From Structure to Function
The Impact of Change

Collaborations for Leadership in Applied Health Research and Care
Theme 1: Health Service Redesign
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The original overarching aim of this five year project was to investigate how three hospitals redesigned their services to meet the changing health needs of the people they serve. The intention was to explore the processes involved using the best research evidence to inform the design of new services.

The approach taken was to build a partnership between the University based research team, key clinical staff in the hospitals, and the people who use those hospitals so that a comprehensive account of what this involves could be developed. This report is presented as an easy to use summary of the vast amount of work that has been conducted on the project since 2008.

Throughout the project our partners consistently argued that practitioners do not have time to read detailed reports and want findings conveyed in a manner that is accessible and concise. The hope is that the format of this report meets this requirement.

The facility to ‘dip in and out’ of the separate sections and the inclusion of signposts to further resources are intended to convey the main findings about change in health care organisations and the use of evidence in practice, to as wide an audience as possible. However it is important to note that this is founded on an extensive programme of research which has involved over 250 interviews; observation and participation at meetings with NHS staff; and analysis of relevant routinely collected quantitative data.

In what follows we hope you will find some interesting accounts of how change has been brought about in three NHS hospital organisations and find out about the challenges and successes we experienced in studying this complex area of health care structures and services. The pressures of an ageing population, fiscal restraint, and the increasing number of people living with long-term conditions mean that hospitals will need to adapt and undertake more radical redesign of services in the future. The findings from our work provide some useful insights on what needs to be done if such change is to be successful.
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Alistair Hewison
A mixed methods study undertaken between 2008 and 2013 investigated the process of Service Redesign in three NHS Acute Trusts. The project involved a total of 254 interviews and the collection of numerical hospital data in order to investigate in depth and in detail how services were changed. It was guided by an advisory group made up of senior NHS staff and the research team. The conduct of the research was also shaped in consultation with a patient representative group.

It was found that planned service change projects were subject to considerable alteration and shifts in focus as the organisational and external environment was transformed by policy change and financial strictures.

The strategic priorities of the Trusts centred on delivering services in different ways, however the levels of success in this regard varied. Change was reliant on local leadership, clinical champions, and availability of resources. Whilst some service change was introduced it tended to be localised and was not always part of a formal redesign strategy.

The process of knowledge transfer is dependent on a complex set of factors. These include the nature of the evidence, the involvement of local ‘champions’ in service change, wider policy pressures, and strategic leadership. In the services where change did occur there was sufficient alignment of a number of these key factors to support it.

There was no overall strategic approach to service redesign in the three Trusts, rather specific service provision was changed in different ways as an outcome of the interplay of the factors noted above. The findings suggest that large scale redesign projects are difficult to sustain because of changing circumstances, staff turnover, and the challenge of maintaining momentum. A more realistic approach centres on building teams, with local leadership, focussed on clinical/patient concerns and engagement with services provided outside hospital. This is more likely to result in meaningful change.
The 2008 NIHR CLAHRC project aimed to explore these ‘translational gaps’ in order to find ways of improving the implementation of theory into routine practice. Within the Birmingham and the Black Country (BBC) project, Theme 1 took this notion most literally, and set out to work with its NHS partners to explore how change was (or was not) implemented, and learn how services could be improved.

As the CLAHRC BBC was largely predicated on collaboration with NHS acute sector Trusts, we developed our ideas in close collaboration with three local Trusts that covered the spectrum from a relatively small district general hospital, through a larger (but still largely secondary service based) Trust, to a University Foundation Trust that offered tertiary (and in some cases quaternary) services. The elements they shared apart from their acute service provision were their acknowledgement of the need for change, and in particular, their emphasis on developing new buildings.

Thus, from the outset, all three had major capital redevelopment programmes planned, two of which were completed during the lifetime of the project (and thus lent themselves to ‘before’ and ‘after’ measurements, although this opportunity was only used in two subsidiary projects). In the third Trust plans for redevelopment were still at the discussion stage by the time the project closed.

We believed that the prospect of new facilities would promote a rash of service change and redesign, a perception that was reinforced by the interviewees in our baseline ‘strategic’ interviews.

Thus, the idea of evaluating the incorporation of change began to percolate through everything we did, and led to the notion of ‘CLAHRCiness’, and so it was not only the opening of the new hospital or the improvement of Heart Failure services that were being studied, but the manner in which change in these areas was presented to staff (clinical and managerial), how they responded, and to what extent planned change occurred.

From these studies, it was hoped that the lessons learned would be relevant to the wider health community.
3.1 Our NHS Partners

Walsall Healthcare NHS Trust
provides local general hospital and community services to the people of Walsall and the surrounding areas.

Walsall Manor Hospital houses the full range of district general hospital services under one roof. The £170 million development was completed in 2010 and the continued upgrading of existing facilities helps ensure the Trust has state of the art operating theatres, treatment areas and equipment.

The Trust also provides community health services from some 60 sites including health centres and GP surgeries. Multidisciplinary services include rapid response in the community and home based care.

Walsall Healthcare NHS Trust was established in April 2011, bringing together Walsall Hospitals NHS Trust and NHS Walsall Community Health.

www.walsallhealthcare.nhs.uk

University Hospitals Birmingham NHS Foundation Trust
runs the Queen Elizabeth Hospital Birmingham (QEHB). It is recognised as one of the leading hospitals in Europe and has an international reputation for quality of care, informatics/Information Technology (IT), clinical training and research.

QEHB successfully transferred its services from two hospitals, a mile and a half apart, into the UK’s newest and largest single site hospital. The £545m construction opened its doors to patients in June 2010.

It is a regional centre for cancer, trauma, renal dialysis, burns and plastics, and has the largest solid organ transplantation programme in Europe. QEHB also hosts the Royal Centre for Defence Medicine (RCDM) and treats all seriously injured British military personnel evacuated from overseas.

www.uhb.nhs.uk

Sandwell and West Birmingham Hospitals NHS Trust
is an integrated care organisation responsible for the care of people in North-West Birmingham and all the towns within Sandwell.

The Trust has two hospital sites – City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. The Trust includes the Birmingham and Midland Eye Centre, the Pan-Birmingham Gynaecology Cancer Centre and the Sickle Cell and Thalassaemia Centre – all based at City Hospital.

Inpatient paediatrics, most general surgery, and a stroke specialist centre are located at Sandwell General Hospital.

Over the next decade the Trust is planning to make major investments in three areas: workforce skills and training; the technology used to both care for and communicate with patients and partners; and in its estate, in part through its plan to build a single-site hospital in Smethwick, and the Midland Metropolitan Hospital to rationalise acute care.

www.swbh.nhs.uk
3.2 Background And Context

What Was CLAHRC BBC?
Collaborations for Leadership in Applied Health Research and Care for Birmingham and Black Country (CLAHRC BBC) was funded by the National Institute for Health Research (NIHR) and matched funds were provided by NHS partners. The programme brought together the University of Birmingham and NHS organisations in the Birmingham and Black Country region.

CLAHRC BBC had three key objectives:
- Conduct high quality applied health research
- Implement the findings from research into clinical practice
- Increase the capacity of NHS organisations and public, private and third sector partners to engage with and apply research

Building on the work of CLAHRC BBC, the new NIHR CLAHRC West Midlands (CLAHRC WM) commences in January 2014. For more information see section 10, The Future of CLAHRC and NHS Change Management.

Who Were Our Partners?
Health Service Redesign (Theme 1 of CLAHRC BBC) was based at the University of Birmingham and worked closely with three NHS Trust partners in the West Midlands: University Hospitals Birmingham NHS Trust, Walsall Healthcare NHS Trust and Sandwell and West Birmingham Hospitals NHS Trust.

One of the reasons for working with these partners was that each was involved in major transformations, including the planning and development of new hospital facilities (although not all of these happened). All were situated within the West Midlands, and each Trust had a different geographical, physical, organisational and historical context.

In each case, services were being redesigned to make them more responsive, accessible and sustainable for the benefit of patients. These changes were initiated by each Trust and the research was designed to determine whether and how change occurred, and what lessons could be learned by the Trusts and the wider NHS community. Wherever possible, cross-site comparisons were also made.

Our collaboration with Trust teams meant we were able to share our findings and discuss outcomes openly. However, in sharing our work with the outside world, and in all publications, findings were anonymised as requested by our partners. In the presentation of our findings here, our partners are referred to as University, Town and Urban.

Create new, distributed models for the conduct and application of applied health research that links those who conduct applied health research with all those who use it in practice across the health community covered by the collaboration.

When Was The Research Carried Out?

The CLAHRC BBC ran from 2008 to the end of 2013.

Initially, Theme 1 carried out a ‘baseline study’, involving 77 in-depth interviews across our three NHS Trust partners and their wider local health economy; this was to create a picture of each organisation, and to establish a ‘baseline’ against which progress could be measured. Our qualitative work was matched with some broad quantitative organisational metrics (see section 3.3 Methodology); the generic findings of this phase were then used, in collaboration with the Trusts, to generate studies for four clinical services that were undergoing similar changes:

- ST Elevated Myocardial Infarction (STEMI), a type of heart attack, as an example of medical unplanned care
- Cholecystectomy (gall bladder removal) as an example of unplanned surgical care
- Heart Failure as a focus for examining change at the primary/secondary care interface
- End of Life Care as an example of complex care

The overall aim of the Health Service Redesign project was to evaluate how Acute Trusts change organisationally and strategically over time in response to different pressures (whether physical, cultural or financial). We used the four clinical services as ‘tracers’ for tracking and comparing these changes.

Why Health Service Redesign?

There is more to the concept of service redesign than the development of new facilities. As medical innovations are developed and society’s expectations of healthcare change, so the delivery of healthcare itself changes. The drive for the provision of more care outside hospitals, reductions in hospital lengths of stay and the pressure and need to provide healthcare services that are seen to deliver value for money, combine to shape, and reshape services.

This, along with the NHS focus on organisational self-sufficiency and the requirement for the achievement of Foundation Trust status, has meant that Trusts across the NHS have been seeking to become more efficient, and better prepared to deliver services to meet the changing needs of patients. Service redesign and changes are more likely to be successful if they are planned, piloted, and fully evaluated. Evaluation should address the cultural and professional dimensions of change, as well as the technical and managerial aspects. If this is done the complexity of the changes that are happening across the NHS can be better understood, and the common lessons for managing change effectively disseminated throughout the service.
The Theme 1 baseline study was designed to be ‘holistic’, and one of its aims was to identify important cultural characteristics of the Trusts and a number of areas where we felt organisational comparison was warranted. We discovered that each Trust was trying to do similar things - in different ways – in unplanned care, the primary/secondary care interface and complex care (where, for example, different illnesses, different sectors and different funding streams might all be relevant).

In order to study the impact of change in these areas in detail, four clinical services were chosen in agreement with our Trust partners, where the potential for redesign had been identified.

Overall, our aims were to:

- Examine the drivers for service redesign
- Assess the impact of the redesign process as reflected in the responsiveness, accessibility, and sustainability of services
- Produce regular reports of progress/interim findings
- Identify the change management processes that seem to be most effective
3.3 Methodology

The Theme 1 research team assessed the factors that seemed to drive health service redesign; we identified and analysed the changes at different levels in each organisation, using a range of qualitative and quantitative methods chosen to produce a comprehensive account of change in the Trusts. The use of ‘mixed methods’ meant that findings could be ‘cross checked’ to identify the facilitators and barriers to the service change.

**Quantitative**

Routinely collected statistical data was gathered from each Trust as well as from regional and national databases. This information was analysed to assess how factors such as clinical outcomes, patient demographics, tariffs and length of stay in hospital changed over time as well as allowing for comparison between Trusts.

**Qualitative**

Semi-structured interviews were carried out with clinical and managerial staff and patients. The interviews were recorded digitally, transcribed and the data analysed using the Framework Method [see 3.4 Case Study] which allows for large datasets to be compared. All interviews were anonymised prior to analysis.

Observation of meetings was undertaken to develop a sense of the process of service redesign in the Trusts, although the data from this method has not been used extensively in reporting the work. Emerging findings were presented to a range of staff in the Trusts at different stages of the work. The discussion that took place at these events influenced the future focus of the study.

**Co-production** = a commitment to working together with our NHS partners, in order to bridge academic and healthcare practice boundaries, and produce useful findings relevant for practice and patient care.

Research outputs included regular reports to our partner Trusts and peer-reviewed, published articles.

Throughout the project our Trust partners pointed out that they did not have time to read detailed reports, and wanted findings conveyed in a manner that was accessible and concise. For this reason, the findings of our work are presented here in a series of short summary reports. For more detailed descriptions of the research outputs, and reports of knowledge transfer activities carried out by the research team and the Trusts, please see section 8.

Ethical approval for the study was granted by the National Research Ethics Service (NRES; Reference 04/02) which categorised it as ‘service evaluation’. The proposal was also considered by a University Ethics Committee and approved (ERN 10-0034). In addition, it was registered with the research and governance departments in each Trust.
3.4 Case Study: Framework Method

Using the framework method for the analysis of qualitative data in multi-disciplinary health research.


Dr Nicola Gale worked as a Medical Sociologist for the CLAHRC Theme 1 project and introduced the Framework Method which was subsequently used throughout this project by researchers.

The Framework Method was developed by researchers, Jane Ritchie and Liz Spencer, from the Qualitative Research Unit at the National Centre for Social Research in the United Kingdom in the late 1980s for use in large-scale policy research. It is now used widely in other areas.

The method is a means of organising and managing qualitative research data. It can be used to identify commonalities and differences in large and complex data sets, focusing on relationships between different parts of the data, and thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes.

Whilst it is an increasingly popular approach to the management and analysis of qualitative data in health research, there is confusion about its potential application and limitations.

Used effectively it is a systematic and flexible approach providing clear steps to follow producing highly structured outputs of summarised data. It is useful when a number of researchers are working on a project, particularly in multi-disciplinary research teams where not all members have experience of qualitative data analysis. It also used to manage large data sets where obtaining a comprehensive analysis of an entire data set is needed.

Implications For Research

Application of the Framework Method in the health service research setting:

- Can support thematic (qualitative content) analysis by providing a systematic model for managing and mapping the data
- When most suitable for analysis of interview data, as it is desirable to generate themes by making comparisons within and between cases
- Provides an intuitively structured overview of summarised data
- Is suitable for interdisciplinary and collaborative projects because of its clear, step-by-step process

Implications For Practice

The Framework Method:

- Requires facilitation by an experienced qualitative researcher
- Needs substantial time investment to produce a matrix fit for the purpose of data interpretation
4.1 ST Elevated Myocardial Infarction (STEMI)

ST Elevated Myocardial Infarction or STEMI is a type of heart attack, caused by prolonged restricted blood supply to the heart muscle as a result of a blocked coronary artery. It can be diagnosed on the basis of characteristic electrocardiogram (ECG) changes.

Research evidence indicates that the most effective method of treatment is primary angioplasty. This involves insertion of a balloon catheter into the blocked artery to restore blood flow. This is also known as percutaneous coronary intervention (PCI); it is termed primary (pPCI) if the treatment occurs without prior thrombolytic or ‘clot-busting’ drugs being administered.

The success of any treatment of this nature depends on how quickly blood flow is restored to the affected part of the heart. The more rapidly the patient can be treated, the greater the chances of preventing the heart muscle from being permanently damaged. Consequently, the mortality rate and the incidence of complications are lower.

National guidelines, based on international evidence, are that for effective pPCI all delays in treatment should be minimised. As a result, there are specific time targets for the main stages of a pPCI pathway.
The STEMI Pathway

Time is of the essence in the treatment of STEMI. The effectiveness of the patient pathway is judged against three criteria:

- **Call to Door (CtD) time**
  - This is the time between the initial phone call and the arrival at a designated treatment centre. It is the responsibility of the paramedics to diagnose the chest pain as STEMI using ECG and, if confirmed, contact a dedicated pPCI centre in order to alert the interventional cardiology team.
  - It is recommended that this part of the pathway takes no longer than 60 minutes.

- **Door to Balloon (DtB) time**
  - This is the time spent in the designated treatment centre between arrival and treatment.
  - This should be no longer than 90 minutes and recent European Society of Cardiology guidelines recommend this be revised to 60 minutes.

- **Call to Balloon (CtB) time**
  - The patient pathway begins with a telephone call to the ambulance service. The call to balloon time is the time between this telephone call and treatment, when the balloon catheter is inserted.
  - Guidelines recommend this should be no longer than 150 minutes.

In order to meet the target performance of the pathway, the accumulating evidence base supports direct transfer of patients from the ambulance to the catheter lab where the intervention occurs, rather than the traditional route of admission via A&E. This bypass of A&E was the main way in which our partner Trusts were hoping to streamline their services.
Findings

Each Trust had a different pathway for STEMI patients:

- Town hospital was bypassed entirely by paramedics with patients treated in a designated pPCI centre. This pathway was fully supported by Town cardiologists. Although there were long CtD times (54 minutes; all times expressed as median), DtB times were short (52 minutes).

- University Trust bypassed A&E with patients treated onsite by the Trust’s pPCI team. A move to the new, single site hospital had reduced CtD times (from 87.5 to 46 minutes). However, at the time of the move DtB times lengthened (37 to 101 minutes) due to the phased opening of facilities in the new building but reduced again with single-site working (54 minutes).

- Urban Trust did not bypass A&E; the Trust’s physical infrastructure did not change and the move to bypass A&E was not initially supported by all the relevant clinicians as A&E was perceived to filter out misdiagnosis. Urban Trust had short CtD times (40 minutes) because of its proximity to its population but long DtB times (78 minutes).

- There was a general consensus that the pPCI teams achieved “very good” team working in all three Trusts, although it was acknowledged that personalities could affect team dynamics.

- It was recognised that direct and effective communication between individual clinicians and across IT systems was improving.

Impact On Practice

- The performance and benchmarking data supplied by Theme 1 researchers was valued for its quality and transparency in all three Trusts and was used to inform service development.

- Benchmarking performance of the pPCI pathway and identifying the facilitators and barriers to changing practice has informed the pPCI service review at the Urban Trust.

- The need to maintain and improve the skills of relevant staff involved in the pPCI pathway was highlighted by the research. It was found that the University Trust’s study days (for paramedics, A&E and CCU staff and led by the pPCI team) were necessary to overcome problems in STEMI diagnosis. These events also helped ensure correct activation of the pPCI pathway and were much appreciated for the overall benefit of raising team awareness of the complete pathway.

“...every single study has always shown that if you activate a pathway and take a patient straight to the Cath Lab avoiding A&E or any other emergency room – the patients get treated quicker...”

Doctor, University Trust

“I can’t see why you wouldn’t use a facility [A&E] that’s fully manned, that are used to dealing with sick patients as a holding bay. I don’t see how it adds any delay...”

Doctor, Urban Trust
STEAMI: A 24/7 Service?

Research findings highlighted that the Call to Balloon performance varied significantly depending on whether the arrival at hospital had taken place in normal working hours or out of hours.

Findings

- In all three Trusts (and in Town’s case its designated pPCI centre) there is a dedicated on-site pPCI team in place between 9am and 5pm, Monday to Friday, ‘in hours’. Outside of this time, ‘out of hours’, the pPCI teams are on call and travel to their hospital from home.

- Most patients are treated ‘out of hours’ with only 36% of STEMI patients arriving ‘in hours’.

- Although CtB times remained within national guidelines, CtB performance was significantly better in hours.

- DtB times were on average 10-15 minutes longer out of hours at Town and University and an average of 19 minutes longer at Urban.

- CtD times were also significantly longer out of hours at the University site.

- Research participants proposed solutions for improving out of hours pathways including resident out of hours cardiologists, a rotation of out of hours centres and a single 24/7 centre.

- There were concerns that any centralisation of the service would lead to vital skills being lost at some hospitals and longer transfer times for those patients who lived furthest from the pPCI centre.

Impact On Practice

- Primary angioplasty pathways require further streamlining and bypassing A&E is crucial to this.

- Trusts need to ensure services provide patients with equitable high quality care, regardless of the time of day or hospital of presentation.

- An alignment of clinical opinion and a focused Trust strategy is required as clinical best-practice evidence emerges.

Every intervention centre is on call 24/7 for this and is that the requirement that we need? Does every hospital need to be on-call for this? … Can we sustain this particularly in the current economical climate?

Nurse, University Trust
At the start of the study, senior managers and clinicians in the three Trusts identified a clear aim to increase the rate of acute cholecystectomies (AC) encouraged by evidence of positive clinical outcomes and the incentives provided by NHS tariffs (see below). During our evaluation of the services, and their planned redesign, we saw that pathways can vary even within Trusts themselves where different specialties have responsibility for the patient.

**Definitions**

In our study patients were divided into four mutually exclusive groups:

**Acute** = Patients who had surgery on their first emergency admission.

**Delayed acute** = Patients who were booked for and operated on electively within seven days of first emergency admission.

**Emergency readmission** = Patients who had surgery during a second or subsequent emergency admission.

**Elective** = Surgery that was performed during a planned, non-emergency admission more than seven days after the first admission.

**NHS tariffs** = Department of Health best practice tariffs aim to improve care and clinical outcomes by financially reimbursing NHS providers for the costs of high quality care.

**What We Found**

- Analysis of Hospital Episode Statistics (HES) showed AC rates decreased at Town and University Trusts and increased at Urban Trust over time (2007-13)
- The steady increase in the rates of ACs at Urban Trust was attributable to a clinical champion for the acute procedure
- NHS guidelines* alone were not sufficient to change practice and increase the rate of ACs
- Despite senior staff expressing the desire to increase AC rates, there was limited awareness amongst clinical staff of this and the potential financial benefits of the acute procedure
- There was little engagement between senior managers and clinicians wishing to change practice and those clinicians carrying out the procedure
- Individual surgeon preference for the type of procedure (acute or elective) was influential
- Cholecystectomies can be carried out within a number of surgical disciplines; therefore ‘ownership’ of the procedure was not clear
- As Cholecystectomy patients may be treated acutely or electively, their condition is not considered a surgical priority. Patients were frequently taken off theatre lists to accommodate cases deemed to be more clinically urgent

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*NHS Institute for Innovation and Improvement. Focus on: Cholecystectomy A guide for Commissioners. UK 2006.*
Acute Cholecystectomy Rate

This is defined as the proportion of the cases in each year of the study that were in the acute group (see overleaf for groupings). The AC rate has been calculated for each Trust separately.

- Lack of timely ultrasound was a barrier to increasing AC rates at Town and Urban Trusts
- Town and Urban Trusts were devising new protocols for cholecystitis to address the issue of clinical priority for cholecystectomy patients on emergency lists
- Outcomes related to the surgical procedure, such as conversion to open surgery and readmission to hospital with complications were expected and were more likely with AC compared to the elective pathway

Implications For Practice

- The strategic aspiration and the incentives to change practice have to be communicated and aligned with clinical need and practice
- Clinical champions to drive the change process should be supported
- Barriers to change such as clinical priority, ownership, and access to diagnostic ultrasound and theatres need to be addressed in parallel

Everybody’s doing something that they perceive is more sexy and exciting than gallbladders

Locum Consultant

There is no uniform pathway at the moment, as far as I can work out. Different surgeons have slightly different ways of working

Consultant Radiologist, Town Trust
Heart Failure (HF) is a complex clinical syndrome. Its diagnosis involves confirming several key physical symptoms along with tests to detect structural or functional abnormalities in the heart. Initial diagnosis – often in primary care – is complicated by the fact that many symptoms are not specific to HF. Further investigation is usually required to identify underlying functional abnormalities in order to confirm the diagnosis.

Heart Failure Symptoms

- Shortness of breath
- Swelling of feet & legs
- Chronic lack of energy
- Difficulty sleeping at night due to breathing problems
- Swollen or tender abdomen with loss of appetite
- Cough with frothy sputum
- Increased urination at night
- Confusion and/or impaired memory

In light of the increasing demand, financial pressures and evidence favouring integrated and community based service delivery for chronic conditions, it was timely to examine the organisational responses of acute NHS Trusts to the challenge of caring for patients with HF. Our study investigated how local HF services were delivered, with a particular focus on how primary and secondary care interact to provide continuity of care for HF patients in the context of increasing demand and financial pressures.

The study focused on evaluating the HF pathway by developing detailed descriptions of services in three NHS Trusts to: compare and inform redesign of pathways; identify barriers and facilitators to service redesign; and assess the attitudes of staff and patients to HF services.

Definitions

**Primary Care** = health and social care provided outside hospital to meet a local community’s needs e.g. GP practices, community nursing.

**Secondary Care** = health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, such as cardiologists in hospitals.

Around 900,000 people in the UK suffer from HF and the condition accounts for 2% of inpatient bed days and 5% of emergency hospital admissions in the NHS in England and Wales (National Institute for Health and Clinical Excellence, 2010).
What Is Known About HF

- Heart failure is an increasingly common, inadequately treated long-term condition. Current UK guidelines for HF propose that care should be delivered in the community by a multidisciplinary team (National Institute For Health And Clinical Excellence, 2010)
- One year survival following hospitalisation is worse than for most cancers (32% mortality)
- Care of patients with long-term conditions requires effective coordination of primary and secondary services, which is not always in place

What We Found

- Different models of HF services were employed in the three NHS Trusts studied

Town

- Nurse-centred service with strong links between acute, community and primary care
- Patients were seen in the hospital for initial treatment and their rehabilitation was managed in the community

University

- Increased prevalence of HF in the locality did not result in increased HF emergency admissions
- Length of stay and readmissions associated with HF inpatient admission decreased over time

- Hospital and consultant led service – a shift towards initial diagnosis and treatment of HF in hospital-based clinics (contrary to current policy) as this was perceived to be a more cost effective model
- Discrepancies in primary care recording of HF patients (numbers falling) and acute/community recording (number increasing)
- The increased ‘supply’ of healthcare options such as elective cardiac procedures fuelled some of the HF inpatient ‘demand’
- Increased prevalence of HF and secondary care activity was adding to the workload of community nurses: referrals were described as ‘pouring in’ whereas discharges were ‘a trickle’
- Inpatient length of stay associated with HF as primary diagnosis fell over time but inpatient activity and the readmission rate was rising
It’s a little place but it’s not bad for heart failure

Nurse, Town Trust
Urban

- Nursing and community focused service with HF consultants leading outpatient clinics
- Two different models of HF service were provided because of site specific differences in organisation, nursing team capacity, staff training and patient needs
- The better funded service employed more community nurses, and was regarded as a successful model
- Increased HF prevalence in the community resulted in a rise in community and outpatient HF activity; inpatient emergency HF admissions remained stable
- Patient demand exceeded the capacity of HF nurses – there was a universal perception of being ‘stretched’ with a clear need for more HF nurses to be employed
- Hospital clinicians expressed concerns about primary care engagement with HF diagnosis and expertise to manage patients long-term
- Fragmented communication between primary and secondary care was a barrier to integrated HF service delivery

Implications For Practice

- A patient-centred approach to Heart Failure management benefits from a nurse-led, community-based service across primary and secondary care
- Current services are limited by nursing capacity – additional funding for specialist nurses should be considered
- Improved communication, information sharing and development of HF relevant clinical skills are vital in primary, community and secondary care settings

...My role [is] to support the patient through the acute journey into primary care...and make that as smooth a journey as possible, and involving everybody in the MDT [multidisciplinary team], and the family as well, and not forgetting the patient

Nurse, Urban Trust

Yeah, heart failure denotes death, you tell someone their heart is failing, they think quite carefully that, well, they will not understand that, your heart is the centre of your life, if that doesn't work, you will die, so we’ve tried to use a term that was less negative [heart assessment]

Nurse, Urban Trust
4.4 End Of Life Care

Around half a million people die in England each year. Two thirds are aged over 75 years and for the majority death follows a period of chronic illness such as heart disease, cancer or stroke. Some die as they would have wished, but many others do not.

The provision of appropriate End of Life (EoL) care can make the process of dying more comfortable and dignified for a person and their family. However evidence suggests that patients have limited involvement in care decisions and this lack of involvement can lead to dissatisfaction and a reduction in the quality of care.

The NHS End of Life Care Strategy was developed by the Department of Health in 2008 to improve care and recommended the use of end of life care pathways to identify people approaching the end of life and the need to have discussions about their care preferences. Our three partner NHS Trusts shared an aim to improve EoL care services using redesign initiatives.

The research team interviewed consultants, nursing staff and managers to evaluate the Trusts’ EoL care service redesign. Efforts were made to collect a wide range of quantitative data, however this information was not available in a consistent format in the Trusts. Furthermore the approach taken to redesigning this service changed markedly in two of the Trusts in the course of the study making access to data problematic.

Where do people die?

- 58% NHS Hospitals
- 18% Home
- 17% Care Homes
- 4% Hospices
- 3% Elsewhere

Source: Department of Health 2008
What We Found

- The presence and involvement of a facilitator was crucial to the successful introduction of the EoL care pathway, as was effective leadership at all levels.
- Education and training are essential; staff need to be familiar with the pathway and its purpose as well as being confident in meeting the complex needs of patients.
- Such training was a significant undertaking for Trusts.
- The need for training was particularly acute with regard to preparing staff for initiating and having ‘difficult conversations’ with patients and their families.
- The decision to place patients on an EoL care pathway was a significant event for all healthcare professionals involved. There was uncertainty amongst practitioners in ‘diagnosing dying’.
- Information systems and communication networks across primary and secondary care are incompatible and do not support the care of the patient. Effective liaison relied on individual links rather than integrated systems.

Implications For Practice

- Leadership at all levels facilitates the introduction of effective care pathways.
- Local champions are able to further aid the process and maintain momentum.
- Training for staff is essential and should be a continuous process. However, other forms of support may need to be employed to enable staff to be confident in providing EoL care such as peer support, clear guidelines, and regular audit of practice.
- Co-ordination of primary and secondary services helps ensure patients experience a ‘good death’.
- End of Life is not a predictable or linear process, the use of tools such as care pathways can only be part of the solution. The introduction of individualised care plans as recommended the Department of Health (2013) is set to address this.

It’s not prescriptive, it’s a guideline, it’s a guide to good care…so that leaves you scope for differences, for different patients...hopefully the tool will support you, bring out the best in you.

Nurse, Urban Trust

We got a new medical director and a new head of nursing and they seem quite proactive really, around end of life care issues, so it seems more positive now.

Nurse, Town Trust
5 Organisational And Cross Cutting Studies

5.1 Strategy And Direction

In an NHS always subject to external forces, it seems as if it is the acute sector that has to evolve and change most quickly. Pressures such as the delivery of efficiency savings and achievement of quality targets, together with policy changes including the structural reform of healthcare commissioning, may place conflicting demands on individual organisations. In our investigation of strategic change we examined whether acute Trusts were able to find ways of incorporating their various pressures into more robust longer term strategic aims.

Each Trust was engaged in transformational change programmes, including the planning and development of new hospital facilities. As part of these, we were told that services were being redesigned to make them more responsive, accessible and sustainable, for the benefit of patients.

We combined analysis of the three rounds of longitudinal ‘strategic’ interviews with the routinely available organisational metrics, and found that the changes at the individual Trusts indicated the challenges facing each organisation with regard to the longer term strategic development it would to determine its own future.

Findings

Three rounds of longitudinal ‘strategic’ interviews and a range of organisational metrics were analysed and used to identify the challenges facing each organisation with regard to the longer term strategic development.

Activity and income

Over the duration of the project, workload and turnover increased at all the Trusts:

- University Trust showed the greatest proportional increase; it had rationalised its estate during this time, and developed a number of additional tertiary services. The Trust’s income streams were more predictable and less affected by the ebbs and flows of emergency care than the other two Trusts (see graphs overleaf)

- Town Trust opened its major new development and integrated the provision of community services, significantly increasing its turnover

- Urban Trust also became a provider of community services although its capital development project was not realised, which may explain why income did not rise to the same extent

Quality

Throughout the project, perspectives of organisational quality varied among the Trusts and their various staff groups.

- University Trust maintained an organisation-wide focus on quality that was consistent and explicit. The Trust’s stance was that once quality is right, everything else fits into place

- Urban and Town Trusts were more concerned with addressing external pressures, such as financial targets and waiting times, and defined quality in these terms. At both these Trusts, the explicit focus on quality grew as the project progressed, and was significantly affected by events such as the 2009 crisis at Mid-Staffordshire Foundation Trust

- Clinicians’ accounts of quality centred on improving patient care and clinical services and, in contrast to managers’ views, rarely
included reference to the financial pressures or performance of their trusts

- Ensuring the focus on quality was translated into a comprehensive patient-centred approach, could be challenging (see Case Study 5.3)

**External Pressures**

The manner in which the Trusts responded to similar external pressures varied markedly in terms of their approach and the priority given to particular issues.

- University Trust focused on its own agenda. For example, an initial preoccupation with information and Information Technology showed itself in the development of an increasing number of practical patient management tools in the second round of interviews, which were being prepared to be marketed commercially by the third round

- Town Trust appeared initially to be much more outward facing, having a reactive approach to the various demands placed upon it. Latterly the organisation seemed to have ‘re-invented’ itself; interviewees had fewer doubts about the viability of the Trust, and had a stable platform on which to plan the future. This new confidence built on the existing loyalty towards the hospital amongst both staff and patients

- In its interactions with the outside world, Urban Trust appeared to balance the need to meet the demands of its external drivers with an ability to be more grounded in the development of its long-term partnership strategy

**Corporate Identity And Management Style**

- University Trust had a very strong sense of corporate identity or ‘brand’, something that featured less at Urban Trust, and which was seen to grow from a relatively low base at Town Trust

- Approaches to management style differed greatly within the three Trusts. At University Trust, the ‘brand’ was introduced very early on in the recruitment and induction of new staff, and developed from there. Particularly among more senior staff, having an ‘organisational fit’ was important; staff who did not fit were unlikely to stay at the Trust for long, however those who did were likely to remain for many years, a feature that was reinforced by the observation that almost all the Trust’s senior management team had been working at the Trust for over a decade

- Urban Trust projected itself as a more consensus driven organisation backed by a significant investment in a Trust wide staff engagement programme which was championed by the Chief Executive. The level of discussion allowed increased staff engagement in the process of change, but also meant that it took longer, and that leadership and decision making were less obvious
• Town Trust implemented similar programmes but with less impact. It was only after the opening of the new facilities and the arrival of the new Chief Executive that the ‘top down’ style began to change and a greater, more meaningful focus on internal organisational development was seen.

Relationships With External Stakeholders

In the emerging ‘commissioner-led’ environment of the NHS, relationships with external stakeholders are clearly important; the Theme 1 study found there was little consistency in approach amongst the three Trusts.

• Urban Trust had the closest relationship with the non-institutional sector, predicated on the existence a long-term cross boundary project that involved close working with both commissioners (PCTs/CCGs) and providers (GPs and community services)

• Whilst good relationships with GPs were acknowledged and the requirement to work with only one commissioning organisation appreciated, there appeared to be no explicit signs of progress in capitalising on the Trust’s ‘head start,’ for instance in its integration of community services.

• Town Trust was awarded the provision of local community services during the course of the study, and was thus well placed to begin providing integrated pathways of care. However there was little sign that these arrangements had significantly changed the modus operandi of the Trust, which still felt very much based in the ‘acute’ mode.

• University Trust was consistent in its interaction with commissioners and senior trust staff discussed approaches to engagement. However the commissioners reported that such dialogue was limited. By the third round of interviews, a Director of Partnerships had been appointed at the Trust, and it was too early to determine if significant progress had been made.

Well some of us pull back from these twee things; [but] the actual activity of getting more involvement in staff in their future directions has been very, very successful

Doctor, Urban Trust

Implications For Practice

• Corporate vision and identity often seem to mirror management style, a factor that should perhaps be considered more often; an explicit strategy for management style may help to maintain organisational momentum, thus enabling more consistency and success in change processes.

• Differences in responses to external pressures in particular, seemed to be associated with the degree of managerial and financial ‘headroom’ available where strategic, long term issues can be considered over and above the challenges of day to day service provision.

• Leading and implementing major programmes of change can be more challenging when stakeholders interpret the purpose of these changes differently (such as for quality); gaining staff alignment with all aspects of the change process should be a very early priority.

• Despite the organisational ‘churn’ in the NHS, acute Trusts still seem to be working in relative isolation; examples of true integrated working were rare, either with commissioners or in the models of provision across primary and secondary care and even to an extent with the incorporation of community services into the acute sector. A better alignment of organisational incentives to achieve integration at all levels is required, along with the preparedness to ‘follow through’, even when the consequences are difficult.
5.2 Culture: Patients, People And Place

Organisational culture is considered by policy-makers, clinicians, health service managers and researchers to be a crucial element in the success of implementing health service redesign.

Our NHS partners recognised the importance of exploring organisational culture within our research as it was perceived to underpin the whole redesign process.

We developed a model for conceptualising organisational culture in health services research: focused on three thematic areas or ‘domains’ in which organisational culture was enacted - patients, people, and place.

The model offers a practical approach to investigating an inherently complex phenomenon and sets out to explain the relationship between observable behaviours and values (‘patients and people’) and the cultural artefacts and basic assumptions underpinning an organisation’s culture (‘place’).

The nature of culture meant that this phase of the analysis of these data had to be completed towards the end of the study period and, at the time of producing this report, the research was still in progress.

It is hoped it could be applied in other settings to help ensure the important elements that contribute to an organisation’s culture are addressed in future research.

Definitions

Our research refers to patients, people and place as separate domains:

**Patients** = the extent to which services are ‘patient centred’.

**People** = the role and influence of the wide range of people working in the Trusts.

**Place** = the impact of the location of services.
5.3 Case Study: Patient-Centred Care

Patient-centred care and patient involvement are central concepts in the policy and delivery of healthcare in the UK and elsewhere.

Lord L & Gale NK Subjective Experience or Objective Process: understanding the gap between values and practice for involving patients in designing patient-centred care. Journal of Health Organization and Management in press.

Emphasis has tended to be on the micro-level: patients engaging and contributing to decisions about their own care, or taking account of the views of family and friends. However there is a strong case for the involvement of patients at service and organisational level.

Despite evidence to suggest that there is an important role for patients in improving the quality and responsiveness of services, there is little consensus concerning how to achieve ‘patient-centred’ care in everyday practice or how to involve patients in service redesign initiatives.

We examined the notion of ‘patient-centred care’ at each of the three Trusts by analysing the interviews of 77 key senior executives, managers and clinicians.

Findings

- Trusts recognised the importance of providing patient-centred care and acknowledged it to be part of their overall vision and values
- While patient-centred care and patient involvement were reported to be important by stakeholders, a gap existed between these values and reported practice
- There was a discrepancy between subjective experience of patients and the objective process of measuring good quality care. While patient-centred care was often described as a subjective experience (e.g. feeling cared for, having a good experience of care), when actual practices were described they focused on the patient as the operational centre of an objective process (e.g. reducing length of stay in hospital)
- There was a belief that patient-centred care would result in improved organisational efficiency and positive financial impact. This mix of financial and quality aims put a greater emphasis on objective markers, resulting in information being collected about patients rather than for patients. There were some exceptions, such as attempts to routinely provide information specifically for patients
- Patients were consulted about proposed changes, however higher levels of involvement in designing services were rare because staff worried that the general public did not understand how the health system worked

Implications For Practice

- Future initiatives to make services more patient-centred need to give more weight and value to the subjective experience of patients
- Redressing this balance should involve rethinking the methods of assessing patient experience; moving from measurement of processes and numerical markers, to more subjective accounts by encouraging patients to talk about their health care experience
Information is essential for planning and managing healthcare; developments in Information Technology (IT), communications and data management can all help to improve the quality and efficiency of health services.

Our initial baseline study identified the ‘provision and handling of information’ as a consistent topic of interest. In the context of IT, the lack of progress with the national Connecting for Health programme (establishing a single electronic database of NHS patient records) resulted in a range of responses from the three Trusts.

- In our subsequent work we qualitatively examined how information was provided and utilised at each Trust at both the organisation and service level, in order to identify how different approaches benefited the Trusts. We also explored the differences in attitudes towards the collection and use of information.

**Findings**

Initially, the Trusts had different views about information:

- Town staff felt their data to be crude and unreliable with poor information management.
- University Trust staff consistently had a positive view of the value of information.
- Staff at Urban Trust rarely mentioned information.

Attitudes towards information changed and developed over time, highlighting the different drivers for change:

- The sophisticated electronic prescribing system at University Trust, introduced before the study began, evolved and developed over the years. The original drive came from a particular senior Director who was its ‘champion’.

‘Data’ comprises simple facts, from many different sources, numerical and intuitive, quantitative and qualitative. When these are collated and analysed, they become ‘information’. Only when information is considered in context and applied to problem solving does it become ‘intelligence’.

Jonathan Shapiro, CLAHRC Theme 1
As additional features were added, the system’s reach broadened to encompass clinical case management, which was then used for the collection of data to inform performance management of services and staff.

By the end of the study, information had become central to the Trust’s philosophy, with most of its clinical (including patient-centred initiatives) and management systems integrated electronically. The Trust was exploring the commercialisation of its expertise, based on its leading edge reputation in this field.

- **Town Trust** exhibited the greatest change in attitude about the use of information; from the initial championing of information and IT only by enthusiasts, to Trust-wide awareness of its importance, as national attention focused on clinical outcomes. The Trust initially had higher than average mortality rates, and so more sophisticated systems were needed to understand and improve these. More importantly, it was in the interests of clinicians to understand the information that clinical activity was producing, and this human driver provoked the change in approach.

- **However** it was felt that the Trust lacked the financial and managerial ‘headroom’ (see also section 5.1) to invest in any ‘whole Trust’ systems and whilst a number of smaller initiatives were in place, they did not initially appear to be significantly ‘joined up’.

- **The perceived attitudes to and use of information** at Urban Trust changed less radically. Interviewees referred to individual enthusiasts compiling and using clinical information, but there was no evidence of a system-wide plan for the integrated management of information. In change management terms, the Trust was at a much earlier phase of change, with an awareness of the need for change that was still developing.

### Implications For Practice

- Awareness of the relevance to clinical practice of better information provision is an important driver for change. This may come from an individual ‘champion’ who has enough authority or personal influence to affect the behaviour of others, or from external drivers such as the focus on mortality.

- National (i.e. external) technological initiatives can be a disincentive to internal organisational innovation. Trusts need to acknowledge potential problems or inertia and develop appropriate, alternative strategies.

- The availability of spare capacity or ‘headroom’ is a vital prerequisite to any proactive organisational development including information management. Awareness of information needs has to be supported by explicitly focused organisational processes.

- Culture change in this area, as in so many others, depends on personal championship at senior level, easily perceived benefits from change and the ability to bring about effective change using ‘quick win’ projects, combined with some clear disincentives for non-compliance.

- Success breeds success: developing momentum in improving the provision of information and IT embeds them in Trust culture, encouraging them to become part of the ‘day job’.
5.5 Case Study: Clinical Leadership

The implementation of any clinical change requires the complete co-operation of clinicians, ‘clinical leadership’ has become an important tool in the NHS’s drive to improve service quality.

The importance of clinical leadership is recognised internationally and there are calls for leadership development programmes to be incorporated into clinical training.

Our analysis of clinical leadership was a result of our co-production approach (see section 6.1). In a feedback discussion of second round strategic findings, an Executive Director at Urban Trust requested additional information on the varying approaches to clinical leadership, as identified by our studies, in order for the Trust to learn from this evidence.

The findings below (which are currently being drafted into an academic paper) reflect qualitative analysis and interpretation based on both the strategic and service interview accounts.

Findings

- The value and approach to clinical leadership varied across the Trusts and over time, subject to the culture and strategic priorities of the organisation
- Organisational culture determines that Trusts will respond in different ways to similar external directives
- Explicit strategies for developing clinical leadership were limited; capable clinical leaders were expected to rise within individual clinical management structures
- Clinical leadership during organisational or service change was facilitated by direct executive or managerial support but also relied on clinical ‘champions’
- Over time, clinical leads were amenable to their organisation’s performance management regimes, providing they retained autonomy for leading their services themselves

Implications For Practice

- The more established an organisation’s corporate culture or the more explicit the organisational strategy, the easier it is to involve clinicians in major change
- Corporate leadership (whether clinical or managerial) is key to aligning organisational change; credible clinical ‘champions’ drive service change and managers facilitate it
- Our findings show the importance of a shared vision, in keeping with the organisational culture, to gain and maintain engagement
- This vision should be cascaded by the Chief Executive and clinical leaders to ensure commitment, focus, engagement and to engender change
- Clinical engagement without clinical accountability is a less effective organisational strategy; the use of management tools can be useful drivers for change, but need time to become embedded and accepted
I think you need more, that kind of management support for the clinicians who are actually movers and shakers.

Consultant, Urban Trust
6 Knowledge Transfer

Knowledge Transfer (KT) is the action needed to close the gap between what we know and what we do. This definition masks the complexity of changing the practice of individuals, teams and organisations. In recent years, there has been increased interest in translational research, which explores the translation of research into practice.

The CLAHRCs were founded on the concept of knowledge transfer and were established to explore one of two specific translation gaps (see section 3) in English healthcare: the introduction of new ideas and products into NHS practice. The CLAHRCs were intended to help the NHS to become more effective in utilising new treatments and research knowledge for the benefit of patients and the population more widely.

The Theme 1 study aimed to capture explicitly how our co-production methods (see section 6.1) of knowledge transfer affected organisational and service change processes. This was done by asking all our interviewees about their experience of the research and the CLAHRC project, and in particular how collaboration could impact on the redesign of services. Interviewee preferences for communication and dissemination were also explored.

In addition to exploring these specific themes in the semi-structured interviews, the content of minutes from the quarterly extended group meetings (of researchers and Trust leads) were also analysed. The final piece of the jigsaw was a focus group involving members of the core research team that examined their perspectives on the KT aspect of the project. The main findings were:

**Findings**

- Identifying and engaging key stakeholders at the onset of the research (or at least very early on) is vital for success
- Clarifying the goals of the research in consultation with collaborators, as swiftly and rigorously as possible, creates a solid foundation for co-production
- NHS Trusts and Universities operate in very different ways. Collaboration was successful when shared goals were identified and maintained by all stakeholders, and when the momentum was maintained
- Having team members spanning the boundaries between the NHS and academia is an effective means of bridging the gap between organisations. They provide visibility, insider knowledge and assist in engendering a sense of collaboration
- NHS staff valued the objective approach of the research team and viewed research findings as a useful means of facilitating change
- How and when findings were disseminated was crucial to the clear and effective transmission of key messages; the more ‘quick wins,’ the better. Equally important was who received the information, what they received the format
- NHS practice and academic research move at different rates. This can create tension between research rigour and the timeliness of sharing findings for use by the organisation and/or service
Implications For Research

- Academic rigour has to be maintained during knowledge transfer, whilst taking into account the needs and expectations of practitioners.
- Research methodology needs to comply with the NHS’s needs: research capacity needs to match the volume and timing of the research to be undertaken, so that the knowledge produced can be applied in a timely fashion.
- Dissemination should be targeted, and practicable: ‘marketing’ research findings in less formal formats enables the knowledge produced to be used after the research ends.

Implications For Practice

- Academic and clinical bodies have their own necessary intra-organisational infrastructure (such as the processes of financial, ethical and human resource management) and formally aligning these processes (ideally in a dedicated, inter-organisational unit) would speed up the knowledge transfer process considerably.
- If dissemination is not built into the research design, the ad hoc sharing of findings may skew the research; thus, it will be impossible to discriminate between any impact of the intervention being evaluated and the impact of unplanned dissemination. Sharing the process of research may be a helpful alternative during the project itself.
- The quality of service redesign research and its subsequent knowledge transfer is dependent on the engagement of the relevant staff in the process and its outcome. Doing research with people is invariably more effective than doing research on them, and this is reflected in the benefits to clinical services and patients’ experience.

Consultant, University Trust

…we don’t have the facility to do what you’re doing and the very fact that you’re not one of us… I suspect that I’ve been a lot more frank with you than I would have been [with] a hospital manager…

Clinician, University Trust

…I think one of the most important things with projects like this is the quick wins and early feedback… I know it’s a longitudinal study … but by the time you’ve found the facts, they’ve changed.
6.1 Case Study: Co-Production

Co-production in research: some reflections on the experience of engaging practitioners in health research.


Co-production can be defined as spanning boundaries between and across communities and perspectives for productive collaborations. These boundaries can be geographical, disciplinary and/or professional.

Three researchers from Theme 1 produced a paper to report some of the approaches undertaken to ensure the Theme 1 project was co-produced with its NHS partners and maintained a commitment to knowledge transfer.

This ethos, and the rationale of the CLAHRC as a whole, reflected a long standing concern that fostering academic-practitioner knowledge sharing is both important and possible.

What We Found

- Building relationships and embedding research findings takes time
- Embedding research findings requires knowledge of local context
- Using a blend of academic and clinical staff within the research team played an important role in building working relationships with the NHS Trusts
- This blend allowed for an understanding of the pressures and concerns faced by the Trusts to be developed
- The ultimate aim of Theme 1 was to foster a ‘community of enquiry’ which would continue after the research was completed

Implications For Research

- Engagement and ‘buy-in’ from Trusts took considerably longer than if the research had taken a more traditional ‘clinical trial’ model
- Investment of time will lead to greater benefits in the longer term

“

A focus on specific projects and teams was found to be a successful way of embedding co-production
7 Developing Research Capacity

The purpose of the CLAHRC was to forge a mutually beneficial, forward-looking partnership between universities and their surrounding NHS organisations in order to create and embed a culture of research and evaluation into the routine activities of the NHS.

To this end, Theme 1 combined a number of novel and established strategies to increase research capacity and embed research firmly within the Trusts, including:

- PhD and MD students working with Theme 1, conducting research in the Trusts
- Communications Fellows based in the Trusts and affiliated to Theme 1 to improve communication in the conduct of the work and the sharing of findings
- Patient and Public Involvement (PPI) Advisors to ensure the patient perspective was accounted for in the design and conduct of the study

In the case of all the MDs, their funding came from Urban Trust, which gained the skills of aspiring surgeons and had to employ fewer locum doctors to fill surgical rotas thus making the appointments cost effective. While the students had the opportunity to carry out rigorous research projects, improving their CVs and assisting the Theme in its aim of increasing research capacity in the NHS. The Communications Fellows’ positions were funded from the research itself, to minimise financial pressure on the Trusts.

Collaborative working in this manner is labour intensive and time consuming but reaps rewards. By bringing together staff with practical research experience and first-hand knowledge of clinical services and the NHS, the Theme 1 team was able to increase research awareness within the Trusts, and feedback findings in a meaningful way.

Nursing Fellows: A Cautionary Tale

The Nurse Fellow roles were devised to fulfil a similar function as the MDs: to increase research knowledge and capacity in the Trusts, and to offer development opportunities to ambitious, able nurses. In the event, the Trusts subjected the recruitment to a formal application process (which had not been the case for other Fellows), and all those who had initially been interested in the role found this off-putting, and withdrew from the scheme.
7.1 Case Study: The PhD Student

Rowena Senior’s PhD Thesis

An ethnographic study of the impact of service transition on the well-being of nurses in two National Health Service Acute Trusts.

The National Health Service (NHS) continues to go through a period of considerable transition as health services change to meet the needs of a 21st century population. Staff are acknowledged as key to this process and staff well-being is a key concept in organisational change literature. It has been recognised, for example, that levels of staff well-being can be used to measure the success of organisational change.

This study focused on the ‘hows’ (in what ways) and ‘whys’ (for what reasons) of staff well-being during organisational transition. The author observed two surgical units, over a period of nine months, both of which were undergoing transitions by relocating to new purpose-built facilities. Prolonged observation of the reality of practice in the two Trusts enabled data to be collected that focussed on staff perceptions and experience of transition.

Findings were arranged around the three different themes: information and communication; the nature of transition and the impact of transition on social structures. Preliminary findings were fed back to the Trusts through presentations and meetings. The research highlighted the following implications for managing transitions in the health service:

“...

It is not unusual to use ethnography to look at the reality of life for patients but to use this methodology to look at staff well-being within the NHS is quite uncommon, staff well-being is more often measured by surveys such as the annual NHS staff survey.

“...

A ‘bottom-up’ approach (such as ethnography) lends an authentic voice to data collection. As a novice in the ward environment I went in with a blank sheet of paper, without preconceptions about what the nurses’ working life was like: I was listening to others rather than just asking the questions I alone thought should be asked.

Rowena Senior
Adopt a systematic approach to communications. Change-related messages should be:

- Consultative/participatory
- Well-scheduled
- Transparent
- Inclusive of job-related technical information

Consider the nature of transition and how this may affect staff well-being:

- Transition can bring about an expectation that problems will be resolved; when this doesn’t happen it can be a cause of distress for staff
- Ensure change does not result in staff working in work spaces they consider to be restrictive or disconnected
- Changes to the pace of work brought about by transition can affect staff well-being

Consider the effects transition will have on existing social structures (relationships):

- Ensure internal and external support structures are in place to assist the transition
- Consider possible changes to team dynamics brought about by the transition as these can also affect staff well-being. For example, a sense of ‘family’ can be lost when small, established teams become subsumed in larger teams. This loss can have a negative impact on staff
7.2 Case Study: The MD Students

Theme 1’s three surgical MDs provided direct clinical input into research and raised the profile of the study within Trusts. Our model is an unusual route for both the MDs and research: we believe our MDs to be the only surgeons in the wider national CLAHRC who chose to explore service design rather than the well-trodden path of clinical trials or bench research. In the longer-term they plan to continue to work in the NHS, and have the potential to contribute to a ‘community of inquiry’, working with others to apply research findings in practice.

Craig Rimmer’s MD Thesis:

Examining the impact of a novel integrated care pathway for faecal incontinence on patients and within a NHS organisation.

Faecal incontinence (FI), the involuntary loss of liquid or solid stool is a common and socially isolating problem. Estimations of FI prevalence varies widely from 1.5% in children to up to 50% in institutionalised patients. The management of people suffering with faecal incontinence is widely reported to be disjointed, with patients forced to navigate complex, fragmented systems over long periods of time, with poor access to the social, psychological and specialist support needed to address their specific needs.

The research examined a novel integrated care pathway, implemented in one of the partner NHS Trusts to help to overcome the problems resulting from an historically disjointed service. The primary aim of the study was to assess how the implementation of the community-based pathway affected key stakeholders, whilst also observing and analysing the process of organisational change.

A patient focus group reported on the positive impact of the dedicated, streamlined pathway but redesign was not without its problems. There was a nine month delay in implementation due to lack of organisational management input and a shortage of key stakeholder time to drive the initiative, plus relatively low initial referral rates.

It was concluded that the new pathway may well prove the answer to the long-standing service delivery issues that have blighted continence services for over a decade.

Craig Rimmer explains why he chose to take a closer look at service redesign:

“Surgeons tend to associate medical research with clinical trials and lab-based work; service redesign didn’t enter into my head until I read the advert for my research post.

“Working on a two year project, I interviewed nurses, consultants and GPs, before the service was introduced, and after. I asked what went well, what didn’t and where people see the service in three years’ time.

“No not only have I produced something tangible for the Trust on the impact of the pathway, I’m hoping this research will help other organisations set up similar services and improve clinical outcomes.”
7.3 Case Study: The Communications Fellows

The CLAHRC purpose is to forge a mutually beneficial, forward-looking partnership between universities and their surrounding NHS organisations in order to create and embed a culture of research and evaluation into the routine activities of the NHS.

CLAHRC BBC to support this goal, Theme 1 of CLAHRC engaged a number of Communications Fellows (one from each of the three Trusts it was working with) to act as a link between the University and their partner Trusts. The brief was to improve Theme 1’s ‘embeddedness’ within the Trusts in order to help the University team better understand the notion of ‘academic marketing’, that is, the importance of communication, whether in a commercial or academic environment.

The role of the fellows included sharing information, facilitating introductions and ensuring Theme 1’s progress was communicated to as many people as possible within the Trusts, whilst keeping the research team informed of developments in the local NHS. The role was supported with NIHR RCF (Research Capability Funding).

Over the course of the project, the appointed fellows moved on (either externally or within their own Trusts) and a single fellow was appointed who sat within the research team and shared information - and feedback – with the partner Trusts and their communications teams. While this ‘in-house’ communications model was successful in maintaining momentum and identifying a wide range of dissemination opportunities, it was not as fully embedded as first envisaged.

What We Found

- Professional communicators working within the NHS were able to translate findings for a wider healthcare audience
- Each Trust had established internal communications channels and was also open to developing innovative ways of communicating with staff
- Each Trust was involved with research to varying degrees; one saw it as a priority, and part of the Trust’s identity, for the others it was more of a novelty
- Momentum can be lost because of staff turnover and the pressures of the ‘day job’ on in-house communication teams
- A Communications Fellow sitting within the research team (rather than the Trusts) has easier access to information but it is much harder to embed the research into Trust communications strategies
- Trusts’ internal communication channels have varying degrees of effectiveness; key stakeholders such as consultants and senior management are harder to reach this way. For these staff regular face-to-face contact is their preferred method of engagement
- Communications Fellows can bridge gaps in understanding between clinicians who may not be aware of academic timescales and potential benefits and researchers who may interpret this as disinterest
Implications For Research

- Start early: ensure communications is on the research agenda from the beginning

- Shared ownership: if research is on the Trust Board’s agenda, this will be reflected in the Communications Team’s activities

- Maintain momentum: take the time to update Trusts, patients and other stakeholders

- Talk the same language: give Trusts the information they need, concisely and in a timely way; messages must be understood, respected and trusted

- Use multiple channels and voices: communication is more effective when approaches overlap. Adapt communication according to the audience and avoid the use of technical research jargon

- Professional communicators can identify stories of interest that could be missed by academics

- Research is a story in itself: for Trusts it is not all about findings, there is a strong internal and external message in collaborative working. Trusts are working towards improving patient experience, through research and clinical outcomes and this should be publicised

- Keep in regular contact: researchers may be busy ‘behind the scenes’ but momentum can be lost in the period between recruitment, data capture and sharing findings
7.4 Patient And Public Involvement

The research team set out to recruit Patient and Public Involvement (PPI) representatives from across the three collaborating NHS Trusts by means of articles and flyers written by the Communications Fellows. The research team also contacted lead nurses at each Trust for each of the ‘tracer’ service areas, to help in identifying service users as potential advisors.

An active PPI group was established, and although some members left, continued recruitment ensured there was a membership of at least six at any one time. Monthly meetings were chaired by a PPI advisor. A member of the group was also invited to attend the research team’s regular management meetings to help in identifying service users as potential advisors.

Terms of Reference and documents outlining the roles and responsibilities of the PPI advisors and the researchers, in relation to the PPI group, were drafted by the group. One purpose of this was to ensure everyone involved was aware of the issues around confidentiality and disclosure of information.

The group had direct input into:

- Development of recruitment materials for patient and staff interviews
- Leaflet and poster design
- Website content
- Reports providing feedback to Trusts
- Patient recruitment methods

Suggestions such as attending outpatient clinics in hospitals, in order to recruit patients to participate in research, were also incorporated into the research methodology.

The group was also instrumental in the successful bid for funding to support an informal networking event to share best practice in PPI outside of CLAHRC.

At the end of the project, a study was carried out to evaluate the success of the PPI Group. The project entailed interviews with past and present members of the group and Theme 1 researchers, asking what can be learnt from the processes involved and the impact of the study on the PPI advisors themselves.

**What We Found**

- There was a shared motivation for joining the PPI group: the majority of the group members felt they had something to offer and ‘give back’
- There was a shared desire to try and help improve services and patient care
- PPI advisors felt they were contributing something to the project from their personal experiences of healthcare, and they could offer a bridging perspective on the research thus providing a fresh insight
- The advisors felt their involvement in the research was not merely a ‘tick box’ exercise because their views were embraced and valued by the researchers
- Well organised communication was seen as essential: researchers fed back to advisors via email, meetings and presentations
- Some of the advisors noted that the group could have been more diverse and recognised there may be barriers to recruiting a wider range of people
It was suggested that holding meetings within the university campus itself could have acted as a barrier to wider recruitment and engagement.

Due to ‘competing priorities’ advisors found it hard to attend every monthly meeting; if they missed more than one meeting in a row, they felt they were having to continually ‘catch up’ and could easily miss important updates.

Several Theme 1 PPI advisors were also members of other patient groups and highlighted that similar work was being carried out at other Trusts and universities.

**Implications For Researchers**

- **Be welcoming**: give all members the opportunity to share their views and opinions – and value their input
- **Create a dialogue**: feedback and communication from the researchers is highly valued
- **Clearly set out the parameters of PPI**, as well as the aims of the research
- **Widening participation** can be achieved by holding meetings on ‘neutral territory’; a community location can make the group more accessible and less intimidating than meeting at the university
- **Speak the same language**: develop clear, concise lay versions of what the research is about and produce clear guidelines on reimbursement for travel expenses
- **Explore using a variety of media** to keep PPI advisors – and the public – informed, including social media and dedicated sections on the website
- **Develop a ‘tap in tap out’ approach to involvement**: using a format where advisors are not ‘tied’ to attending every meeting is beneficial for people who have work and family commitments, enabling them to play a more active role
- **Consider developing different ‘levels’ of PPI**: for example, from lay advisor, to those with a greater understanding of research or healthcare. Reinforcing the value each advisor brings to research would ensure each person feels valued and can support group members to develop skills
- **Network with other PPI groups**: sharing experiences can avoid duplication and aid collaboration

**Case Studies: Patient And Public Involvement**

**Bhap Guru, Theme 1 PPI Advisor**:
“Theme 1 has given me an opportunity to make a difference to the wider health economy by the influence I have had on how research impacts upon front-line health care. It is valuable to have an opinion, be heard and know that a contribution from a member of the public is being taken seriously at all levels – an ideal chance to make a difference to people’s lives and especially those people/service users who are not always able to articulate their views.”

**Graham Bunch, Theme 1 PPI Advisor**:
“My thoughts, experiences and the benefits of PPI? Being involved in a practical way to comment on various research bids and papers; being able to offer alternative perspectives; to be able to compare and contrast different procedures and priorities across three health Trusts.”

**Sylvia Bailey, Theme 1 PPI Advisor**:
“Many PPI advisors/members, like myself, are motivated by interest and own life experiences of health care delivery, either personally or by a loved one.”
“Positive and worthwhile research cannot be successful unless PPI is working hand in hand with academics as theory, science and experience at point of delivery have to be considered and evaluated.

“Too often the very word ‘research’ will be intimidating to the majority of end health service users as communication between academics and lay people is very often not compatible or comprehending. Additionally lay people can often think ‘health research’ is simply about ‘experimenting’ with drugs/treatments and not about experience of health service delivery they have received, or are conversant with.”

Dr Jonathan Shapiro
Principal Investigator, CLAHRC BBC Theme 1 2008–2012

“Think of a clinical parallel to PPI: we do complicated tests on people in hospitals, but if they don’t make a difference, why do we do them? We do them because the ‘rules’ tell us to, but it’s expensive, it’s disempowering and it’s a waste of time.

“In the same way, if you involve patients in strategic research and evaluation – firstly, they’d wonder what on earth they’re being asked about, secondly, it won’t reinforce their own sense of value and worth and thirdly, it’ll just fizzle out because no-one would give it the credence that it needed.

“Whereas using PPI in the way we’ve done it, getting patients very deeply involved when their specific clinical services are involved, then people can see the relevance to them, their Trust, their condition, to the NHS. That’s when we involved patients most, and that really paid off in terms of their input to service change, to organisational identity, and even (in a roundabout way) to strategic change.

“So we’ve aligned the incentives, and I think that’s really important, because if you don’t, you may get engagement once, but you won’t manage to do it regularly.”

It is valuable to have an opinion, be heard and know that a contribution from a member of the public is being taken seriously at all levels.

Bhap Guru,
Theme 1 PPI Advisor
8 Summary Of Outputs

Publications


How to lose friends and alienate people – British Medical Journal (published 18th May 2011) – Authors: Shapiro J, Colin-Thomé, D, and Mulla A

Leadership in the NHS – British Medical Journal (published May 31st 2011) – Authors: Shapiro J, and Rashid S


Dying cases in emergency places: Caring for the dying in emergency departments – Social Science & Medicine (published November 2011) – Authors: Bailey C et al

Co-production in research: some reflections on the experience of engaging practitioners in health research – Public Money & Management (published May 2012) – Authors: Hewison A, Gale N, and Shapiro J

An evaluation of staff engagement programmes in four National Health Service Acute Trusts – Journal of Health Organization & Management (published 2013) – Authors: Hewison A, Gale N, Yeats R and Shapiro J

Using the framework method for the analysis of qualitative data in multi-disciplinary health research – BMC Medical Research Methods (published 28th September 2013) – Authors: Gale N et al *gained “highly accessed” status*

Subject experience of objective process: understanding the gap between values and practice for involving patients in designing patient-centred care – Journal of Health organisation and Management (manuscript accepted for publication) – Authors: Lord L, and Gale N

The patients, people, place model – Researching organisational culture during service redesign – Implementation Science (provisional acceptance, final changes made and revision submitted) – Authors: Gale N et al

‘It’s been quite a challenge’ – Re-designing End of Life Care in acute hospitals – Submitted to Palliative and Supportive Care – Authors: Hewison A, Lord L, and Bailey C

‘The team for both sides’? A qualitative study of change in heart failure services at three acute NHS Trusts – (Submitted to Health and Social Care in the Community-decision awaited) – Authors: Lord L, Dowdswell G and Hewison A

‘Just get on with it’ – Exploring Senior Nurses’ experiences during organisational change. – (Submitted to Journal of Advanced Nursing-decision awaited) – Authors: Boyal A and Hewison A

‘It’s much safer and a far better quality of care for the patients now’: Improving primary angioplasty services – (manuscript in preparation) – Authors: Mulla A, Jenkinson D et al

Time for centralised and resident 24/7 primary angioplasty services? – (manuscript in preparation) – Authors: Mulla A, Jenkinson D, et al

Examining the barriers to increasing acute cholecystectomy rates: ‘everybody’s doing something that they perceive is more sexy and exciting than gallbladders’ – (manuscript in preparation) – Authors: Boyal A et al

Engendering Clinical Leadership in Acute Trusts – (manuscript in preparation) Authors: Mulla A, Shapiro J and Hewison A

Conferences, Workshops And Seminars


“Co-designing research through effective partnerships” – Presenter: Dr A Hewison – CLAHRC for South Yorkshire Conference/CLAHRCs Learning Together event – October 2010, Sheffield

“CLAHRC Theme 1: Service Redesign the story so far” – Presenter: Dr J Shapiro – CLAHRC for Birmingham & Black Country Dissemination Event “Research for health in the new world” February 2011, Birmingham

“Researching organisational culture during service redesign: moving from woolly concepts to rigorous and relevant research” – Presenter: Dr N Gale – CLAHRC for Birmingham & Black Country Dissemination Event “Research for health in the new world” – Scientific Advisory Group (SAG) February 2011, Birmingham

“Health Service Redesign – Taking part in research to improve the NHS” – Presenters: Dr A Mulla & Ms L Lord – Black Country Cardiovascular Network meeting, September 2011

“Health Service Redesign Workshop – Learning and applying the lessons” – Presenter: Dr A Mulla, CLAHRC for Birmingham & Black Country Redesign Workshop, February 2012, Birmingham

“Patient-centred care as subjective experience or as objective process: understanding the gap between values and practice in service redesign” – Presenters: Dr N Gale and Ms L Lord – Organisation Behaviour in Healthcare Conference April 2012, Dublin, Ireland

“CLAHRC Theme 1 STEMI emerging findings” – Presenter: Dr A Mulla, Birmingham Cardiac Network, May 2012,
“Collaborative Research on Service Redesign in Hospitals: Strategies for Improving Knowledge Translation” – Presenter: Ms A Boyal – 18th Qualitative Health Research (QHR) Conference, October 2012, Montreal, Canada

“What becomes of the blocked hearted? Importance of good communication and speedy coordination of care” – Presenter: Ms L Lord – Midlands Health Psychology Network, February 2013, Birmingham

“What becomes of the ‘broken’ hearted? Heart Failure: the service redesign lessons so far” – Presenter: Ms L Lord – RCN International Nursing Research Conference, March 2013, Dublin, Ireland

“Coping with Organisational Change: Senior Nurses’ Perspective” – Presenter: Ms A Boyal – RCN International Nursing Research Conference, March 2013, Dublin, Ireland

“Herding cats – how may change be engendered amongst clinicians?” – Presenter: Dr A Mulla – IRSPM healthcare conference: Theme “Managing Healthcare Professionals”, April 2013, Prague, Czech Republic

“STEMI (ST elevated myocardial infarction) – A tale of three pathways’ Improving call to balloon times: a mixed methods evaluation of three primary angioplasty services in the West Midlands” – Presenter: Dr A Mulla, NIHR Seminar Series, University Hospitals Birmingham NHS Foundation Trust, July 2013, Birmingham

“Let’s overturn scientists’ prejudice against marketing” – Presenter: Dr J Shapiro – Society for Academic Primary Care (SAPC) 2nd Dangerous Ideas Soapbox, July 2013, Nottingham

“Knowledge brokering through boundary spanning: The role of a CLAHRC MD student” – Presenter: Mr C Rimmer – CLAHRC B&BC dissemination event September 2013, Birmingham

“Exploring the Policy Implications of Service Redesign in Healthcare” Presenter: Dr A Hewison – Health Services Management Centre (HSMC) Policy Breakfast, October 2013, Birmingham

“Knowledge transfer of health services research is impeded by a lack of policy levers” – Presenter: Dr A Mulla – Health Services Research training session (preconference event to EPH Conference), November 2013, Brussels, Belgium

“Your NHS needs you! Your Views Matter” – Sandwell and West Birmingham Hospitals NHS Trust Annual General Meeting, September 2011, Birmingham

“The eye of the storm: Acute Trust strategy in times of change” – Health Services Research Network (HSRN) Delivering Better Health Services Symposium, June 2012, Manchester

“The importance of bypassing A&E in primary percutaneous coronary intervention (PPCI)” – School of Health & Population Sciences Poster session, October 2012, University of Birmingham, Birmingham

“Lessons in knowledge transfer: involving professionals in change – sell it, don’t tell it” – Evidence Live, March 2013, Oxford

“This is all the medical equipment you need to make a difference in health research.” – University Hospitals Birmingham NHS Foundation Trust Research Showcase, May 2013, Birmingham

“Delivering an Acute Cholecystectomy pathway: Barriers and facilitators to increasing Acute Cholecystectomy Rates (ACR)” – Association of Surgeons of Great Britain and Ireland (ASGBI)’s 2013 International Surgical Congress, May 2013, Glasgow, Scotland

“Does performing a “hot” cholecystectomy increase readmission rates? – Association of Surgeons of Great Britain and Ireland (ASGBI)’s 2013 International Surgical Congress, May 2013, Glasgow, Scotland

“Health Service Re-design Revolutions” – CLAHRC B&BC dissemination event September 2013, Birmingham

“What becomes of the ‘broken’ hearted: the role of the specialist nurse in providing psychosocial support for patients with heart failure” – British Psychological Society – Annual Health Psychology Conference, September 2013, Brighton

*Won best conference poster award

“CLAHRC Communications – Trust Staff, Stakeholders, Patients And Public Dissemination

“CLAHRC Research Theme 1: From structure to function; health service Redesign” – Baseline report, April 2010

“Help Shape the Future of Patient Care” – article on CLAHRC PPI event in Sandwell and West Birmingham Hospitals NHS Trust Membership newsletter, Spring 2013

“Patient involvement in research is: “fundamental to success”” – GP Bulletin Walsall Healthcare NHS Trust, April 2013

“We need to get over our fear of talking about dying” – by Dr C Bailey – article on The Conversation website, May 2013

“Research project puts service redesign under the microscope” – article on CLAHRC MD student Craig Rimmer, in Heartbeat – The pulse of Sandwell, City and Rowley Regis Hospitals and Sandwell community health, May 2013

“Spreading the word about research” – article in news@QEHB – For patient, staff, visitors and volunteers, June 2013

“Five minutes with Governor Graham Bunch (an active member of CLAHRC Theme 1 PPI group)” – article in Trust in the future – The newsletter for members of UHB NHS Foundation Trust, Summer 2013

“Death pathway label does little to help the dying” – by Dr C Bailey – article on The Conversation website, July 2013

“CLAHRC researchers share findings” – article posted on Birmingham Health Partners website, September 2013
9 Tips For Collaborative Working And Knowledge Transfer In Health Services Research

Tips For Researchers...

• **Collaborative working is labour intensive**: to reap the benefits, allocate appropriate time.

• **Align the incentives**: focus on current organisational and clinical challenges that are important to the service.

• **Build knowledge transfer into research timescales**: share relevant findings at agreed intervals to inform service redesign processes.

• **Create impact**: ensure that the methodological approach suits the environment; NHS staff are usually interested in benchmarking and often prefer statistical data, so start projects by capturing quantitative data that address their problems. In this way, they are more likely to become engaged in the process.

• **Share more than findings**: maintain momentum and engagement by communicating the research process, the *hows* and *whys* as well as the results.

• **Be open**: be explicit about the realities of research timelines and the use of research to investigate practice, not always to change it.

• **Be seen**: the visibility of researchers in the study settings is influential in expediting the research process. This can be best achieved by ‘embedding’ researchers in the partner organisation, even if only for short intervals; consider all feasible mechanisms (e.g. honorary contracts, secondments, shared posts) to ensure that researchers and NHS colleagues work alongside each other.

• **Build rapport**: encourage staff to meet and work together, whether managers and clinicians, senior and junior, NHS and research staff. All those involved need to recognise and value each other’s contribution and benefits of collaboration.

• **Speak the same language**: NHS staff are very busy, so long, detailed reports with technical research terminology can be off-putting and are unlikely to be read. Short focused reports that highlight the clinical and practical applications are a much better approach.

• **Translate**: Clinical and Communications Fellows span boundaries, translating research processes and findings for the NHS and clinical practices for researchers; create a community of inquiry that will live beyond the research project.

• **Be clear who benefits from the research**: NHS staff will not ‘buy in’ if they think it is not relevant. The work has to be seen to be primarily for their individual, organisational and patient benefit to create any chance of serious engagement.
...And Tips For Health Services Staff

- **Collaboration is more likely to be successful when NHS staff are equal partners:** research is an effective way of sharing good practice and attaining wider recognition.

- **Make research easy:** streamline the formal mechanisms that deal with research governance, and respond to researchers’ requests for information.

- **Share knowledge:** NHS staff spanning the boundary with academia in health services research help to build long term internal capacity for successful redesign.

- **Planning redesign? Think evaluation!** Start collection of data before change is implemented, capturing it before, during and after the change occurs. Timely data is essential in determining the impact of change.

- **Research provides rigour:** active participation by NHS organisations and staff as research champions is required to provide the relevance.

We work in a very complex NHS which is there to improve patient care and ensure a seamless patient journey...we are not here to be content in current practice.

**Clinician, Town Trust**

Team Member, CLAHRC Theme 1
A further £10 million from the National Institute for Health Research has been awarded to CLAHRC to continue evaluating and developing health services over the next five years. The great attraction of this award is that the NIHR funding complements the NHS contribution with £20.6 million matched funding from local health and social services.

Expanding its geographical footprint the new CLAHRC West Midlands (CLAHRC WM) is a partnership between local health services, universities, and local authorities focussing on four crucial areas of health:

- Health for Mothers and Children
- Mental Health
- Care for Long-Term Conditions
- The Prevention of Disease

CLAHRC WM’s mission is to create lasting and effective working relationships and an environment where close collaboration is the rule, not the exception. This work is supported by new scientific ways to measure the impact of changes and to make sure the best care is spread so that it can be delivered everywhere. In five years, the outcome should be better health, a better prospect of staying healthy, and a service in which every pound of the public’s contribution goes on services that use the best evidence of what works.

For more information visit www.clahrc-bbc.nihr.ac.uk or call 0121 414 9079

The NHS Change Model

In July 2013 the NHS Change Model was launched and a website created to support all staff involved in change projects within the NHS.

The NHS Change Model is a framework for change to help NHS commissioners and providers improve how they go about improvement and deliver NHS goals for quality and value through a common language for change. Building on what is collectively known about successful change the model has been developed in consultation with hundreds of senior leaders, clinicians, commissioners, providers and improvement activists.

The model’s eight components (see image) highlight many of the characteristics described in this report such as the importance of a shared approach (collaboration), spread of innovation and engagement to mobilise (knowledge transfer); improvement methodology and transparent measurement (applied research); rigorous delivery (timeliness); system drivers (identification of facilitators and barriers) and leadership for change (change champions) and as such can be seen as an evidence-based tool to support change processes in the NHS.

For more information see www.changemodel.nhs.uk
Our shared purpose

Does this improvement meet our shared NHS purpose?

Leadership for change
Do all our leaders have the skills to create transformational change?

Spread of innovation
Are we designing for the active spread of innovation from the start?

Engagement to mobilise
Are we engaging and mobilising all the right people?

Improvement methodology
Are we using an evidence-based improvement methodology?

System drivers
Are our processes, incentives and systems aligned to enable change?

Rigorous delivery
Do we have an effective approach for delivery of change and monitoring of progress towards our planned objectives?

Transparent measurement
Are we measuring the outcome of the change continuously and transparently?
11 Contributors

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Thank you to all our PPI advisors for their valued contribution.
Images courtesy of University Hospitals Birmingham NHS Trust, Walsall Healthcare NHS Trust and Sandwell and West Birmingham Hospitals NHS Trust and the University of Birmingham unless otherwise stated.