Project Title

Learning from National Clinical Advisory Team Reviews - 12/5001/59

Summary of Research:

We propose to conduct a qualitative content analysis of all the NCAT reviews undertaken and published between 2007 and 2012, over 100. This will be supplemented by a targeted literature review of the themes to emerge from the qualitative analysis. This will enable us to set the themes in the context of the current evidence base in each area.

NCAT Review Content analysis - We would develop our coding scheme using a mixture of deductive and inductive reasoning. This coding scheme will operate using a range of units of analysis pertinent to the information being sought. We would then conduct open coding, following the approach recommended by Strauss (1987). This coding scheme will have clearly defined and mutually understood analytical categories and systematic criteria for selection of data from the review documents into those categories.

Our coding scheme would aim to capture the essential attributes of the NCAT reviews pertinent to our research questions, such as:

- Location
- Scale (e.g. ward/service/multiple service/whole organisation/whole locality/whole region)
- Speciality category
- Time period over which the reconfiguration took place
- Who initiated the reconfiguration
- The key drivers for change (clinical and non clinical)

The type of evidence used by the NHS in the case for change and assessed by NCAT, including:-
Use of outcome indicators; Use of peer reviewed literature for example for cases based on volume and outcomes; Compliance with national service standards (eg stroke strategy); Workforce - quality of environment for training - College and Deanery inspections; Workforce - capacity to recruit and retain staff to provide safe level of cover; Service adjacency issues; Compliance with college guidance; Impact on patient access, Affordability issues; Quality of physical environment.
Quality of evidence used by NCAT in their assessment of NHS case, including

- Concurring with local case for change (with no additional evidence cited)
- Introduction of additional evidence (as above + including reference to new alternative models of care)

NCAT conclusions and recommendations, including:

- Whether or not agreed with case and key challenges made
- Assessment of safety and quality of clinical service model proposed
- Assessment of degree of engagement from clinicians, patients and GP commissioners
- Recommendations for action

Once the reviews were coded they would then be analysed by the research team using NVIVO to identify thematic patterns and conclusions emerging from the data.

Literature Review - We will undertake a literature review after the NCAT reviews content analysis.
We will conduct an exhaustive literature search of available management and biomedical databases that index research relevant to reconfiguration of services. This will involve

- scoping searches to help identify appropriate keywords, synonyms, spelling variations, etc
- search using both free text and database specific subject headings, e.g. MeSH, Thesaurus terms
- using advanced Boolean, truncation, "explode" and other search techniques
- If appropriate, use search filters for specific publication types e.g. systematic review

The search terms and inclusion and exclusion criteria for the literature review will be determined by the outcome of the qualitative analysis. We will first review abstracts. The full text of papers to be included will then be retrieved and reviewed by a researcher. Information extracted will be documented systematically and synthesised for write up under the themes identified in the review of NCAT submissions.

The research team, would then triangulate the original NCAT review, the evidence base, and any relevant underpinning documentation , to gain insight into the NCAT process and its strengths and weaknesses.

Background & Rationale (NB References provided at the end of this document)

Edwards and Harrison (1999) argued that research into the running and planning of hospital services has been neglected "it's rare for the results of hospital reconfiguration to be evaluated" (p1363). In the intervening period little has been done to address this gap. Perhaps the most significant piece of research was the work done by Spurgeon et al (2010) and funded by NIHR. The research used three case studies supported by a wide review of relevant literature to analyse and explain the process of reconfiguration and evaluate the consequences. One of their key conclusions was to view reconfiguration not as a singular event but a continuing process. They recommended more studies to follow through reconfigurations from planning to implementation. They also argued for a greater understanding of local solutions and the factors that led to their success.

As The King's Fund pointed out in our recent briefing (Imison, 2011), in any reconfiguration of hospital services there are four interlinked drivers: quality (including safety), workforce, cost and access. The challenge is to try to arrive at a configuration that optimises all these elements – as far as this is possible given the complex trade-offs that exist between them. Quality considerations include: access to highly trained professionals in all relevant disciplines, compliance with clinical guidelines, access to diagnostic technologies and other support services, as well as strong clinical governance and, for some conditions, the time it takes to access services. There are trade-offs between the quality and financial gains achievable through the concentration of services and the social and clinical costs to the patient of reduced access. There are also interdependencies between services – for example, withdrawal of paediatric services can threaten obstetric services, which rely on paediatricians to provide care for the newborn child.

The current evidence that can be drawn up to develop a clinical case for change has its limitations. There is good evidence to support centralisation of some services like stroke and trauma and highly specialist surgery such as

children's heart surgery (Spurgeon et al 2010, NHS Specialised Services, 2011). But for many other conditions there is no clear causal link between volume and outcome and where there is a link, the threshold for quality improvement can be quite low (Glanville et al 2010). Other factors can be just as important, such as nurse staffing (Friese et al 2008), hospital system resources (Bellal et al 2009), compliance with guidelines and knowledge transfer (Schell et al 2008).

A more compelling and linked driver for reconfiguration of services in many trusts is their capacity to provide junior and senior medical cover 24/7. Workforce drivers sit behind much of the recently published Royal College guidance (RCP,2010; RCOG, 2011; RCPCH 2011). Since the application of EWTD to junior doctors there has been a 50 per cent increase in the number of junior medical staff required to fill a rota and provide 24/7 care, and many units have struggled to achieve this. The RCPCH conducted a survey in 2009 that suggested that almost three-quarters of the trusts that responded would not be able to cope with the demands placed on them by the changes; they have calculated that overall there is a shortfall of 600 doctors and as a consequence some paediatric units will have to close (RCPCH 2011, p 16). Our analysis of the reviews conducted by the National Clinical Advisory Team will deepen our understanding of the reconfiguration process and will provide new insight to the clinical evidence base used by the NHS and the gaps that exist in the current evidence.

Why this research is needed now

The number of hospitals reconfiguring their services is growing. For example, in 2008, NCAT conducted 16 reviews. In 2012, NCAT have already undertaken 27 reviews with a further 11 in the pipeline.

The recent reforms to the NHS(Health and Social Care Act, 2012)have removed much of the organisational structure (Strategic Health Authorities and Primary Care Trusts)that provided leadership and governance to NHS reconfiguration processes. It is unclear where the leadership will come from in the future.

In this context, the role of the National Clinical Advisory Team becomes even more important as a source of good impartial advice and guidance. Work that can facilitate this is important and timely.

Aims & Objectives

What do the NCAT reviews undertaken and published between 2007 and 2011 tell us

- about the current pressures for reconfiguration within the NHS in England and the solutions proposed.
- the quality of evidence used by the NHS and NCAT, in making and reviewing the case for change

respectively, any key evidence gaps, and the opportunities to strengthen the clinical case for change.

Research Plan/Methods

Search Strategy

A search strategy is not relevant to the analysis of the NCAT reviews as all completed reviews within the period 2007 -2012 will be included.

Review Strategy

We will be undertaking a qualitative content analysis of all 100 NCAT reviews completed between 2007 and 2012. The coding scheme will be developed using a mixture of deductive and inductive reasoning. The coding scheme will operate using a range of unite of analysis pertinent to the information being sought. We would then conduct open coding. The cording scheme will have clearly defined and mutually understood analytical categories and systematic criteria for selection of data from the review documents into those categories.

We will undertake a literature review after the NCAT reviews content analysis. The search terms and inclusion and exclusion criteria for the literature review will be determined by the outcome of the qualitative analysis.

Design & Theoretical/Conceptual Framework

We propose to conduct a qualitative content analysis of all 100 NCAT reviews undertaken and published between 2007 and 2012. We would develop our coding scheme using a mixture of deductive and inductive reasoning. This coding scheme will operate using a range of units of analysis pertinent to the information being sought. We would then conduct open coding, following the approach recommended by Strauss (1987).

Sampling

100 NCAT reviews will be analysed.

Setting/Context

Not applicable

Data Collection

We will not be collecting any quantitative data.

Projected Outputs and Dissemination

In addition to providing the research report for the NIHR, we would produce a report for the National Clinical Advisory Team and their host the NHS Commissioning Board. We would also produce a King's Fund Briefing with the key messages for those undertaking and engaged in the reconfiguration of clinical services. The King's Fund publication would be supported by a targeted communications strateg developed by our specialist communications team. The King's Fund has strong relationships wiht the NHS Management and clinical community, policy makers and the media, and has a proven track record of applying research findings to shape policy and practice.

We will also aim to publish the findings in peer-reviewed journals.

As standard our communications strategy would involve:

All outputs would be freely available to download from our website and actively promoted within the NHS management and clinical community.

Press releases targeted at appropriate publications, organisations and individuals

A well publicised seminar or conference at which findings will be presented.

Project Management

Time Line - (More detailed Project Plan at end of this document)

Month 1

Set Up Phase

Month 2

Pilot coding framework

Month 3 & 4

Analysis of reviews

Months 5

Literature Review

Month 6 & 7

Write up findings

Month 8

Publication process

Month 9

Dissemination activity including writing articles for peer-reviewed journal

Research Management Arrangements

The grade 7 researcher will act as project manager for the work.

A project reference group will be established and serviced by the project team.

The reference group would include at least one of those involved in the previous SDO work funded in this area (Spurgeon et al, 2010)

SHA Reconfiguration lead

At least one of the Medical Royal Colleges

Independent Reconfiguration Panel

NHS Confederation

NHS Commissioners and Providers

Patient representative organisation such as National Voices

If ethics approval is NOT required, then justify

The work does not include any clinical intervention or involve scrutiny of clinical records or interviewing patients.

References

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Friese CR, Lake ET, Aiken LH, Silber JH, Sochalski J (2008). 'Hospital nurse practice environments and outcomes for surgical oncology patients'. Health Services Research, vol 43, no 4, pp 1145–63.

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Nicholson D (2010). NHS Reconfiguration Guidance, 29 July 2010. Gateway Reference Number 14543. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_117899.

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Schell MT, Barcia A, Spitzer AL, Harris HW (2008). 'Pancreaticoduodenectomy: Volume is not associated with outcome within an academic health care system'. HPB Surgery, article 825940.

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Strauss AL (1987). Qualitative Analysis for Social Scientists. New York: Cambridge University Press.

Project Plan Overview

NIHR - HSDR programme – Researcher Led work stream
Proposal: **Learning from National Clinical Advisory Team Reviews**