<td>80.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>I believe my practice, in terms of care and compassion towards patients, will improve as a result of using the resource</td>
<td>Post</td>
<td>3.7%</td>
<td>11.1%</td>
<td>77.8%</td>
<td>7.4%</td>
</tr>
<tr>
<td>I regularly use interactive e-learning resources</td>
<td>Pre</td>
<td>5.6%</td>
<td>47.2%</td>
<td>38.9%</td>
<td>8.3%</td>
</tr>
<tr>
<td>The Avatar is an accurate reflection of real practice</td>
<td>Post</td>
<td>3.7%</td>
<td>22.2%</td>
<td>70.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td>It was easy to engage with the avatar resource</td>
<td>Post</td>
<td>0%</td>
<td>14.8%</td>
<td>74.1%</td>
<td>11.1%</td>
</tr>
<tr>
<td>I found the interactive nature of the resource helpful</td>
<td>Post</td>
<td>0%</td>
<td>22.2%</td>
<td>59.3%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data
The majority of respondents were positive about the resource, both in advance of the sessions and after having attended the VLE learning session. Where statements represented the same construct pre- and post the VLE learning session, there appeared to be little change in opinion, with the majority of respondents remaining positive about the resource across the range of issues. Most stakeholders attending the VLE sessions (88.9%) were looking forward to using the resource, and subsequently enjoyed using it. Further, the vast majority (91.7%) of respondents expected the VLE resource to improve their practice in terms of providing compassionate care for patients, and 85.2% agreed that the resource was indeed effective in this way after having used it.

5.3.6.2.1 Educational methods and media

In terms of the design of the VLE and use as a learning tool, the majority of respondents (74%) agreed that it accurately represented real life suggesting that the resource has validity, Further; most stakeholders (85.2%) found it easy to engage with the resource and 77.8% found the interactive nature of the tool helpful (table 15).

Despite less than half the respondents (48.2%) regularly using interactive e-learning resources, the majority of individuals attending the VLE sessions agreed that it was an accurate reflection of real practice (74.1%), that the resource was easy to engage with (85.2%) and that the interactive nature of the resource was helpful (77.8%). Almost three quarters of respondents (72.2%) had not used avatars or gaming technology to learn prior to their experience of the VLE resource, suggesting that this technology remains fairly novel even amongst students.

The distribution of respondents’ age groups were fairly evenly spread, (27.8% being 16-25 years; 25% being 26-35 years; 22.2% being 36-45 years; 22.2% being 46-55 years and 2.8% being 56-65 years old).

Respondents were asked whether they had had other formal educational sessions regarding the provision of compassionate person-centred care. Around half of respondents had attended other educational sessions or CPD in this area, including:

- Lectures / Midwife-led teaching sessions (x 8)
- Child protection study days
- Introductory session for Compassionate Connections (x 2)
- Introduction to Counselling course
- Hypnobirthing, bereavement

In terms of receiving feedback regarding their performance with regard to the delivery of compassionate person-centred care, only 28.6% had previously received feedback in this area. Students noted that they had received feedback from their mentors in practice.

Regarding the scheduling of the VLE learning session, 81.6% reported the session as having been scheduled within their timetable. From those responding who are NHS professionals, they reported having protected time for such events ‘once or twice per trimester’ or ‘as per study leave hours’.
5.3.6.2.2 Perceived impacts on practice

Respondents were asked to rate their own abilities across the VLE learning outcomes against a 10 point scale where 0 = very poor and 10 = Excellent, before and after they had participated in the session.

Although different individuals often responded to the pre- post- questionnaires, the results for each question are presented together (see figure 7) to enable any differences in the pattern of outcomes to be observed.

The results were positive, with average ratings in the upper half of the scale across all areas ranging from 5.7 to 7.6. An increase in ratings (and hence perceived ability) was suggested in a number of areas:

- Stakeholders’ perceived ability in using an assets-based approach to improve health outcomes (average ratings increased from 5.7 to 6.6)
- Stakeholders’ perceived ability in using available collective resources that promote the coping/decision-making abilities of women (average ratings increased from 6.2 to 6.4)
- Stakeholders’ perceived ability in using available collective resources that promote the self-esteem of women (average ratings increased from 6.3 to 6.4).

Interestingly participants’ average scores were lower in relation to six outcomes in the post-session questionnaire – in particular in understanding the concept of person-centredness in relation to working practice (7.6 – 6.8). However, one possible explanation for this may be that the resources had increased knowledge, and therefore may have decreased perceived ability as individuals become more aware of the relevant issues.

In the pre-session questionnaire for the evaluation of the VLE resource, respondents were asked to name three things they would like to learn from the resource, and in the post-session questionnaire they were asked to name three things that had learned from the resource. The comments provided most frequently are shown in table 16 (pre-session questionnaire) and table 17 (post-session questionnaire – learning outcomes). Comments suggest that many respondents felt that the resource was helpful to them and they learned useful information.
Figure 7: Perceived achievement of VLE learning outcomes

Table 16: Areas identified by respondents that they anticipate learning during the VLE session.

<table>
<thead>
<tr>
<th>Anticipated Learning Outcome</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build on existing knowledge / better understanding about compassionate care.</td>
<td>10</td>
</tr>
<tr>
<td>To experience a new method of learning / how to use the resources effectively</td>
<td>7</td>
</tr>
<tr>
<td>Ways to engage women who are not interested in stopping smoking.</td>
<td>4</td>
</tr>
<tr>
<td>Techniques to improve the compassionate care I provide, especially when under time constraints.</td>
<td>4</td>
</tr>
<tr>
<td>How to advise and support women who would like to give up smoking during pregnancy.</td>
<td>3</td>
</tr>
<tr>
<td>Insight / feedback on my practice regarding compassionate caring.</td>
<td>3</td>
</tr>
<tr>
<td>How to care for women, not just on a practical level (in terms of tests and procedures) but to better their wellbeing.</td>
<td>2</td>
</tr>
<tr>
<td>To develop my skills and help me to be a better student midwife</td>
<td>2</td>
</tr>
<tr>
<td>Interested to see if it makes me feel more compassionate as I already have a person/family centred approach to my work.</td>
<td>2</td>
</tr>
<tr>
<td>How it impacts on women in my care</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data
Table 17: Learning outcomes identified by respondents following the VLE session

<table>
<thead>
<tr>
<th>Learning Outcome</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>How reflection can be used to help women learn about what worked for them in the past</td>
<td>5</td>
</tr>
<tr>
<td>I was always under the wrong impression that it was good to encourage women to try and cut down smoking to 5 per day which I learnt is incorrect. I should be encouraging them to quit completely / how not to approach smoking cessation.</td>
<td>4</td>
</tr>
<tr>
<td>Good ways to approach the subject of smoking cessation with women.</td>
<td>2</td>
</tr>
<tr>
<td>Importance of the right approach to supporting women / looking at womens’ perception</td>
<td>2</td>
</tr>
<tr>
<td>Practical example of how to use motivational language in a conversation</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: SMCIA PCA analysis of evaluation data

5.4 The case studies

5.4.1 Introduction

Case studies were developed to explore session participants’:
• Views about the Compassionate Connections resources.
• Impacts on their practice.

Case studies were selected from session participants who had:
A. Attended a SW 1 and 2 session and completed at least the post Q for SW 1
B. Attended a SW introductory/train-the-trainers session and one other session (SW 1 or 2 or VLE) AND completed at least the post-Q for the introductory session
C. Attended a VLE session and completed a VLE pre- and post- Q

Students were not invited to participate in an interview to develop a case study because they had not had an opportunity to experience impacts on practice.

Neither of the two potential Compassionate Connections trainers/facilitators responded to the invitation to participate in a telephone interview to develop a case study. Only one SW learner responded to the invitation to participate in a telephone interview to develop a case study; although a case study was developed from this individual, it is not included here as it would provide an over representation of one person’s perspective.

Five of the ten VLE learners responded to the invitation to participate in a telephone interview to develop a case study. See table 18.

Table 18: Case studies

<table>
<thead>
<tr>
<th>Potential numbers</th>
<th>Actual number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential CC trainers/facilitators: attended a SW introductory/train-the-trainers session and one other session (SW 1 or 2 or VLE) AND completed at least the post-Q for the introductory session</td>
<td>2</td>
</tr>
<tr>
<td>SW learners: attended a SW 1 and 2 session and completed at least the post Q for SW 1</td>
<td>6</td>
</tr>
<tr>
<td>VLE learners: attended a VLE session and completed a VLE pre- and post- Q</td>
<td>10</td>
</tr>
</tbody>
</table>
5.4.2 VLE learner case studies

All VLE case studies were Band 6 midwives; one was community based.

Views about the resource

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of stories in learning</strong></td>
<td>It wasn’t belittling. The women weren’t being talked down to. But I don’t think the stories mirror my situation with clients – they’re not an accurate reflection of the scenarios I come across in my job.</td>
<td>I like the stories that the Avatar showed, as you can try and see how they fit with the cases that you see in the clinic – you can put it into context, so that’s good for learning.</td>
<td>The use of stories in the avatar was really good. You got a lot of background information on the client, especially background info on their other life stressors.</td>
<td>I thought that the use of stories was quite good. I’m a practical learner so it suited me well. It’s much easier to learn like this than having something written down.</td>
<td>I thought the use of stories was excellent, because telling a story makes it more real.</td>
</tr>
<tr>
<td><strong>Accurate reflection of real life scenarios</strong></td>
<td>I found the resource quite simplistic in that she gives advice and it’s taken on board. With my clients, a brief intervention on smoking is the last thing they would consider. These women have complex lifestyles .. they have a huge number of other things to deal with, and smoking is often the only thing that they’ve got (i.e. as a crutch, comfort).</td>
<td>I thought that the stories were quite realistic.</td>
<td>Yes I did think it was an accurate reflection. I felt the characters were very apt and reflected what we tend to see in our clinics, right down to the type of clothing worn. And another thing – the posters that were on the clinic wall in the avatar scene were the same as those that we use in our clinic, and the leaflets too, so I could relate this straight back to my clinic.</td>
<td>I think this was an accurate reflection but as I’m not a community midwife I can’t say for sure.</td>
<td>I think for some people it will seem accurate. The avatar was good because it showed the attitude that you’re meant to have.</td>
</tr>
<tr>
<td><strong>Use of reflection in learning</strong></td>
<td>This is a really good tool because it uses the use of reflection in learning. The avatar made me think about</td>
<td>The reflection is good. It makes you think .. I think about my body language more.</td>
<td>It was ideal that you were given the opportunity to reflect as part of the avatar session. It’s easy enough to</td>
<td>Reflection in learning is good as it reinforces what you’ve taken in. It’s much better than just having the</td>
<td>The avatar was great as it enabled me to sense-check my own skills and check my compassionate</td>
</tr>
<tr>
<td><strong>Digital/virtual format</strong></td>
<td>It was easy to watch. I did enjoy watching it, and it looks like a useful tool.</td>
<td>The virtual format was good, though because I wasn’t used to it, it was a bit strange to watch at first. I like watching as a means of learning rather than just reading though. The avatar kept you interested, it kept you watching.</td>
<td>I liked the virtual format – it looked a bit cartooney I suppose but it was fine.</td>
<td>The virtual format was good, but I thought the wee boy – her son – was very ugly, which was unfortunate. <strong>The virtual format was a bit robotic, but it didn’t detract from the learning.</strong> It didn’t make it harder to tune in. To visually see something is much better than just having to read in a learning session.</td>
<td>The virtual format was new to me - I haven’t seen a resource like that before, but it was fine. It looked real, even though it wasn’t real, if you see what I mean, because it was done so well. I didn’t find it off-putting in any way.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Accessibility and ease of use</strong></td>
<td>It looked simple to use. I haven’t really got any negatives to say.</td>
<td>It seemed to be accessible and self-explanatory. It wasn’t confusing in any way, and it seemed easy to navigate around.</td>
<td>The girl came along with her laptop and it all went fine, but how accessible will it be for other staff members?</td>
<td>I didn’t have any problems navigating my way around. It was easy enough.</td>
<td>The questions were good as they make you stop and think.</td>
</tr>
</tbody>
</table>

*NB evaluator emphasis (emboldened)*
<table>
<thead>
<tr>
<th>Learning outcomes</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing motivational communication skills that guide women to self-reflection and empower positive behaviour change.</td>
<td>Smoking is important, but I don’t want to give them too much information to have to reflect on. It’s a delicate balance – they often know the things they should be doing for better health already. But the avatar resource has highlighted again that smoking is a big problem. It’s one of many things that I have to make sure that I continue talking with women about. I could easily not talk about it, but it has to be addressed.</td>
<td>We always used motivational communication skills before, but now since the avatar session I think I think more about language and how you communicate with women. I don’t think I have CHANGED my skills, but I think I am more aware of how I act, and more aware that I adapt the way that I am according to each client’s needs.</td>
<td>Yes I do think the avatar session has improved my communication skills – it’s expanded what I already thought – I think more about women now as a whole. We should be asking open questions like in the avatar resource.</td>
<td>Now I spend more time summarising what someone I’m talking to has said, in a positive manner, to reinforce it with them. I didn’t do that so much before, so it has made me think about my communication skills as a result. And I think it’s really important to do that, as there is so much going on in women’s minds when they come into hospital, and you can’t expect them to remember everything really. So this was a good take home message for me, to repeat what’s been said in a positive, reinforcing way.</td>
<td>Yes, I suppose the avatar resource has changed my practice a bit here, because it made me think that you have to weigh up how the woman is feeling – I think it’s made me more aware of that.</td>
</tr>
<tr>
<td>Identifying the protective factors that support health and wellbeing with a</td>
<td>The avatar resource hasn’t changed/improved my practice in this regard.</td>
<td>I don’t think I have changed the way I practice in this sense. I’m still doing what I’ve always done. I think</td>
<td>I suppose I had the knowledge about this before the avatar session, but it’s come to the fore</td>
<td>I don’t think the avatar has changed the way I work in this respect, no.</td>
<td>No, not really.</td>
</tr>
</tbody>
</table>
### focus on the collective resources available that promote self-esteem and coping/decision-making abilities of women.

<table>
<thead>
<tr>
<th>Exploring the concept of person-centeredness in relation to working practices and attitudes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The avatar resource helped me to reflect on my own person-centred approach to practice. <strong>It confirmed for me that I am striving to use a person-centred approach.</strong> It helped me to clarify and consolidate my approach toward the women I work with.</td>
</tr>
<tr>
<td>The avatar reinforces that everyone is an individual and encourages reflection on that.</td>
</tr>
<tr>
<td>More than anything the Avatar made me realise sometimes we prejudge women – but they often have more going on than we think. <strong>The avatar has changed the way I work with all women of all classes – middle class too. It’s hard though because you have a time constraint on you too.</strong> You only get a 15 minute appointment with each woman which is why we use a tickbox system (i.e. for questions such as ‘do you smoke’ y/n response) and then we just refer them on if necessary.</td>
</tr>
<tr>
<td>No, I don’t think it has had an impact on this either.</td>
</tr>
<tr>
<td>I think that possibly I haven’t changed my practice in this way. I’d like to think I was compassionate to begin with. I always say with regard to smoking cessation with the girls that we’re help to help, and we’re not the smoking police, so I try not to be judgemental.</td>
</tr>
</tbody>
</table>

that the avatar just reinforces practice. We try and encourage them to cut down – and congratulate them on any positive behaviour changes that they are able to make. So we reinforce it, and that in turn increases their self-esteem. **We’ve always done that here. It’s a central part of good practice.**
| Using an asset-based approach to improve health outcomes. | The avatar resource hasn’t changed/improved my practice in this regard. | I’ve done that before the avatar resource came along, so it hasn’t changed my practice there. | You can apply the principles to other areas of healthcare too, just as I have with the weight loss in pregnancy classes. | No, I don’t think that really is applicable to me in my role. | I’d like to think that I do that anyway, but you know, our booking session is only 15 minutes long, and we don’t have much time – there is so much to go over. I would hope that our cessation midwives do the asset based thing. I’d like to think I was doing it where I can already. |
| Detailed knowledge and understanding of smoking cessation in pregnancy. | The resource has better equipped me with knowledge on reducing smoking during pregnancy. That information was really helpful. | I think it did change my practice here. I found it interesting. I assumed that it’s as simple as that some women do and some women don’t want to stop smoking. It didn’t occur to me that they may want to stop but have other issues that take over. I suppose it’s made me think a bit more out of the box. | I think I had a good amount of knowledge in this area already. But I was always very judgemental whereas the avatar has changed my viewpoint. | It was good to get some insight into how the cessation professionals might work with pregnant women. | Yes it has improved my practice here. I thought with the smoking information that I was good at sharing smoking facts with clients, and that I knew quite a lot about it. I think the avatar resource was really good for the smoking-related information it portrayed. |

*NB evaluator emphasis (emboldened)*
5.5 Compassionate Connections sessions summary

5.5.1 Analysis of learning outcomes

All sessions provided outwith HEIs were facilitated by the Compassionate Connection Practice Educators. Specific learning outcomes for sessions were developed by the PEs as appropriate to their target participants.

5.5.2 Session impacts

5.5.2.1 Non-learning sessions: awareness raising and introductory sessions

Participants at introductory sessions were more positive about the resources than those at awareness-raising sessions – except in relation to the usefulness of stories for staff development, were both groups were equally positive. Introductory session participants were significantly more optimistic about organizational support for the implementation of the resources. Around one third of the respondents to the questionnaire surveys of both groups considered that there were other available formal educational sessions or CPD around compassionate person centred care; and 20% - 26% considered that there were other feedback mechanisms in place for staff around the delivery of compassionate person centred care. See table 19.

Table 19: Awareness raising and introductory sessions: summary perspectives on the resources

<table>
<thead>
<tr>
<th></th>
<th>Awareness-raising sessions</th>
<th>Introductory/train-the-trainers sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accurate reflection of real life scenarios</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>Digital/virtual resources helpful for staff development</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Use of stories useful for staff development</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Resources affirm practice</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>Resources provide greater insight into compassionate patient-centred care</td>
<td>81%</td>
<td>96%</td>
</tr>
<tr>
<td>Resources enable staff to make effective cross-sectoral links</td>
<td>82%</td>
<td>89%</td>
</tr>
<tr>
<td>Resources help staff to translate strategic policy aspirations into meaningful practice</td>
<td>87%</td>
<td>99%</td>
</tr>
<tr>
<td>Resources will be useful beyond the wider maternity care workforce</td>
<td>86%</td>
<td>93%</td>
</tr>
<tr>
<td>There will be organisational support for the implementation of the resources</td>
<td>66%</td>
<td>72%</td>
</tr>
<tr>
<td>Other available formal educational sessions or CPD around compassionate person centred care</td>
<td>33%</td>
<td>35%</td>
</tr>
<tr>
<td>Other feedback mechanisms in place for staff around the delivery of compassionate person centred care</td>
<td>20%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: SMCI APCA analysis of evaluation data

Participants at awareness-raising sessions were fairly optimistic about the potential positive impact on practitioners' ability in relation to Compassionate Connections learning outcomes, with average
scores ranging from 6.5 to 7.1: they were slightly more optimistic in relation to the resources impacting on understanding of the principles of compassionate care (7.1) and collaborative working (6.9).

Participants in the introductory/train-the-trainers sessions were rather more optimistic than participants in the awareness-raising sessions, with average scores ranging from 7.1 to 7.8: they were slightly more optimistic in relation to the resources impacting on understanding the principles of compassionate care (7.8), and least optimistic in relation to the impact on collaborative working with other health and social care agencies (7.1) – although they were reasonably optimistic in relation to the impact on collaborative working with women and their families (7.6).

5.5.3 Compassionate Connections learning sessions

5.5.3.1 Story Worlds learning sessions

Of the participants in SW learning sessions who responded to the survey questionnaires:

- All thought that the Story Worlds resource was easy to use; notably, one third of respondents (33%) had had experience of using stories as a learning tool previously. The majority of these respondents were in the younger age groups (37% from age 16-25; and 44% from age 26-35).
- Were comfortable using the resource and considered that they had had the opportunity to reflect when using the resource (92%).
- Thought the resource was an accurate representation of real practice (81%).
- Expected that the learning session would improve their practice in terms of care and compassion towards women and families (90%); however, after attending the session this reduced to 78% respondents reporting an intention to change practice as a result of the session. Around one fifth of respondents did not intend to change their practice as a result of the SW learning session. This may be because the session actually affirmed their practice.

Respondents were asked to rate their own abilities across the SW learning outcomes before and after they had participated in the session. Participants in Story Worlds learning sessions generally perceived that their ability in relation to the SW learning outcomes had improved. This was most noticeable for:

- Understanding the principles of compassionate person centred care (7.7 – 8.6), in particular in how it relates to practitioners' own roles within maternity care services (7.1 – 8.5)
- Identifying opportunities to use strengths-based approaches in the delivery of maternity care (6.1 - 7.5)
- The delivery of inequalities sensitive maternity care (from 6.3 to 7.7)
- Identifying opportunities to support health behaviour change in the delivery of maternity care (from 7 to 8).

5.5.3.2 VLE learning sessions

Although 92% respondents expected the VLE resource to improve their practice in terms of providing compassionate care for patients, after using the VLE, only 85% agreed that it had improved their practice. Again this may be because the resource affirmed their current practice.
Respondents were asked to rate their own abilities across the VLE learning outcomes before and after they had participated in the session. Interestingly participants’ average scores were lower in relation to six outcomes in the post-session questionnaire – in particular in understanding the concept of person-centredness in relation to working practice (7.6 – 6.8). However, participants considered that they had improved their practice in relation to:

- Using an assets-based approach to improve health outcomes (5.7 – 6.6)
- Using available collective resources that promote the coping/decision-making abilities of women (6.2 to 6.4)
- Using available collective resources that promote the self-esteem of women (6.3 to 6.4).
6 Strategic stakeholder perspectives

6.1 Introduction

This chapter provides summary key stakeholder perspectives on:
- The learning materials
- Organisational barriers and enablers
- Compassionate Connections development and management
- Potential transferability.

Stakeholders were identified in discussion with NES, and participated in telephone interviews, see appendix D for details.

6.2 Perspectives on the learning materials

The Compassionate Connections materials comprised:
- Two Story Worlds which used a mixture of audio and visual slides to enable learners to explore the delivery of compassionate person centred maternity care through fictionalised drama.
- A virtual learning environment (VLE) which supports learners to understand person-centred approaches to maternity care, with a particular focus on smoking cessation.

6.2.1 Story Worlds

6.2.1.1 Nature of the resource

Strategic stakeholders all considered that the Story Worlds resources:
- Worked best in discussion-based groups
- Were realistic:
  - People really relate to the scenarios because they’re ‘real life’
  - It’s built on real relationships, the dynamics of conversations.
  - It’s based on real life events so you can connect with it at an emotional and professional level.
  - It’s a good education tool: I saw myself in some of the scenarios, and I saw things that would happen in units.
  - The bit that hits you is seeing yourself in it.
  - I think it’s really useful – the narrative approach is powerful.
  - It’s nice to get stuff that’s Scottish and that demonstrates health inequalities: it draws out issues of power and control. It’s good for this.
- Were non-judgemental
  - It doesn’t give a right or wrong answer – it gives a different approach.
  - It’s about talking about ‘hard to have’ conversations.
  - Showing examples of good and bad communication is a good way of role modelling.
  - SW shows compassion in action – it shows the gold standard. It’s personal stories illustrating how to act in a compassionate way. It compares good and bad practice;
practical hints, tips and strategies for providing assets based care. Then I can use reflection to develop learning and practice.

- You can get the point across in a very safe way – it’s a very safe resource for challenging the culture: it shows that things don’t need to be done that way. It’s supportive of staff and enables them to speak openly.

- Worked well because of their visual nature:
  - It’s visual – so it can be used in lots of different ways, to deliver multiple messages.
  - Its visual impact helps learning
  - Story Worlds is such a visual thing. It shows two different approaches and provides two different outcomes ... it allows staff to reflect upon their practice.
  - It’s very visual, it makes it real. It evokes a lot of emotion and debate among students.

Stakeholders were disappointed that the Story Worlds resources were not ‘a film’:

- I thought that [the Compassionate Connections resources] would be more fluid – like a soap opera. It’s very slow, with stills and voice-overs.
- I was disappointed that the Story Worlds resource was just storyboards and not a live play: I have to shut my eyes so that I can listen ... It would have more impact if it was an actual story.
- For the stories, I thought that there would be a narrator .. more story telling. I didn’t like it at first, but the dialogue draws you in.
- It’s a shame that it’s still – not in real time.
- It took me a while to get used to the clips – it’s not a film – but I got it eventually.

Technical issues also detracted from the potential usability and impacts of the resources:

- I couldn’t use the DVD at work – I had to use my husband’s laptop so that I could show it to midwives.
- It’s difficult accessing the online version – so the PDF version helps.
- The look of the CD needs to change – and it would be much easier to use if you could fast forward.
- You need to be very motivated to use the interactive PDF – but if there’s someone there to show you then that’s much easier.

Despite these technical issues, stakeholders considered that the Compassionate Connections resources were:

- Accessible:
  - It’s easily accessible
  - It’s very easy to use and adaptable.
  - It’s immediately assessable.
  - It’s easy to use – and engaging, attractive learning package, with a strong focus on improving communication.

- Flexible – which was perceived as both:
  - A strength
    - Its flexible – you can use it for a whole day or a bit of a session; with groups or with individuals.
The Story Worlds resource is very flexible and adaptable – everyone can take something from it.

The structure of the resource makes a difference: it gives you the power to take it and use it and apply it to practice.

And a weakness

It really jumps around and doesn’t address learning outcomes – so it’s difficult to follow and the book is confusing. I had to really look for the scenes that I needed for each learning outcome – it wasn’t clear. It would have been much easier if it had a clear structure, for example saying scene 1 relates to learning outcomes XYZ.

In terms of the content of the resources (see also section 6.6 below), stakeholders considered that it needs to include more specific content, including:

• It needs to focus on the transfer from midwife to health visitor, and from health visitor to nursery.
• The stories don’t include motivational interviewing.
• It deals with generalities in communication – but no specifics, for example open questioning and affirmation. The scenarios are about ‘being nice’.

Strategic stakeholders considered that it was very important to explicate the relevance of Compassionate Connections resources; in particular to:

• Explicitly connect Compassionate Connections to relevant local and national workforce development frameworks and initiatives:
  o If it was linked to the KSF\(^{28}\) it would help promotion – you need to have that currency. It would enable a conversation to take place if there was a need for a [staff member] to develop a competency).
  o It needs to be fitted into the effective practitioner framework for 5s and 6s\(^{29}\).
  o It could be mapped to the competency frameworks that the sectors use.
  o I was initially worried, but I’ve enjoyed using the resource. It needs to be tied into the themes more.
• Explicate the target learning levels:
  o I used it in a learning session with trainee GPs – I used a 10 minute clip. It was a mixed response: they were third year trainees, so all qualified doctors. They thought that it was aimed at a lower level, perhaps undergraduate medical students. I won’t use it with GP trainees again.
  o We used it with first year [undergraduates]– in a very descriptive way; and for third years at a level higher than SCQF 7, using it to critically analyse practice.
  o We can use it across all three undergraduate years.

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It’s not defined at any level – you just play a clip and then as the questions and then reflect. We target it to band 3 support workers who are already employed and new workers.

- Explicitly relate it to the target group:
  - We used the Story Worlds with a second year [student] group within a public health module on strengths based approaches to health promotion. I’ll use it again because it made students think about communication.
  - We’ve had similar things before, but it’s always difficult to get them to fit, so initially I was a bit hesitant.
  - It addresses the relevant policy drivers – it’s about documents that people know about but don’t understand: it brings the policy alive. It makes it tangible and relevant and makes staff a part of it – makes them feel part of the bigger picture.
  - It’s difficult to fit it into the other things that we have to do – this is important for selling it.

- Explicate individual relevance:
  - So it’s very versatile, but unless you actually see it, it’s difficult to understand it and how it can be used: it needs people to show how it’s relevant to me. This is the key challenge [for further implementation].

Strategic stakeholders considered that the Compassionate Connections workforce development resources were not a ‘standalone’ resource: they need to be linked in with other relevant workforce development resources and initiatives:

- In relation to the pre-registration curriculum:
  - Compassionate Connections gives you a hook to develop compassion as an integral part of the curriculum. It’s not assessed at all – but we could….
  - You can’t assess Compassionate Connections learning outcomes, but you can use it as a guide to learning outcomes – it really complements our learning and teaching strategies.

- I used one of the stories to help the group get into the spirit of motivational interviewing. It’s a good wee trigger.

- The resource isn’t a training programme: it’s a teaching resource, a trigger.

- It needs to be used to complement face-to-face training – and good face-to-face training. The resource is only a trigger – but this isn’t explicit. It needs to explicitly be located as part of the reflective learning cycle. It’s not a standalone resource.

- I thought about having a whole day [on CC] but I decided that the most effective way was to embed it in current courses, for example, mandatory updates, the SVQ on maternal and child wellbeing. We can use it as a resource to complement what we already deliver.

- It should be included as part of a full programme. We used it for 7 study days to cover all hospital midwives and women and children staff.

The flexibility of the Compassionate Connections resources is regarded as both its strength and its weakness. Strategic stakeholders see the role and skills of the facilitator as being key to successful implementation of the programme:

- The facilitator needs to be very skilled and adaptable.
• It [the Compassionate Connections programme] doesn’t lead into what specifically can I do to change my practice. So it needs back-up. It needs clear guidance to facilitators, and it needs to lead onto specific skills training. The Story Worlds leaves people a bit high and dry – what do they do next?

• Its weakness is that it’s hugely patient led … it doesn’t address issues of child protection and the need to step in to raise your concerns. It’s very subjective … and so it needs strong facilitation skills to ensure that the messages are the right ones.

Further issues identified by strategic stakeholders include:
• That it is time-consuming
  • They’re quite long, time intensive. So time may be an issue.
  • It’s very time consuming to use – it covers huge areas.
  • Time is limited, so I don’t have the luxury to use the whole programme.
• It will need to be constantly revisited and updated
• It can be perceived as patronising:
  o I’m not sure that it appeals to people who need it – the tone can be a bit patronising.

6.2.1.2 Views on / plans for the use of the resources

Strategic stakeholders consider that the Compassionate Connections resources could be helpful:
• In complementing induction and supervision of midwives:
  o Maternity care has to implement lots of new standards – so this could be very helpful.
  o I shared it with the Supervisors of Midwives group – and I’m keen that they use it in annual reviews with midwives. I’ve used it in 2 or 3 so far.
  o I’ll use it in the induction for new midwives to focus on professional behaviours, and in the light of the recent Scottish Maternity Care survey30.
  o There’s loads of similar tools addressing the same themes: you can use this as part of the suite of tools available. Staff are saturated, so that’s why we’ve combined it in one day with all the other tools.
• Addressing complaints in relation to staff attitudes
  o I’ve used it in complaints issues – dealing with someone who was really really angry and quite aggressive – and I stayed calm and played to her strengths. [Compassionate Connections] really complements assets based training.
  o In complaints people focus on things like dignity, staff attitudes … these are issues that were raised in the recent Scottish Maternity Care survey31
  o It’s helpful in dealing with complaints – especially about staff attitudes.

6.2.2 The VLE

Most strategic stakeholders had not encountered the VLE. Those who had seen it considered that:

- It was better suited to individual use than groups – perhaps because of IT issues:
  - Some things don’t work with the VLE – the writing doesn’t work on a big screen: it’s perfect on a PC. Some bits of dialogue are too long. I’m not sure that the avatars look real.
- It was novel, and perhaps best suited to confident learners:
  - With the VLE people need to be confident about learning in alternative ways.
  - I was surprised that there were still photos in the VLE – but this was because I didn’t know what to expect: VLE was beyond my experience. I thought that it would maybe be a cartoon.
- The information was good
  - Learners tell me that they keep going with the VLE because the information is good. I don’t think that it could work without the avatar – it catches people’s attention, it makes it interesting
- It suited a certain level (and perhaps that should be made explicit):
  - I showed the avatar to a couple of girls – they thought that it was really condescending and stilted. It’s maybe more of an undergraduate tool.

6.3 Perspectives on organisational barriers & enablers

Strategic stakeholders identified the following key organisational factors:

- Management support at Board level
  - You need support [to implement CC] at a local level – our education lead is supportive.
  - You need the right infrastructure for implementation – and the NES team is an important part of that – but you need support at the local level as well.
  - Boards need to take ownership.
  - It’s difficult to get management to allow time for people to use the resource.
Here stakeholders recognise the importance of getting the Compassionate Connections programme explicitly mentioned in operational (if not strategic) plans in order to secure management support with concomitant (at least time) resources.

- Local ownership
  - I’d like Compassionate Connections to be owned by the team leads – so that they use it as a resource that they deliver themselves.
  - There needs to be the involvement of the local health improvement department – because health improvement is the key point for using the resources.
  - It needs people working at a local level to implement it.
  - It needs champions who are steeped in to run it at the local level – it needs peer support, not NES parachuting in. A few people skilled in delivery – and this is a big challenge.

- Resources and staff capacity
  - The key issue is staff capacity to support the use of the programme
  - Time and money [are the future challenges]
I’d like to use this for training for all named persons [GIRFEC] … we’d need a whole day, but this is a big commitment and I’d need sign-off from my management team.

It can be difficult to allocate resources to using it – that’s where it’s helpful to link it with things like GIRFEC. It would also be good if it was linked to eKSF and PDPs.

The challenge is capacity – physically getting people together [to use it].

Making Compassionate Connections a part of mandatory update/training

I’d like to make it part of the mandatory annual update

I hope to build the DVD into registered nurse and midwife induction. I’ve selected which scenes to use.

We’re thinking about using it as a part of health visitor training on GIRFEC. We’re thinking about the development of a learnpro module on this – but I haven’t done a business case to management yet.

We bolted Compassionate Connections onto the mandatory record keeping sessions.

6.4 Perspectives on development & management

Strategic stakeholders identified the following summary views on the development and management of the Compassionate Connections programme:

- It needs to be adopted by the clinical area … and for that to happen we need to acknowledge that practice is not as compassionate as it should be. Compassionate practice is a very personally sensitive issue for staff.
- It needs to be effectively targeted.
- There needs to be follow-through: the introductory sessions need to support the delivery of the story world sessions.

6.5 Perspectives on potential transferability

All stakeholders recognised the potential transferability of the Compassionate Connections programme to other areas. In particular, the generic nature of the programme was noted:

- Its relevance is wider than maternity care – it’s about dealing with people
- It’s really relevant to Francis, health and social care integration.
- It’s really helpful on professional behaviours – even for band 2s.
- It’s not just a maternity tool – the scenarios are transferable, especially if different staff – nurses, medics – are used in the scenarios.
- Midwives have a lot of tools, assessments, inquiries to carry out: It’s all about the public role of the midwife – which is not just about the midwife; it’s about the wider workforce. It’s a whole new way of thinking about things. It fits with patient safety, the quality strategy, everything… Compassionate Connections needs to be clearly linked with the new model of maternity care.
- In midwifery we often take things from nursing – here midwifery can take the lead!
- It’s useful for any people dealing with patient face-to-face, not just nurses and midwives, but receptionists, GPs, domestic staff.

Some stakeholders saw Compassionate Connections as particularly relevant to specific national programmes/initiatives:
• GIRFEC
  o I could see where the [CC] tools would fit in well with GIRFEC, so I piloted a Compassionate Connections session on GIRFEC and then did a 4 week follow-up reflection session. We’d done training on GIRFEC before, but it wasn’t ‘real’: Story Worlds really helped to make it real and to develop the GIRFEC practice model. The learners have come back now and said that ‘what we need now is more on the paperwork’ [ie not compassion].
  o We’ve built it in as a resource when planning for the unborn child especially in the drug and alcohol field.
  o Built into the [NHS Board’s] GIRFEC strategy group – they’re taking things forward in terms of partnerships and joint working

• Early Years
  o I’d like to use it as an Early Years Collaborative test of change – we need another year of ongoing evaluation including as an Early Years Collaborative test of change – before we can see any added value.

• Family Nurse Partnership
  o The Family Nurse Partnership builds on a strengths based approach, seeing that even in the most dismal circumstances you can still get a positive outcome. Compassionate Connections is a resource that can encourage staff to look for positive outcomes.

• Breast feeding standards
  o Compassionate Connections is maybe a vehicle for staff to use when implementing the new BFI (Baby Friendly Initiative) standards32.
  o We may write up the Compassionate Connections session as a test of change for implementation of BFI [Baby Friendly Initiative] standards33.

• Gender Based Violence
  o Compassionate Connections could be used as a test of change in relation to routine inquiries about gender based violence.

6.6 Stakeholder perspectives on future development

Engaged stakeholders were optimistic about future of the Compassionate Connections resources; they did, however point to the following key areas for consideration in future development:

• The IT infrastructure:
  o Hopefully it will eventually go online and then we can signpost midwives to particular parts.
  o It could become a learnpro module, and annually updated with new stories, scenarios and key topics eg obesity.

• The need for ongoing updating and relevance checking:
  o It’s new and interesting materials – but I’m not sure how long the newness will last. It needs to be developed further otherwise people will get fed up with it.
  o I worry about sustainability – it will wear out quite quickly.

• Effective focus / targeting:

32 http://www.unicef.org.uk/babyfriendly/
33 http://www.unicef.org.uk/babyfriendly/
It needed to be properly targeted with HEIs and clinical practice – student might get it as students and then again in practise.

It needs to be focused to identify when it is appropriate to use it to avoid overkill.

6.7 Summary

The implementation of the Compassionate Connections resources focused on the Story Worlds materials: most stakeholders had not heard of the VLE.

The Story Worlds resource was considered to be:
• Best for discussion-based groups
• Realistic, relevant and non-judgemental
• Accessible and flexible

The visual, story-based format worked well for participants’ learning; but technical problems were an issue.

Furthermore, the generic nature of the content of the resources was also an issue – being both strength and a weakness:
• A strength because it provides complementary content/learning to other person-centred workforce initiatives
• A weakness because it has no clear locus: this really needs to be explicated at national and local levels to ensure that the programme has relevance.
7 Wider stakeholder perspectives

The evaluation team shared headline findings with participants at the national stakeholder conference on the Compassionate Connections programme in February 2014 (see appendix F for programme and participant list). Participants were then engaged in groupwork to consider the findings (see appendix Fii for groupwork guidance) and to:

- Identify tangible outcomes of the programme by April 2015.
- Consider how NHS Boards can be supported to use the Compassionate Connections resources.
- Identify one key consideration for future implementation of the Compassionate Connections resources.

Participants noted the following outcomes for the learner

- Wider and deeper access to the Compassionate Connections resources, in particular
  - Access through e-learning
  - As part of induction
  - Through pre-registration training
  - Developed links with other resources and frameworks
  - Incorporate into existing mandatory training i.e. mentor updates - 20 minutes on Compassionate Connections

- Enhanced practice and concomitant confidence:
  - Confidence in 'raising the issue'
  - Enabled to use assets based approaches
  - Improved communication across and between professions
  - Increased ability for reflection/insight into how practice impacts on work colleagues/families
  - Increased job satisfaction
  - Increasing confidence of staff in caring for people holistically
  - More able to pull relevant information together to help service-user
  - More engagement - better use of time
  - Understanding how this pulls agendas together (20:20, Person-centred, GIRFEC)
  - Staff able to have courageous conversations using assets-based approach, and discuss issues/practice skills safely

- Enhanced knowledge:
  - Deeper exploration of issues
  - Raised awareness of impact of broader determinants of health

Participants noted the following outcomes for the service-user

- Better relationships with healthcare practitioners
  - A more person-centred, therapeutic relationship
  - Responsive relationships
  - Non-judgemental approach
  - Individuals all feel respected
  - Feeling supported
Feeling valued and listened to
Building levels of trust, control, self-efficacy, social cohesion, honesty during sessions
Caring conversations become the norm across all professions

- Better experience and engagement
  - Continuity from professionals involved with service-users
  - Earlier and continued engagement
  - Increased engagement with services by women - especially in more vulnerable groups
  - Involvement in care planning
  - More 'seamless' approach
  - Person-centred care
  - Improved patient experience
  - Reduction in complaints? Particularly about professional behaviour and communication
  - Seamless person-centred care

- Improved health outcomes
  - Improved engagement with services leading to opportunities for more health and well-being improvement
  - Improved outcome - long term - for child/children
  - Positive behaviour changes (reduced smoking rates)

- Improved personal outcomes
  - Increased confidence to cope
  - More empowered
  - Feeling respected/cared for
  - Promotion of strengths-based approach to care
  - Reduce health inequalities
  - Reduced reliance on agency support

Participants noted the following outcomes for organisations:

- Improved efficiency
  - Appropriate referrals to other services
  - Fewer complaints
  - Improved partnership working
  - Fewer defaulting appointments
  - Lower staff turnover

- Enhanced workforce capabilities, confidence and motivation
  - Better informed workforce
  - Better skilled workforce
  - Increase staff motivation
  - Increased staff confidence in care provision
  - Staff feel invested in and supported

- More compassionate organisational culture
  - Compassion between and within levels of staff and staff groups
  - Change in culture
  - Client centred culture for organisation
  - Culture of care
• Improved culture and behaviour
• Improved culture within workplace

• Making the connections from Compassionate Connections:
  o Linking with other person-centred programmes i.e. Person-centred, Safety programmes, GIRFEC, EYC
  o Links with KSF
  o Working towards Francis report re: communication

Participants considered that the following could support NHS Boards to use the resources:
• Resources/capacity building – in particular for facilitation
  o Facilitation skills for key people (trainers/PEFs)
  o Facilitators training without costs
  o Capacity
  o Funding
  o Allowing time - facilitators training
  o Releasing staff to complete training
  o Reduced reliance on external NES team to facilitate learning opportunities

• Structured organisational support for the resources:
  • Senior management and strategic support
  • Designated lead
  • Champions with dedicated time to run sessions
  • Having local champions to embed at every level or organisation

• Information technology
  • Adequate IT infrastructure
  • IT access
  • IT support

• Building it into structured staff development/supervision
  • Annual supervision
  • PDPs
  • Clear links with KSF

• Demonstrating how Compassionate Connections relates to other resources/programmes/initiatives
  • Assist boards to recognise how the resource can be used to meet learning needs within a variety of contexts.
  • Link to other agendas i.e. Quality strategy, GIRFEC
  • Linking in with other initiatives and training on engaging and collaborating with clients
  • Linking with health promotion and other person-centered initiatives
  • Use the Early Years Collaborative networks as a means of spreading Community Planning partnerships

Participants identified the following key considerations for future implementation:

• Organisational integration
  • It needs to be rolled out across health and social care as it cuts across both areas of work.
• The values and principles of Compassionate Connections need to be embedded across NHS culture before staff can use it. There needs to be a top down approach with everyone respecting each other and treating each other with compassion. If you treat staff well they will in turn treat others well.

• You need multi-professional involvement – this is key – so reaching out to paediatricians, social work, and so on. This goes way beyond midwives, and should span across health and social care.

• You need professional engagement and leadership, and this leadership has to come from the top down so that it can become embedded in culture at Board level.

• We would be keen to see Compassionate Connections rolled out with promotional training, using a multi-agency approach to implementation.

• This resource should be rolled out across Boards, including through voluntary agencies. It needs both top down and bottom up approaches though, and sustained funding.

• We should try and avoid the ‘train and hope’ or ‘spray and pray’ approach to training. Both ongoing support (for staff involved in delivery) and follow up (longer term evaluation) will be necessary.

• Consideration should be given to organisational culture. There are a number of issues related to person-centred outcomes – how do we give them as much credibility as other, ‘hard’ outcomes. Also, leadership needs to be near the point of delivery and not remote.

• Boards will need to ensure that there is good enough IT access, time for attendance and overall capacity for implementation.

Connections with other resources/initiatives

• There needs to be careful consideration of how Compassionate Connections links to GIRFEC – we need to engage with other groups and link this in with other resources so it’s not seen in isolation.

• We think that the key consideration is one of integration – both across all workstreams (for example early years, person-centred) and across all relevant disciplines.

• The Continuous Improvement Model (PDSA) should be utilised to address issues of longevity.

7.1 Summary

Participants at the national conference identified the following tangible outcomes for the programme by April 2014:

• For learners:
  o Wider and deeper access to the Compassionate Connections resources
  o Enhanced practice and confidence
  o Enhanced knowledge

• For service-users:
  o Better relationships with healthcare practitioners
  o Better experience and engagement with healthcare
  o Improved health outcomes
  o Improved personal outcomes
• For organisations:
  o Improved efficiency
  o Enhanced workforce capabilities, confidence and motivation
  o A more compassionate organisational culture
  o Making the connections from the Compassionate Connections programme and other relevant programmes, policies and learning/workforce development frameworks.

The following areas of support for NHS Boards in using the Compassionate Connections resources were identified:
• Resourcing
• Capacity building for facilitation
• Strategic support/champions
• IT
• Building Compassionate Connections into structured staff development/supervision
• Demonstrating how the resources relate to other resources/programmes/initiatives
8 Conclusions

The Compassionate Connections workforce development pilot programme was designed to test the implementation and impacts of educational resources comprising:

- Two Story Worlds which use a mixture of audio and visual slides to enable learners to explore the delivery of compassionate person centred maternity care through fictionalised drama.
- A virtual learning environment (VLE) which supports learners to understand person-centred approaches to maternity care, with a particular focus on smoking cessation.

Compassionate Connections programme aimed to enable participants to achieve the following learning outcomes:

- Demonstrate knowledge of the impact of health and social circumstances on engagement with services and on clinical outcomes.
- Work collaboratively with women, their families, colleagues and other health and social care agencies.
- Identify opportunities to support health behaviour change and use strengths based approaches in the delivery of inequalities sensitive maternity care.
- Understand the importance of flexible person centred risk-management to improving health and clinical outcomes.
- Understand the principles of compassionate person centred care and how these relate to your own role within maternity care services.
- Critically reflect on the issues raised in the Compassionate Connections resource and how these impact on your own contribution to improving maternal, newborn and infant health and well-being.

Implementation engaged six NHS Boards across Scotland and the three HEIs which deliver pre-registration midwifery programmes in Scotland. NES appointed four (3.5 WTE) Practice Educators to support implementation. The evaluation ran in parallel with implementation, designed to provide formative as well as summative input. Implementation ran from September 2013 to March 2014.

Implementation centred on the delivery of events (meetings, workshops, lectures – collectively referred to as ‘sessions’) designed to introduce and pilot the programme:

- Awareness-raising sessions, designed to introduce the programme resources to a very wide range of strategic and operational stakeholders. These sessions often opportunistically ‘piggy-backed’ onto existing and/or scheduled meetings and events to make the best use of time.
- Introductory sessions, designed to introduce the programme to staff who had the potential to run Story Worlds learning sessions with their own clinical teams or colleagues (‘introductory’ ‘facilitators’ or ‘train-the-trainers’ sessions).
- Story Worlds learning sessions, designed to use the Compassionate Connections resources within a learning context with relevant staff or students (SW1). These sessions were followed up with a Story Worlds reflection session (SW2), to engage learners in reflecting on
how they had made use of their learning in practice, since attending the Story Worlds session.

- Virtual Learning Environment (VLE) learning sessions, designed for individuals or groups to access and learn through the VLE.

Our conclusions are structured so as to relate explicitly to the evaluation specification (see section 8)

### 8.1 The educational methods and media

The implementation of the Compassionate Connections pilot programme focused on the Story Worlds materials: most stakeholders interviewed had not heard of the VLE. The Story Worlds resource was considered by both stakeholders and learners to be:

- Best for discussion-based groups
- Realistic, relevant and non-judgemental
- Accessible and flexible
- High quality

The visual, story-based format worked well for participants’ learning; but technical problems were an issue.

The literature on narrative pedagogy shows that this approach can be useful in developing critical thinking and reflection with health care staff, particularly around challenging, complex or sensitive areas of practice, providing a ‘safe environment’ to consider these issues. The use of digital approaches and multimedia have been reported as advantageous in terms of enhancing authenticity and fidelity.

### 8.2 Extent to which the learning materials have enabled the learners to achieve the learning outcomes

Most sessions provided outwith HEIs were facilitated by the Compassionate Connection Practice Educators. Learning sessions were delivered in relation to both the SW and the VLE resources: specific learning outcomes for sessions were developed by the PEs as appropriate to their target participants.

The learning outcomes were not assessed in any formal way – with the SW2 (reflection) session providing an informal opportunity to reflect on the achievement of learning outcomes; however, attendance at these sessions was low. The session participant survey provided an opportunity to elicit individual perspectives on their achievement of the learning outcomes.

Participants in Story Worlds learning sessions generally perceived that their ability in relation to the SW learning outcomes had improved as a result of the learning session. This was most noticeable in relation to:

- Understanding the principles of compassionate person centred care, in particular in how it relates to practitioners’ own roles within maternity care services
• Identifying opportunities to use strengths-based approaches in the delivery of maternity care
• The delivery of inequalities sensitive maternity care
• Identifying opportunities to support health behaviour change in the delivery of maternity care

Participants in VLE learning sessions considered that their ability in relation to the VLE learning outcomes had improved in relation to:
• Using an assets-based approach to improve health outcomes
• Using available collective resources that promote the coping/decision-making abilities of women
• Using available collective resources that promote the self-esteem of women.

8.3 Extent to which participants feel able to apply the outcomes to practice

The timescales for the evaluation of the pilot programme made it impossible to make any effective evaluation of the extent to which participant felt able to apply the learning outcomes of the Compassionate Connections resources in practice. Nevertheless, almost all (90%) participants in Story Worlds learning sessions expected that it would improve their practice in terms of care and compassion towards women and families; however, around one fifth of respondents did not intend to change their practice as a result of the SW learning session. This may have been because the session was experienced by some participants as affirming their practice.

Similarly, almost all (92%) participants in a VLE learning session expected it to improve their practice in terms of providing compassionate care for patients.

The evaluation of the pilot programme provides the potential to develop more longitudinal evaluation of impacts on practice, for example by following up case studies and/or individuals who participated in the learning sessions.

8.4 User and stakeholder perceptions

Users and stakeholders were fairly optimistic about the potential positive impact on practitioners' ability in relation to Compassionate Connections learning outcomes, whilst recognising that it was too early to see the impact.

Stakeholders interviewed considered that the generic nature of the content of the resources was both a strength and a weakness:
• A strength because it provides complementary content/learning to other person-centred workforce initiatives.
• A weakness because it has no clear locus: this really needs to be explicated at national and local levels to ensure that the programme has relevance.

Stakeholders and participants noted that there are other available educational resources around compassionate person centred care; and other feedback mechanisms in place for staff around the delivery of compassionate person centred care.
8.5 Potential transferability of learning resources

The literature on narrative pedagogy shows that the use of narrative and stories has been successful across a range of contexts, in particular in relation to health promotion (across diverse groups). Within health professions education, the use of narrative is often focused towards developing individuals’ knowledge or competence with regard to ‘sensitive’ areas of practice, including compassionate care, emotionally challenging practice, and developing empathy.

Stakeholders interviewed pointed to the relevance of the Compassionate Connections programme to wider health and social care workforce groups, and to national programmes/initiatives, notably:

- GIRFEC
- The Early Years Collaborative
- The implementation of the new Baby Friendly Initiative standards.

They did, however, note that it would be important to explicate the relevance of the Compassionate Connections programme to other workforce groups, programmes and initiatives.

8.6 Development and management of the pilot programme

The pilot programme was implemented by a NES team of Practice Educators (PEs) in partnership with early implementer Boards and the three HEIs delivering pre-registration midwifery education in Scotland. It centred on the promotion of the Compassionate Connections resources through ‘sessions’ of three types: awareness raising sessions, ‘train-the-trainers’ sessions, and learning sessions.

The NES Compassionate Connections team went to significant effort to engage as many stakeholders as possible. This succeeded in reaching strategic and senior staff in awareness-raising sessions; and in engaging relevant staff (i.e. those with an education remit) in introductory sessions.

Midwifery and maternity-related staff were well represented in Story Worlds learning sessions, with pre-registration students being best able to attend reflection (SW2) sessions. The VLE resource was not promoted as strongly as the SW resource, and was delivered mainly to students and/or through individual sessions.

Strategic stakeholders considered that the provision of strong, skilled facilitators was a key factor in the successful implementation of the Compassionate Connections programme – in particular to make the links/connections with other relevant policies, initiatives and workforce development frameworks: some considered that this should be at a national level and independent of the territorial NHS Boards, others considered that this should be retained at local levels.

The NES PE team was seen as playing a key role in promoting/marketing the Compassionate Connections resources, with some stakeholders considering that the NES focus was too much on promotion and less on effective delivery.
8.7 The Practice Educator role

The key role of the Compassionate Connections PEs\textsuperscript{34}, was seen by stakeholders and PEs themselves as the promotion/marketing the Compassionate Connections resources. Successful promotion of the resources was perceived as requiring three main attributes:

- ‘Belief’ in the ‘message’ of the resources
- Skills in stakeholder management and brokerage. This was facilitated by:
  - Having identified ‘champions’ at Board level.
  - Being able to access relevant networks
  - Being able to explicate the relevance of the resources and the links that they have with key national frameworks – such as the KSF – and other key resources and initiatives.
  - Being able to demonstrate the relevance of the resources
  - Fitting in with what’s already there
- Facilitation of many different and complex groups to address the same issues. This required:
  - Clarity of the purpose.
  - Significant knowledge in addition to midwifery clinical practice
  - The development of an approach to assure the integrity of the Compassionate Connections message

8.8 The 2012 learning needs analysis

The 2012 learning needs analysis identified a range of core competencies required to support implementation of the Refreshed Framework, which were mapped to those developed through other relevant training programmes, including the Family Nurse Partnership (FNP) training programme and GIRFEC multi-agency training. It recommended that NES consider the development of training and development related to the Continuous Learning Framework for Social Services and the FNP programme; both of which demonstrated a good fit with the core competencies required to implement the Refreshed Framework.

The learning needs analysis also identified a number of factors that contribute to effective training for the maternity care workforce, recommending that training activities and resources must be flexible, accessible, and meeting the following core components:

- Using a blended approach (i.e. interactive group based learning, supplemented with online resources, opportunities to continue/take forward learning (e.g. resource pack to take away and share with colleagues), a range of tools (e.g. DVD resources, scenarios, tutor led discussion, group work and reflection)
- Multi-disciplinary training (i.e. include profession specific elements so that the training feels relevant, develop shared understanding of the roles and remit of different groups in the workforce)
- A staged approach (i.e. provision of background information)

\textsuperscript{34} Detailed findings in relation to this aspect of the evaluation have been provided to NES as a separate confidential appendix. This is because the PE team is very small, and easily identifiable. It is not appropriate to provide such personalised data in an evaluation report such as this.
• Self-assessment of learning needs (i.e. benchmarking of knowledge, skills, values and attributes, training sessions, reflection – mentoring, coaching and reflective logs, follow up)

• Quality (i.e. high quality resources, skilled facilitators, relevance to practice)

The Compassionate Connections workforce development pilot programme was structured around generic learning outcomes – rather than competencies. This evaluation indicates that the generic nature of the content of the resources was also both a strength and a weakness:

• A strength because it provides complementary content/learning to other person-centred workforce initiatives - such as GIRFEC.

• A weakness because it has no clear locus: this really needs to be explicated at national and local levels to ensure that the programme has relevance.

The pilot programme used a blended approach to deliver multi-disciplinary training – with some tailoring to specific target audiences (eg in relation to GIRFEC). It offered resources that were regarded as very high quality – but which needed to be delivered through highly skilled, knowledgeable and consistent facilitation. It was designed to facilitate reflective learning and practice, but provided no benchmarking of knowledge, skills, values and attributes – for example in relation to the KSF or the Continuous Learning Framework for Social Services.
9 Recommendations

The implementation of the pilot programme has succeeded in significantly raising awareness of the Compassionate Connections resources. The positive response to this will support further implementation – and it may also necessitate some demand management. The pilot programme has also enabled the implementation team to ‘test’ the resources in a wide variety of different contexts, and with a wide range of stakeholders and learners. The evaluation findings show that the resources are valued, and that there is an anticipated impact on practice. In order to maximise that anticipated impact, we propose the following recommendations:

1. **Focusing implementation** ...
   ... by doing less awareness-raising; and more capacity building (i.e. through training-the trainers) at Board level.

2. **Making the connections** with Compassionate Connections explicit; notably in relation to:
   a. Other programmes/initiatives/resources at local and national levels
   b. Career development structures and frameworks
   This will demonstrate the relevance of the programme, and help to:
   - Sharpen learning outcomes
   - Secure strategic/management support/buy-in to the programme by showing how it can support the achievement of strategic outcomes.

3. **Addressing the use of the VLE**:  
   Significant investment has already gone into this resource. The pilot programme did not strongly promote it; nevertheless, the evaluation has indicated that learners like it – particularly in terms of the quality of its information.

4. **Demonstrating impacts on practice**...
   ... by building capacity for ongoing self-evaluation; and light touch external evaluation to support self-evaluation and provide programme level independent evaluation. Findings should be disseminated so as to provide ongoing feedback to Boards on impacts, which in turn will support the sustainability of the programme.
10 Appendices

A. Session questionnaires
B. Case study template
C. Interview topic guide
D. Interviewees
E. Session information analysed
   i. Target groups
F. Compassionate Connections National Workshop 25th February 2014
   i. Programme
   ii. Groupwork
G. Compassionate Connections Implementation and Planning Event 3rd September 2013
   i. Programme
   ii. Groupwork
Compassionate Connections stakeholder questionnaire

Introduction

Compassionate Connections is a programme of work supported by NHS Education for Scotland (NES) and NHS Health Scotland to support the implementation of the Refreshed Framework for Maternity Care in Scotland (2011) and Improving Maternal and Infant Nutrition - a Framework for Action (2011).

NES has commissioned SMCI Associates with PCA Consulting Ltd to evaluate two pilot learning resources:

- Two fictionalised story worlds
- A scenario based virtual learning environment

This short questionnaire is part of the evaluation. It will take you no more than 10 minutes to complete, your responses are confidential.

SMCI Associates is registered under the UK data protection act 1998: our registration number is Z1092649.

If you have any questions about the evaluation, please contact Dr Sheila Inglis (Director, SMCI Associates) sheila@smciassociates.com. If you have any questions about the Compassionate Connections programme, please contact Sandra Smith, Educational Projects Manager, NES, Sandra.smith@nes.scot.nhs.uk

Please tell us where you are employed / studying:

• NHS Highland
• NHS Fife
• NHS Glasgow
• NHS Tayside
• NHS Lothian
• NHS Lanarkshire
• Robert Gordon University
• Napier University
• University of the West of Scotland
• Other
• NHS Borders

If you chose "other", please provide details below:

Please provide details regarding your role:

Main area of practice (e.g. Midwifery, Nursing etc)  
Job Title

Please tell us how you know about Compassionate Connections

Please tick all that apply

☐ There was a presentation about Compassionate Connections at a meeting / event that I attended
☐ I went to a specific meeting about Compassionate Connections
Please tell us about your perception of the Compassionate Connections resources, by telling us about how much you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>I really like the Compassionate Connections resources and anticipate that staff will engage with and learn from them</td>
<td>○</td>
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<td>I don't think that digital / virtual resources are helpful in developing staff understanding and knowledge</td>
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<td>I think that the story worlds accurately reflect real life scenarios</td>
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<td>I think that the reflective process used in the resources is appropriate to meet the learning outcomes</td>
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<td>I think that the use of stories is a useful learning approach</td>
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<td>I think that the story worlds will help the maternity care workforce to make effective cross sector links</td>
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<td>I think the story worlds learning resource will be useful to disciplines beyond the maternity care workforce</td>
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<td>I believe that practitioners / students should have 'protected' time built into their work schedule / timetable to use these resources</td>
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<td>I don't feel there will be much organisational support for the story worlds resources</td>
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Are you aware of any other formal educational sessions / CPD around compassionate person-centred care?
Are you aware of any existing feedback mechanisms for practitioners in terms of their ability to deliver compassionate person-centred care?

- Yes (please provide details) ________________
- No
- Don't know

How effective do you think that the Compassionate Connections resources will be in having a positive impact on practitioners’ ability in the following areas (1=no anticipated impact on practice / 10=substantial impact on practice):

1. Knowledge of the impact of health and social circumstances on engagement with services.
   - No impact on practice

2. Knowledge of the impact of health and social circumstances on clinical outcomes.
   - No impact on practice

3. Working collaboratively with women, their families, colleagues, and other health and social care agencies.
   - No impact on practice

4. Working collaboratively with colleagues.
   - No impact on practice
How effective do you think that the Compassionate Connections resources will be in having a positive impact on practitioners' ability in the following areas (1=no anticipated impact on practice / 10=substantial impact on practice)?

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<thead>
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<th>Area</th>
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<tr>
<td>(v) Working collaboratively with other health and social care agencies.</td>
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<td>(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.</td>
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<td>(vii) Identifying opportunities to use strengths based approaches in the delivery of maternity care.</td>
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<td>(viii) The delivery of inequalities sensitive maternity care.</td>
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(ix) Understanding the importance of flexible person centred risk management to improve health and clinical outcomes.

0 1 2 3 4 5 6 7 8 9 10

No impact on practice

(x) Understanding the principles of compassionate person centred care.

0 1 2 3 4 5 6 7 8 9 10

No impact on practice

(xi) Understanding how the principles of compassionate person centred care relate to practitioners' own roles within maternity care services.

0 1 2 3 4 5 6 7 8 9 10

No impact on practice

(xii) Critically reflect on practice issues.

0 1 2 3 4 5 6 7 8 9 10

No impact on practice

Please provide any additional comments here

________________________________________________________________________
________________________________________________________________________
Many thanks for your time. Please click 'submit' to save your responses.
Evaluation of the NES Compassionate Connections Educational Resources

Compassionate Connections is a programme of work supported by NHS Education for Scotland (NES) and NHS Health Scotland to support the implementation of the Refreshed Framework for Maternity Care in Scotland (2011) and Improving Maternal and Infant Nutrition - a Framework for Action (2011).

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If you have any questions about the Compassionate Connections programme, please contact Sandra Smith, Education Programmes Manager, NES sandra.smith@nes.scot.nhs.uk.

Your personal information will be kept confidential within the evaluation team unless you give consent otherwise.

Please provide your full name

____________________________________

Please tell us where you are employed / studying:

- NHS Highland
- NHS Fife
- NHS Glasgow
- NHS Tayside
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- NHS Lanarkshire
- Robert Gordon University
- Napier University
- University of the West of Scotland
- Other

If you chose "other", please provide details below:

________________________________________________________________________

Please provide details regarding your role:

Main area of practice (e.g. Midwifery, Nursing etc)

____________________________________

Job Title

____________________________________

Please tell us your AfC band:

If you chose "other", please provide details below:

________________________________________________________________________
Now that you’ve heard about the Compassionate Care learning resources, please tell us about your expectations about them

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- Other

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<tr>
<th>Expectation</th>
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I don’t feel there will be much organisational support for the story world’s resource.

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Are you aware of any other formal educational sessions / CPD around compassionate person-centred care?

- Yes
- No
- Don't Know

Please provide details:

---

Are you aware of any existing feedback mechanisms for practitioners in terms of their ability to deliver compassionate person-centred care?

- Yes
- No
- Don't Know

Please provide details:

---

From the information given during this session regarding the Story Worlds resource, how effective do you think they will be in having a positive impact on practitioners' ability in the following areas: (0=No impact on practice / 10=Substantial impact on practice)

(i) Knowledge of the impact of health and social circumstances on engagement with services.

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No impact on practice

(ii) Knowledge of the impact of health and social circumstances on clinical outcomes.

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No impact on practice

(iii) Working collaboratively with women, their families, colleagues and other health and social care agencies.

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No impact on practice
From the information given during this session regarding the Story Worlds resource, how effective do you think they will be in having a positive impact on practitioners' ability in the following areas: (0=No impact on practice / 10=substantial impact on practice)

(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.

No impact on practice
(viii) The delivery of inequalities sensitive maternity care.

No impact on practice

(ix) Understanding the importance of flexible person centred risk-management to improving health and clinical outcomes.

No impact on practice

(x) Understanding the principles of compassionate person centred care.

No impact on practice

(xi) Understanding how the principles of compassionate person centred care relate to practitioners own roles within maternity care services.

No impact on practice

(xii) Critically reflect on practice issues.

No impact on practice
MANY THANKS FOR YOUR TIME

PLEASE PRESS "SUBMIT" TO ENSURE YOUR ANSWERED ARE SAVED BEFORE EXITING THIS SITE.
Compassionate Connections: Pre-Session Questionnaire for the Evaluation of the Story World Learning Sessions

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• Napier University
• University of the West of Scotland
• Other

If you chose "other", please provide details below:

Please provide details regarding your role:

Main area of practice (e.g. Midwifery, Nursing etc)

Job Title

Please tell us your AfC band:

If you chose "other", please provide details below:
• 1
• 2
• 3
• 4
• 5
• 6
• 7
• 8
• 9
• Other

Please tell us your age group

☐ 16-25 years
☐ 26-35 years
☐ 36-45 years
☐ 46-55 years
☐ 56-65 years
☐ 65+ years

Have you ever used stories as a learning tool before?

☐ Yes
☐ No
☐ Don't know

Please tell us about your expectations about the Story Worlds session telling us about how much you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>I am looking forward to this learning session</td>
<td>○</td>
<td>○</td>
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<tr>
<td>I expect this session to improve my practice in terms of care and compassion towards women and their families</td>
<td>○</td>
<td>○</td>
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<tr>
<td>I regularly use e-learning resources</td>
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<tr>
<td>I enjoy using reflection during learning sessions</td>
<td>○</td>
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<tr>
<td>I find group discussion a helpful way to learn</td>
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<tr>
<td>I hope the story worlds will accurately reflect real practice</td>
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</tbody>
</table>

Have you had any other formal educational sessions / CPD around compassionate person-centred care?

Please provide details:

• Yes
• No
• Don't Know

_____________________________
Have you ever received feedback on your ability to deliver compassionate person-centred care?

- Yes
- No
- Don't Know

Please give details including how often:

Was the time for this session scheduled into your working day (i.e. ‘protected time’ at work or study timetable at University)

- Yes
- No
- Don't Know

Please state how often you get protected time during work (NHS Staff only)

Please rate your own ability in the following areas (1=very poor / 10=Excellent)

(i) Knowledge of the impact of health and social circumstances on engagement with services.

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No impact on practice

(ii) Knowledge of the impact of health and social circumstances on clinical outcomes.

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No impact on practice

(iii) Working collaboratively with women and their families.

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No impact on practice

(iv) Working collaboratively with colleagues.
<table>
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<tr>
<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(v) Working collaboratively with other health and social care agencies.

<table>
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<tr>
<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.

<table>
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<tr>
<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(vii) Identifying opportunities to use strengths based approaches in the delivery of maternity care.

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<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(viii) The delivery of inequalities sensitive maternity care.

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<tr>
<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

Please rate your own ability in the following areas (1=very poor / 10=Excellent)

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<tr>
<th>Substantial impact on practice</th>
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</table>

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.

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<thead>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(vii) Identifying opportunities to use strengths based approaches in the delivery of maternity care.

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<th>Substantial impact on practice</th>
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</table>

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice

(viii) The delivery of inequalities sensitive maternity care.

<table>
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<tr>
<th>Substantial impact on practice</th>
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| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No impact on practice
(ix) Understanding the importance of flexible person centred risk-management to improving health and clinical outcomes.

No impact on practice 0 1 2 3 4 5 6 7 8 9 10

(x) Understanding the principles of compassionate person centred care.

No impact on practice 0 1 2 3 4 5 6 7 8 9 10

(xi) Understanding how the principles of compassionate person centred care relate to your own role within maternity care services.

No impact on practice 0 1 2 3 4 5 6 7 8 9 10

(xii) Critically reflecting on practice issues.

No impact on practice 0 1 2 3 4 5 6 7 8 9 10

Please state THREE things that you would like to learn during the learning session

1
2
3
MANY THANKS FOR YOUR TIME

PLEASE PRESS "SUBMIT" TO ENSURE YOUR ANSWERED ARE SAVED BEFORE EXITING THIS SITE.
Compassionate Connections: Post-Session Questionnaire for the Evaluation of the Story World Learning Sessions

Compassionate Connections is a programme of work supported by NHS Education for Scotland (NES) and NHS Health Scotland to support the implementation of the Refreshed Framework for Maternity Care in Scotland (2011) and Improving Maternal and Infant Nutrition - a Framework for Action (2011).

NES has commissioned SMCI Associates with PCA Consulting Ltd to evaluate two pilot learning resources:
- Two fictionalised story worlds.
- A scenario-based virtual learning environment.

This short questionnaire is part of the evaluation. It is designed for people who have participated in the Story Worlds learning sessions. The questionnaire will take you no more than 10 minutes to complete; responses are confidential: the evaluation team will not share any personal details with NES or your Board/HEI. SMCI Associates is registered under the UK Data Protection Act 1998: our registration number is Z1092649.

If you have any questions about the evaluation, please contact Dr Sheila Inglis (Director, SMCI Associates) sheila@smciassociates.com.

If you have any questions about the Compassionate Connections programme, please contact Sandra Smith, Education Programmes Manager, NES sandra.smith@nes.scot.nhs.uk.

Your personal information will be kept confidential within the evaluation team unless you give consent otherwise.

Please provide your full name

________________________

Please tell us about your experience of the Story Worlds session by telling us about how much you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tr>
<td>I enjoyed this learning session</td>
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<td>As a result of this session I intend to change my practice in terms of care and compassion towards women and families</td>
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<tr>
<td>The story worlds resource was easy to use</td>
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<td>I feel comfortable using this resource</td>
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<td>I was able to reflect on my own performance in practice during this session</td>
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<td>I found the group discussion a helpful way to learn</td>
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I think the Story Worlds are an accurate reflection of real practice

I feel able to apply what I've learn in this learning session in practice

Now that you have completed the Story Worlds session, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(i) Knowledge of the impact of health and social circumstances on engagement with services.

No impact on practice

(ii) Knowledge of the impact of health and social circumstances on clinical outcomes.

No impact on practice

(iii) Working collaboratively with women and their families.

No impact on practice

(iv) Working collaboratively with colleagues.

No impact on practice
(v) Working collaboratively with other health and social care agencies.

No impact on practice

(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.

No impact on practice

Now that you have completed the story worlds session, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(vii) Identifying opportunities to use strengths based approaches in the delivery of maternity care.

No impact on practice

(viii) The delivery of inequalities sensitive maternity care.

No impact on practice

(ix) Understanding the importance of flexible person centred risk-management to improving health and clinical outcomes.
No impact on practice

(x) Understanding the principles of compassionate person centred care.

No impact on practice

(xi) Understanding how the principles of compassionate person centred care relate to your own role within maternity care services.

No impact on practice

(xii) Critically reflecting on practice issues.

Do you think protected time should be scheduled into your working day/study timetable for educational sessions such as this?

- Yes
- No
- Don't know

Please state THREE things that you learned during the learning session

1  
2  
3  
MANY THANKS FOR YOUR TIME

PLEASE PRESS "SUBMIT" TO ENSURE YOUR ANSWERED ARE SAVED BEFORE EXITING THIS SITE.
Compassionate Connections: Follow-up Questionnaire for reflection on the Story World Learning Sessions

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Your personal information will be kept confidential within the evaluation team unless you give consent otherwise.

Please provide your full name

_____________________

Now that you have had time to reflect on the Story Worlds sessions, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(i) Knowledge of the impact of health and social circumstances on engagement with services.

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<td>Substantial impact on practice</td>
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No impact on practice ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(ii) Knowledge of the impact of health and social circumstances on clinical outcomes.

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No impact on practice ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
(iii) Working collaboratively with women and their families.

(iv) Working collaboratively with colleagues.

(v) Working collaboratively with other health and social care agencies.

(vi) Identifying opportunities to support health behaviour change in the delivery of maternity care.
Now that you have had time to reflect on the story worlds session, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(vii) Identifying opportunities to use strengths based approaches in the delivery of maternity care.

No impact on practice

(viii) The delivery of inequalities sensitive maternity care.

No impact on practice

(ix) Understanding the importance of flexible person centred risk-management to improving health and clinical outcomes.

No impact on practice

(x) Understanding the principles of compassionate person centred care.

No impact on practice

(xi) Understanding how the principles of compassionate person centred care relate to your own role within maternity care services.

No impact on practice
(xii) Critically reflecting on practice issues.

Substantial impact on practice

0 1 2 3 4 5 6 7 8 9 10

No impact on practice

How effective do you think this approach was for improving caring, compassionate and person-centred practice?

- Not at all
- A little
- Very effective

Would you recommend attending these sessions to your colleagues?

- Yes
- No

Please let us know if your practice has changed as follows:

- Delivering care that is compassionate
  - YES, I have changed practice
  - NO, my practice has not changed

- Delivering care that is person-centred
  - YES, I have changed practice
  - NO, my practice has not changed

- Delivering care that is safe
  - YES, I have changed practice
  - NO, my practice has not changed

- Delivering care that is responsive and appropriate
  - YES, I have changed practice
  - NO, my practice has not changed

- Involving women & their family’s experiences to inform the care I provide
  - YES, I have changed practice
  - NO, my practice has not changed

- Communicating with women in a compassionate way at all times
  - YES, I have changed practice
  - NO, my practice has not changed

- Communicating and working effectively with other professionals and multi-agency partnerships
  - YES, I have changed practice
  - NO, my practice has not changed

- Understanding how my own attitudes & behaviours impact on my practice
  - YES, I have changed practice
  - NO, my practice has not changed

---

MANY THANKS FOR YOUR TIME

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Your personal information will be kept confidential within the evaluation team unless you give consent otherwise.

Please provide your full name

Please tell us where you are employed / studying:

• NHS Highland
• NHS Fife
• NHS Glasgow
• NHS Tayside
• NHS Lothian
• NHS Lanarkshire
• Robert Gordon University
• Napier University
• University of the West of Scotland
• Other

If you chose "other", please provide details below:

Please provide details regarding your role:

Main area of practice (e.g. Midwifery, Nursing etc)

Job Title

Please tell us your AfC band:

If you chose "other", please provide details below:
Please tell us your age group
- 16-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 65+ years

Have you ever used avatars or gaming technology as a learning tool before?
- Yes
- No
- Don't know

Please tell us about your expectations about the Avatar by telling us about how much you agree with the following statements:

- I am looking forward to using this resource
- I expect this session to improve my practice in terms of care and compassion towards women and their families
- I regularly use interactive e-learning resources

Have you had any other formal educational sessions / CPD around compassionate person-centred care?
- Yes
- No
- Don't Know

Please provide details:

Have you ever received feedback on your ability to deliver compassionate person-centred care?

Please give details including how often:
* Yes
* No
* Don't Know

Was the time for this session scheduled into your working day (i.e. 'protected time' at work or study timetable at University)

Please state how often you get protected time during work (NHS Staff only)

* Yes
* No
* Don't Know

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Please rate your own ability in the following areas (1=very poor / 10=Excellent)

(i) Using motivational communication skills

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No impact on practice

(ii) Enabling women to use self-reflection.

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No impact on practice

(iii) Empowering women to make positive behaviour changes.

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No impact on practice

(iv) Identifying the protective factors that support health and wellbeing.

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No impact on practice
(v) Using available collective resources that promote the self-esteem of women.

(vi) Using available collective resources that promote the coping/decision-making abilities of women.

(vii) Understanding the concept of person-centeredness in relation to working practices and attitudes.

(viii) Using an asset-based approach to improve health outcomes.
(ix) Having detailed knowledge and understanding of smoking cessation in pregnancy.

0 1 2 3 4 5 6 7 8 9 10
Substantial impact on practice

No impact on practice  ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Please state THREE things that you would like to learn from this resource

1

2

3

MANY THANKS FOR YOUR TIME

PLEASE PRESS "SUBMIT" TO ENSURE YOUR ANSWERED ARE SAVED BEFORE EXITING THIS SITE.
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Please provide your full name
_____________________

Please tell us about your experience of the avatar by telling us how much you agree with the following statements:

<table>
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<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>I enjoyed using this resource</td>
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<tr>
<td>I believe my practice, in terms of care and compassion towards patients, will improve as a result of using the avatar resource</td>
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<tr>
<td>The avatar is an accurate reflection of real practice</td>
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<tr>
<td>It was easy to engage with the avatar resource</td>
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<tr>
<td>I found the interactive nature of the resource helpful (i.e. quizzes etc.)</td>
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Now that you have worked through the avatar, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(i) Using motivational communication skills

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No impact on practice

(ii) Enabling women to use self-reflection.

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No impact on practice

(iii) Empowering women to make positive behaviour changes.

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No impact on practice

(iv) Identifying the protective factors that support health and wellbeing.

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No impact on practice

(v) Using available collective resources that promote the self-esteem of women.

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</table>

No impact on practice
(vi) Using available collective resources that promote the coping/decision-making abilities of women.

Now that you have worked with the avatar resource, please rate your own ability in the following areas (1=very poor / 10=Excellent)

(vii) Understanding the concept of person-centeredness in relation to working practices and attitudes.

(viii) Using an asset-based approach to improve health outcomes.

(ix) Having detailed knowledge and understanding of smoking cessation in pregnancy.

Please state THREE things that you learned from using this resource

1
2
MANY THANKS FOR YOUR TIME

PLEASE PRESS "SUBMIT" TO ENSURE YOUR ANSWERED ARE SAVED BEFORE EXITING THIS SITE.
**Evaluation of the Compassionate Connections Project:**

**Development of Educational Resources to Support Implementation of the Refreshed Framework for Maternity Care in Scotland**

**Case Study template (VLE Learners)**

During the discussions with case studies please draw out as much information as possible, so as to develop their ‘story’ using the following template

<table>
<thead>
<tr>
<th>Evaluation team member name</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
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<tr>
<td>Main area of practice</td>
<td></td>
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<tr>
<td>Job title</td>
<td></td>
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<tr>
<td>AfC Band</td>
<td></td>
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<tr>
<td>Date/s and type/s of CC sessions attended</td>
<td></td>
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<tr>
<td>Date/s of phone interviews to collate case study</td>
<td></td>
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<tr>
<td>Views about the CC session/s attended</td>
<td></td>
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<tr>
<td>Use of stories in learning</td>
<td></td>
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<tr>
<td>Accurate reflection of real life scenarios</td>
<td></td>
</tr>
<tr>
<td>Use of reflection in learning</td>
<td></td>
</tr>
<tr>
<td>Digital/virtual format</td>
<td></td>
</tr>
<tr>
<td>Accessibility and ease of use</td>
<td></td>
</tr>
<tr>
<td>Anything else about the nature of the resources</td>
<td></td>
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<tr>
<td>Tell us about whether and how the CC session/s changed/improved your practice (Draw)</td>
<td></td>
</tr>
<tr>
<td>Developing motivational communication skills that guide women to self-reflection and empower positive behaviour change.</td>
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<tr>
<td>out to provide examples)</td>
<td>Identifying the protective factors that support health and wellbeing with a focus on the collective resources available that promote self-esteem and coping/decision-making abilities of women.</td>
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<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Exploring the concept of person-centeredness in relation to working practices and attitudes.</td>
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<tr>
<td></td>
<td>Using an asset-based approach to improve health outcomes.</td>
</tr>
<tr>
<td></td>
<td>Detailed knowledge and understanding of smoking cessation in pregnancy</td>
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<tr>
<td>Anything else?</td>
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</tbody>
</table>
January 2014

Dear Colleague

Evaluation of the COMPASSIONATE CONNECTIONS learning resources to support the implementation of the Refreshed Framework for Maternity Care in Scotland

Compassionate Connections is the overarching project title for work undertaken by NHS Education for Scotland (NES) and NHS Health Scotland to support the implementation of the Refreshed Framework for Maternity Care in Scotland (2011) and Improving Maternal and Infant Nutrition - a Framework for Action (2011). The aim of the workforce development activities of the project are to:

- Increase understanding of the impact of health and social circumstance on engagement with services and clinical outcomes.
- Enable staff to make the most of their individual and collective contributions towards improving maternal, newborn and infant health and well-being.
- Build on the existing knowledge and skills staff currently have and connect them with new insights, experiences and understanding.

NES’s work on compassionate connections\(^1\) has resulted in the development of two pilot learning resources:

- Two fictionalised story worlds.
- A scenario based virtual learning environment.

These learning resources are being piloted by NES between October 2013 and February 2014 in six early implementer Boards and three HEIs.

NES has commissioned SMCI Associates with PCA Consulting Ltd to evaluate:

- The extent to which the educational outputs of the Compassionate Connections Project are meeting the project aims and learning outcomes.
- The perceptions and experiences of key stakeholders across Scotland, of the project in terms of its relevance to and impact on the current policy landscape.
- The role of the Practice Educator in building capacity and capability for ongoing dissemination of the resources.

---

The evaluation will be complete by mid-March 2014. The research does not require NHS ethical approval as it relates to practice and workforce development, and involves NHS staff only\(^2\); ethical approval is currently being sought from HEIs to enable the engagement of students and staff in the pilot and the evaluation.

The Principal Researcher is Dr Sheila Inglis, and she and/or her colleagues will be in touch with you and/or your relevant colleagues to arrange interviews/and or focus groups at your convenience. I would be very grateful if you would participate in this important evaluation as fully as possible.

If you have any questions about the work, please don’t hesitate to contact me, or to contact the researchers directly (sheila@smciassociates.com).

Thank you,

Yours faithfully,

Sandra Smith
Educational Projects Manager
NHS Education for Scotland
sandra.smith@nes.scot.nhs.uk

\(^2\) Confirmed in email correspondence between the research team and NRES. See [http://www.nres.nhs.uk/](http://www.nres.nhs.uk/) for further details.
Compassionate Connections Workforce Development Programme

Interview topic guide

1. Introduction, confidentiality.

2. Your role

3. Your team/unit/department

4. Your main area of practice

5. Your involvement with the wider maternity workforce

6. Your involvement with the Compassionate Connections programme

7. Your perceptions of the Compassionate Connections programme/materials

8. Do you think that the Compassionate Connections programme will increase understanding of the impact of health and social circumstance on engagement with services and clinical outcomes?

9. Do you think that the Compassionate Connections programme enable staff to make the most of their individual and collective contributions towards improving the health and well-being of mothers, newborn babies and infants?

10. Do you think that the Compassionate Connections programme will build on the existing knowledge and skills that staff currently have?

11. Do you think that the Compassionate Connections programme will connect staff with new insights, experiences and understandings?

12. Wider implications of the programme

13. Potential transferability of the learning resources

14. Key strengths of the programme

15. Key weaknesses of the programme

16. Key challenges for the future of the programme

17. Any other comments
Session information to collate for analysis

For each session, the following information was requested from the PEs. The evaluation team provided guidance in word and excel format. Often the PEs were reliant on receiving the information from third parties (the NHS Board or HEI providing the session).

The table below shows how the information relates to the evaluation and to programme implementation. It also shows how it was be used in the evaluation.

<table>
<thead>
<tr>
<th></th>
<th>Essential for evaluation</th>
<th>Desirable for evaluation</th>
<th>Use in evaluation</th>
<th>Essential for programme implementation</th>
</tr>
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<tbody>
<tr>
<td>Region</td>
<td>✓</td>
<td></td>
<td>Analytic category</td>
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<tr>
<td>NHS Board/HEI/other</td>
<td>✓</td>
<td></td>
<td>Analytic category</td>
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<tr>
<td>Venue</td>
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<tr>
<td>Date</td>
<td>✓</td>
<td></td>
<td>Q dissemination and analysis</td>
<td></td>
</tr>
<tr>
<td>Target group/s</td>
<td></td>
<td>✓</td>
<td>To compare with actual participants (via job title)</td>
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</tr>
<tr>
<td>Participant name</td>
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<td>✓</td>
<td>To track participation</td>
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</tr>
<tr>
<td>Participant email address</td>
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<td>✓</td>
<td>To send out Qs, To track participation</td>
<td></td>
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<tr>
<td>Participant job title</td>
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<td>✓</td>
<td>To compare with target group</td>
<td>Analytic category</td>
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<tr>
<td>Participant organisation</td>
<td></td>
<td>✓</td>
<td>Analytic category</td>
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<tr>
<td>Participant consent to participate in session form (copy)</td>
<td>✓</td>
<td></td>
<td>Required by HEIs. Copy to eval team for info</td>
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<tr>
<td>Type of session</td>
<td></td>
<td>✓</td>
<td>Analytic category</td>
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<tr>
<td>Awareness raising sessions</td>
<td>Agenda/programme</td>
<td>✓</td>
<td>To analyse where awareness raising is happening</td>
<td></td>
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<tr>
<td></td>
<td>CC presentation/info provided</td>
<td>✓</td>
<td>To analyse how awareness raising is being done</td>
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<td></td>
<td>Event/meeting minute/report</td>
<td>✓</td>
<td>To analyse any comments/actions/decisions taken as a result of the session</td>
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<td></td>
<td>Event/meeting follow-up</td>
<td>✓</td>
<td>To analyse if anything has happened as a result of the session</td>
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<tr>
<td>Story Worlds Introductory</td>
<td>Specific learning objectives</td>
<td>✓</td>
<td>To analyse and map to the SW learning objectives</td>
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<td>Session report</td>
<td>✓</td>
<td>To analyse any comments/actions/decisions taken as a result of the session</td>
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<td></td>
<td>Session follow-up</td>
<td>✓</td>
<td>To analyse if anything has happened as a result of the session</td>
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<tr>
<td>Story Worlds learning 1</td>
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<td>Session report</td>
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<td>To analyse any comments/actions/decisions taken as a result of the session</td>
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<td><strong>Story Worlds</strong></td>
<td><strong>Specific learning objectives</strong></td>
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<td><strong>To analyse and map to the</strong></td>
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<td><strong>SW learning objectives</strong></td>
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<tr>
<td><strong>Session report</strong></td>
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<td><strong>To analyse any</strong></td>
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<td><strong>comments/actions/decisions</strong></td>
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<td><strong>taken as a result of the</strong></td>
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<td><strong>session</strong></td>
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<tr>
<td><strong>Session follow-up</strong></td>
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<td><strong>To analyse if anything has</strong></td>
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<td><strong>session</strong></td>
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<td><strong>Avatar session</strong></td>
<td><strong>Presentation/info/doc</strong></td>
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<td><strong>To analyse how the avatar is</strong></td>
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<td><strong>provided</strong></td>
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<td><strong>being presented/promoted</strong></td>
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happened as a result of the session
Targeted groups

Awareness sessions
Target groups included:

• Child Health Management team
• Child Protection
• Clinical Educators
• Clyde Senior Charge Midwives
• EPM, healthcare workers
• Family Nurse Partnership
• Fife Early Years Implementation Group
• Gender-based violence team
• Health Improvement Group
• Health Promotion
• Health visitors
• Improvement and Implementation Strategic Group Meeting
• Lead Midwives Meeting
• Maternal and Gynaecology Governance Implementation Committee
• Maternity and Infant Nutrition Strategy Group
• Medical staff and Midwives
• Midwife Leadership Event
• Midwifery Lecturers and PEFs
• Midwifery Lecturer’s Monthly Meeting
• Midwifery Supervisors
• NES Glasgow Operational Meeting
• NHS Medical Education
• NHS Scotland Trainers Development Event (morning session)
• North of Scotland Supervisors Study day
• Partnership meeting
• PEF NES Glasgow Meeting
• Practice Education Midwives
• Practice Educators meeting
• Practice Educators NES
• PRM Supervisor’s Meeting
• Professional Midwifery Forum
• Professional Practice meeting
• Public Health
• Regional PEF Event
• Senior Charge Midwives
• Senior Managers
• Senior Nurses for Education in Training
• SGH Supervisors meeting
• Sisters
- South CHP meeting
- Students
- Supervisors Quality Improvement Group meeting

Additionally, several individuals were targeted for awareness raising session; these included:
- Chief Nurse for R&D
- Child Protection Advisor
- Consultant Obstetrician/Medical Educator
- GP Training Fellow
- GP/Educational Supervisor/Fellowship Coordinator
- Head of Midwifery
- Infant Feeding GG&C Coordinator
- Midwifery Team Leader
- NES Practice Educator
- Nursing Lecturer
- Substance misuse midwife

**Introductory sessions**
Target groups included:
- Educationalists
- Health Professionals across Health and Social Care
- Lecturers
- Maternity Care staff
- Medics
- Mixed Professionals
- NHS Staff
- Organisational Development Consultants
- RGU HEI
- Student Midwives

**Story Worlds 1 sessions**
Target groups included:
- 1st Year Student Midwives
- 3rd year Student Midwives
- Community Midwives
- Doctors
- Midwives
- Public Health Staff Nurses

**Story Worlds 2 sessions**
Target groups were those who attended the SW1 session.
VLE
Target groups included:
• 1st Year Student Midwives
• 2nd year student midwives
• ASH Scotland
• Midwifery Supervisor
• Midwives
• Smoking cessation staff
• Special Needs in Pregnancy Midwife
Compassionate Connections Programme

25 February 2014

Stirling Management Centre

09.00 - 09.30
Registration & Coffee

09.30 - 09.45
Welcome

Introduction to the Story Worlds Learning Resource

09.45 - 11.15
Concurrent workshops

applying the learning approach to:

1. Getting it Right for Every Child
2. Raising Sensitive Issues
3. Understanding Health Inequalities
4. Using Strength based Approaches
5. Collaborative Working and Perception of Risk

11.15 - 11.30
Morning Coffee

11.30 - 13.00
Programme Evaluation

emergent findings and issues workshops

13:00 - 14.00
Lunch and Marketplace

14:00 - 15.30
Story Worlds Learning Approach to Action

15.30 - 16.00
Afternoon Tea and Reflection Exercise

16.00 - 16.30
Plenary

16.30
Close

Tweeting? Use #compassionateconnections and follow us @NHS_Education

By attending this event you will have the opportunity to:

- Experience how the story worlds learning approach can be applied to key topics for practice improvement.
- Contribute to evaluation of the programme
- Experience the story worlds approach in action using a live simulated case study
Compassionate Connections

Evaluation workshop, 25\textsuperscript{th} February 2014

\textbf{Group facilitator}
Please identify a facilitator for your group. The role of the facilitator is to keep the group discussion focused on the issues that we are asking you to consider.

\textbf{Group scribe}
Please also identify a scribe for your group. The role of the scribe is to note the groups agreed response to each issue, and to note any key areas of disagreement, using the worksheet provided. \textit{The worksheet should be used to note the conclusions of your group, and handed to the facilitators – you don’t need to do any writing up after this event!}

1. In your group please use the worksheet overleaf to consider
   a. The tangible outcomes that you would expect to see by April 2015
   b. How NHS Boards can be supported to use the resources

2. Finally, please agree \textbf{one key consideration} for the future implementation of the Compassionate Connections resources.
   Please note this here; and identify a spokesperson to share this during the plenary session.

\begin{center}
Please remember to hand this worksheet to Sheila or Rachel: this will inform the evaluation report
\end{center}
## Compassionate Connections: Evaluation workshop

<table>
<thead>
<tr>
<th>What tangible outcomes would you expect to see by April 2015</th>
<th>Outcomes for the learner</th>
<th>Outcomes for the service-user</th>
<th>Outcomes for the organisation</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How can NHS Boards be supported to use the Compassionate Connections resources?</th>
<th>Outcomes for the learner</th>
<th>Outcomes for the service-user</th>
<th>Outcomes for the organisation</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please remember to hand this worksheet to Sheila or Rachel: this will inform the evaluation report.
IMPLEMENTATION AND EVALUATION PLANNING EVENT
3rd September 2013. 10.00 – 16.00
COSLA, Verity House, 19 Haymarket Yards, Edinburgh EH12 5BH
0131 474 9200

Aims:
• To enable participants to consider how the Compassionate Connections resources can support the learning and development objections of their organisations
• To develop an implementation plan for the delivery and evaluation of the resources during the pilot period
• To clarify roles and responsibilities and communication networks with the group

PROGRAMME

10.00 10.30 Registration and Coffee

10.30 11.00 Welcome and introduction Sandra Smith

11.00 11.15 General questions and response to the resource Sandra Smith

11.15 11.30 Introduction to the evaluation Sheila Inglis

11.30 12.45 Group work 1. Planning to train the trainers and Coffee Sandra Smith

12.45 13.00 Plenary: key considerations in running a Compassionate Connections training the trainers workshop

13.00 13.45 LUNCH

13.45 15.00 Group Work 2.Planning to reach the learners Sheila Inglis

15.00 15.20 Coffee

15.20 15.55 Plenary: key considerations in running Compassionate Connections learning and reflection sessions Sandra Smith

15.55 16.00 The next steps and close Sandra Smith
Groupwork 1: Training the trainers

Please identify a facilitator for your group. The role of the facilitator is to keep the group discussion focused on the issues that we are asking you to consider.

Please also identify a scribe for your group. The role of the scribe is to note the groups agreed response to each issue, and to note any key areas of disagreement, using the worksheet provided. The worksheet should be used to note the conclusions of your group, and handed to the facilitators – you don’t need to do any writing up after this event!

1. In your group please use the worksheet overleaf to develop an action plan for running Compassionate Connections train-the-trainers workshops.

   The aims of the training the trainers workshops are:
   a. To introduce the compassionate connections story world learning resource.
   b. To introduce the smoking cessation virtual learning resource.
   c. To work with participants to develop a plan for using the Story Worlds learning resource and facilitating access to the virtual learning resource.

   working with staff to:
   i. Increase their understanding of the impact of health & social circumstance on engagement with services and on clinical outcomes.
   ii. Enable staff to make the most of their contribution towards improving maternal, newborn and infant health and wellbeing.

2. Finally, please agree one key consideration in running a Compassionate Connections train-the-trainers workshop. Please note this here; and identify a spokesperson to share this during the plenary session before lunch.

The Compassionate Connections implementation process:

Please pass this worksheet to one of the facilitators before lunch, so that it can be copied and returned to you before you leave the workshop today.
<table>
<thead>
<tr>
<th>Training the trainers workshops: (October – December 2013)</th>
<th>Assumptions</th>
<th>Risks</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>Who will lead the workshop?</td>
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<tr>
<td>Which potential participants are you targeting?</td>
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<tr>
<td>What resources will you need?</td>
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<tr>
<td>How will you get the resources you need?</td>
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<tr>
<td>How will you reach your target group/s?</td>
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<tr>
<td>What is your target date for running the train the trainers session?</td>
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<tr>
<td>How will you use the reflection log and action plan?</td>
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<tr>
<td>How will you facilitate access to the Sarah avatar?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>For whom?</td>
<td></td>
<td></td>
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</table>

Please pass this worksheet to one of the facilitators before lunch, so that it can be copied and returned to you before you leave the workshop today.
Compassionate Connections Project

Workshop: Tuesday 3rd September 2013

Groupwork 2: Reaching the learners

Group facilitator
Please identify a facilitator for your group. The role of the facilitator is to keep the group discussion focused on the issues that we are asking you to consider.

Group scribe
Please also identify a scribe for your group. The role of the scribe is to note the groups agreed response to each issue, and to note any key areas of disagreement, using the worksheet provided. The worksheet should be used to note the conclusions of your group, and handed to the facilitators – you don’t need to do any writing up after this event!

1. In your group please use the worksheet overleaf to develop an action plan for:
   a. Running learning and reflection sessions using the story worlds learning resource
   b. Facilitating access for learners to the virtual learning scenario
   working with staff to:
      i. Increase their understanding of the impact of health & social circumstance on engagement with services and on clinical outcomes.
      ii. Enable them to make the most of their contribution towards improving maternal, newborn and infant health and wellbeing.

2. Finally, please agree one key consideration in running Compassionate Connections learning and reflection sessions. Please note this here; and identify a spokesperson to share this during the plenary session at the end of the day.

The Compassionate Connections implementation process:

Please pass this worksheet to one of the facilitators before lunch, so that it can be copied and returned to you before you leave the workshop today.
<table>
<thead>
<tr>
<th>Learning sessions (November 2013 – January 2014)</th>
<th>Assumptions</th>
<th>Risks</th>
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<tbody>
<tr>
<td>Who will lead the Story Worlds session/s?</td>
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<td></td>
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</tr>
<tr>
<td>Who are your target learner/s?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>What resources will you need?</td>
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<tr>
<td>How will you get the resources that you need?</td>
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<tr>
<td>How will you reach your target group/s?</td>
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<tr>
<td>What is/are your target date/s for running the Story Worlds session/s?</td>
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<tr>
<td>How will you use the reflection log and action plan during the reflection session/s?</td>
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<tr>
<td>How long after the learning session should the reflection session be?</td>
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</tr>
<tr>
<td>How will you facilitate access to the virtual learning scenario and to whom?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please pass this worksheet to one of the facilitators before the tea break, so that it can be copied and returned to you before you leave today.