Commissioning Brief
13/07 - After Francis: Research to strengthen organisational capacity to deliver compassionate care in the NHS
Closing date: 30 May 2013

1. Purpose of call

This call invites research to support NHS organisations in responding to particular aspects of the Francis Inquiry, in strengthening local systems to deliver compassionate, patient-centred care. The results of the wide-ranging investigation into failings at the Mid-Staffordshire NHS Foundation Trust were set out in two reports. The first[1] focused on the neglect of patients and poor standards of care. The second[2] considered the adequacy of regulatory and supervisory systems. It also highlighted issues of negative culture, tolerance of poor standards and disengagement from managerial and leadership responsibilities. Some of the problems experienced at Mid-Staffordshire were extreme. However, all NHS organisations can learn from key system weaknesses identified in this thorough investigation.

The NIHR Health Service & Delivery Research (HS&DR) Programme funds robust research on the quality, access and organisation of health services. It addresses areas of uncertainty for local service leaders, rather than addressing questions of central policy. This call is focused on particular areas highlighted in the Francis reports where local organisations are asked to take action to **strengthen patient voice, improve frontline care and change culture through leadership.** Other questions of the national regulatory framework are beyond the remit of this Programme. This call asks for research which is not just descriptive, but tests interventions to improve care. It builds on existing work funded by the HS&DR programme on the quality of care for older people, organisational culture, governance, patient safety and staff wellbeing. It adds to other relevant work commissioned by the HS&DR Programme in direct response to the first Francis report (Department of Health 2010). The Francis Inquiry is important and will generate much debate and reflection. Further areas of research need may be identified which can be addressed in future calls.

2. Remit of this call: main topic areas identified

This call invites robust evaluations of interventions to improve the leadership, organisational culture and quality of frontline care across a broad range of staff. Although the Francis Inquiry focused on hospital care, this call welcomes high quality evaluations of relevant interventions in a variety of primary, community, mental health, joint health/social care and acute care settings.

Key findings from the first report of the Francis Inquiry (Department of Health 2010) included evidence of neglect, under-staffing and poor care in emergency departments and on general wards; disengagement of clinical staff from management and quality assurance; weak governance, staff engagement and supervision and handling of patient complaints. There were not only deficiencies in basic care – unobserved falls and failures in hydration, nutrition and continence care – but also problems of communication breakdown, lack of compassion and respect in the attitude of staff to vulnerable older patients. These `softer' aspects are key. They were highlighted by patients and families in evidence to the first Inquiry. Research has shown that it is often the relational aspects of care which determine levels of patient and carer satisfaction.

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[1] Department of Health (2010). Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009. Chaired by Robert Francis. HC 375-1. Stationery Office.
[2] Department of Health (2013). Report of the Mid Staffordshire Foundation NHS Trust Public Inquiry Volumes 1-3. HC-898-I-III. Stationery Office

Other important findings, highlighted particularly in the second report (Department of Health 2013) relate to the organisation – negative culture, poor clinical and managerial leadership and a lack of openness in discussing and acting on poor performance and quality failings. At all levels, the patient voice was not heard. It is now well established that safer organisations are those which share information about problems – for instance, with high levels of reported adverse incidents. Many organisations are trying different approaches to make their organisations safer, and to restore and maintain high standards of nursing and basic patient care. However, there is little evidence on what works best at what cost for whom.

The following areas have been identified as promising interventions where well-designed evaluation would provide useful evidence for clinical leaders and managers. The supporting information provides some background evidence for some of these exemplar initiatives which could be evaluated. This is not an exhaustive list. Other studies which test ways of improving compassion and dignity in care and strengthening organisational culture and leadership would also be welcome.

Sample initiatives to enhance dignity and compassion have been grouped under the following general headings:

- Strengthening patient voice
- Improving frontline care
- Changing culture through leadership

STRENGTHENING PATIENT VOICE

One of the consistent threads in evidence to the Francis Inquiry was the weak representation of patients and carers at all levels of the organisation. Across organisations, there are inconsistent approaches to measuring involvement and impact of patients and the public, over and above statutory requirements. Different organisations are experimenting with new approaches – structured `patient stories' at the Board, real-time patient feedback, involvement of lay members in patient environment and clinical audits. One trust has an action group of staff, patients and carers to set challenging targets for improving dignity. These and other initiatives need evaluation.

Measuring patient and carer experience is crucial for organisations to understand whether they are providing good care. Annual patient surveys may not provide enough information for action and understanding of underlying system weaknesses. Service or specialty-level patient-reported experience measures may be most helpful in identifying areas for improvement, together with patient tracker and real-time data. . Research is needed to develop and test valid measures of patient experience, with a focus on compassion and dignity, and to evaluate the way such tools can be used to influence staff behaviours and systems.

IMPROVING FRONTLINE CARE

Ward/team leaders have a critical role to play in setting values, expectations and behaviours to provide patient-centred care. It may be helpful to look at high-performing clinical teams or wards to understand better what works and why. This might take the form of case study/observational research on purposively sampled clinical teams. It would also be important to identify those organisational features which support high-performing teams – and the interactions between trust structures or processes (meso-level) and clinical

micro-systems (wards or teams). Work is also needed to develop and validate routine measures of ward or team-based activity and local climate, which are clinically meaningful and include dimensions of compassionate care.

Staff training needs to enforce values and relational aspects of care (kindness, empathy and respect) as well as developing clinical competences. This includes pre- and post-registration training for clinical staff (with review of current curricula) and wider training for all staff. Interventions differ, from simulation and group work to mentoring and coaching both within and across disciplines. Other important initiatives include staff training in emotional resilience, including mindfulness, compassionate mind training and stress management techniques. Research could include evaluation of initiatives such as the US-developed Schwartz round, providing a structured, facilitated forum for staff to consider the emotional challenges of caring for patients. Other organisations have set up compassion circles or seminars. Initiatives such as these could be evaluated to identify what kind of training, development and emotional support initiatives are most cost-effective for different groups of staff and settings.

Other ward-based interventions to improve the quality of basic care need evaluation. This includes the impact of structured (or intentional) nursing rounds, with regular – often hourly – checks of patients by nurses and assistants using standard prompts and scripted tools, including open questions to check on patient wellbeing as well as functional issues such as hydration and pain control. There may also be scope for work to strengthen quality of care on the ward, such as assessing changes to medical ward rounds to provide multidisciplinary input, structured bedside reviews and debriefing.

CHANGING CULTURE THROUGH LEADERSHIP

The second report of the Francis Inquiry (Department of Health 2013) highlighted key failings of the Board and senior trust leadership. The report highlighted the ways in which the Board was weak, with a negative culture, professional disengagement, poor governance and lack of focus on standards of service. Evidence has helped to highlight some features of good clinical and corporate governance and high-performing Boards. For instance, we know that structured Board walkabouts appear to be effective. However, other measures such as appointing Board-level chief experience officers are unproven. Some organisations have also undertaken fundamental `compassionate redesign', with a whole system service improvement to review services and processes through the lens of compassionate care. Evaluations of cultural improvement initiatives like these are needed, with careful study design to be able to generalise findings while recognising the importance of local context. Some work has been done to review tools to measure organisational culture but more work could be done on their use and impact. At the same time, mixed-method studies are needed to examine the relationship between organisational culture and performance in a range of healthcare settings.

More evidence is needed on the role of senior managers and clinical leaders in setting expectations and values of patient-centred care. This includes the function and behaviour of Board members and demonstrable vertical awareness of and response to evidence of patient experience. To date, more attention has been paid to medical managers, but research would be helpful to understand and improve the effectiveness of nurse directors and leaders in developing and sustaining compassionate care `from ward to Board'. This might include examination of distributed leadership and patterns of formal and informal authority among nurses within organisations and impact in driving patient-centred care.

Another important area in strengthening Board capability and focus on quality of patient care is the use of intelligence. The second Francis report noted the `lack of critical analysis and openness' at mid-Staffordshire hospital (Department of Health 2013).

Different kinds of dashboards have been developed at trusts, combining various process measures (waiting times, staffing levels and absence rates), clinical markers (infection or surgical complication rates) and patient experience (complaints, feedback surveys). More work is needed to test the impact of different bundles in measuring quality. For instance, recent debate has warned against over-reliance on mortality measures and under-use of important information such as clinical audit data. Many existing Board-level metrics fail to capture some of the relational measures of good care, which need to be considered alongside `hard' indicators of performance.

3. Key requirements

High quality health services research is invited to address key knowledge gaps. Most of these will involve complex service initiatives and mixed-methods will usually be needed. All applicants should consider the following key criteria for successful projects:

- Led by research teams with track record in complex service evaluations across settings
- Focused on plausible interventions, with clear description of intervention and evidence to support this (for instance, a particular training method) – but note, the development of new service interventions will not be funded as part of this call
- Robust study design which allows control and comparison with generalisable findings, while giving weight to local context.
- Potentially scaleable to the wider NHS
- Generating durable findings, which would remain relevant in 3-5 years' time.

Further information on the background to this call, including knowledge gaps and relevant research is given in supporting information.

4. Notes to Applicants

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care.

The NIHR Health Services and Delivery Research programme is funded by the NIHR, with contributions from NISCHR in Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams (this call is under the commissioned workstream); Researcher-led and Commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research.

5. Application process and timetable

Please ensure you have read the guidance notes and all documents provided to support this call.

Should you have any questions or require any further clarification please refer to the NETSCC FAQs at HS&DR programme - FAQs, if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the HS&DR website by **1pm** on **30 May 2013**. All proposals will initially be checked for remit and competitiveness[3].No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in **July 2013**. Shortlisted applicants will be invited to submit a full proposal via the HS&DR website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in **December 2013**. Please note that these dates may be subject to change.

6. Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at:

http://transparency.number10.gov.uk/
http://www.ogc.gov.uk/policy_and_standards_framework_transparency.asp
http://www.contractsfinder.businesslink.gov.uk/

[3] '***Non-Competitive***' means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the HS&DR programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team.