NIHR HS&DR Full Application: Detailed Project Description

Full title of project: A Longitudinal National Evaluation of Schwartz Centre Rounds®: an intervention to enhance compassion in relationships between staff and patients through providing support for staff and promoting their wellbeing.

Introduction

Schwartz Rounds background and description

Schwartz Center Rounds® ('Rounds') were developed by the Boston-based Schwartz Center for Compassionate Healthcare[1] fifteen years ago following the death of Kenneth Schwartz, who died in 1995 from lung cancer. During his treatment, Ken Schwartz noted how some healthcare staff were able to be compassionate whilst others were not and how the same staff member could be compassionate one day and not the next. Before his death, he set up the Schwartz Center as a not-for-profit organisation designed to nurture compassion in healthcare, to encourage healthcare workers to make "the unbearable bearable" through "the smallest acts of kindness" and to strengthen the relationship between patients and their clinical caregivers. The premise is that caregivers are better able to make personal connections with patients and colleagues when they have greater insight into their own responses and feelings and have an opportunity and space to process these feelings by listening and sharing their experiences with colleagues.

The Rounds are a multidisciplinary forum, where clinical and non-clinical staff from across the healthcare setting / hospital come together to discuss the non-clinical aspects of caring for patients i.e. the psychological, emotional and social challenges associated with their jobs. Rounds typically take place once a month and are held at lunchtime, with lunch provided. They offer healthcare providers a regularly scheduled time to openly and honestly discuss the social and emotional issues they face in caring for patients and families, in a safe and confidential environment. In contrast to traditional medical rounds, the focus is on the human dimension of medicine.

Each Round lasts for one hour and begins with a multi-disciplinary panel presentation of a patient case by the team who cared for the patient. The panel that presents describe the impact that the experience of looking after that patient has had on them. A trained facilitator then guides discussion of emerging themes and issues, allowing time and space for the audience to reflect with the panel on similar experiences that they have had. Attendance is voluntary and staff attend as many or as few Rounds as they are able. In 2013 Rounds are currently running in 300 healthcare organisations in the USA and 31 in the UK.

Schwartz Rounds evaluations

Rounds commenced in the USA in 1997 in Massachusetts General Hospital, Boston. In 2008 the Schwartz Center Boston commissioned an evaluation by which time Rounds were provided in more than 135 hospitals across the USA. The evaluation aimed to assess the impact of the rounds on self reported changes amongst attendees about their beliefs about patient care; their behaviours during healthcare interactions; their participation in teamwork and their sense of stress and personal support. A prospective on line survey was sent to staff attending rounds at 10 new provider sites at baseline and after 7 rounds had been held and analysis of retrospective surveys at six 'experienced' rounds sites was undertaken. Forty four interviews were undertaken with participants, facilitators, Rounds leaders and hospital administrators. (Results of this US evaluation suggest a 'dose' effect, with those who attend more frequently reporting the greatest benefit (Lown and Manning 2010)). Attendees reported that attending rounds enhanced their likelihood of attending to psychosocial and emotional aspects of care, reported better teamwork (especially when attending rounds with co-workers) and there was a decrease in stress. Rounds were said to be restorative; to allow staff to constructively process difficult patient care experiences, and to gain reassurance, support and new ways of coping; they were said to *provide an opportunity for dialogue that doesn't happen anywhere else in the hospital.* Respondents also described changes in institutional culture and greater focus on patient –centred care (Lown and Manning 2010).

In 2009-10 the pilot of Rounds in two UK hospitals was evaluated (Goodrich 2011). The primary purpose was to test feasibility and acceptability - whether Rounds could transfer successfully from the States to the UK and the extent to which they had a similar impact on attendees as reported in the US evaluation. The evaluation used feedback from participants after each round, a pre-post survey of Rounds participants and interviews with key staff in both trusts. In this small pilot Participants reported benefits for their day-to-day care of patients and that team work is strengthened. Rounds are experienced as a source of support in day-to-day patient care and small

[1] www.theschwartzcenter.org

but noteworthy changes in hospital culture were reported. Attending Rounds helped staff to feel part of a whole organisation rather than feeling isolated and working in what can feel like fragmented services. Staff also reported that the presence of the Rounds and being able to attend them in work time, made them feel proud to work for their organisation (Goodrich 2011). Limitations of this evaluation include small numbers involved in the pre- and post- pilot survey, no observation of Rounds or practice. However the primary purpose of this evaluation was feasibility and acceptability and it concluded that the Rounds had transferred successfully from the United States to the United Kingdom, with similarities between the two pilot trusts and Rounds providers in the United States being more marked than any differences. A need for Rounds was revealed and participants from many backgrounds valued them. This evidence encouraged The Point of Care programme to continue to facilitate the spread of Rounds in other hospitals in England.

Schwartz Rounds in the UK

In 2009 the Point of Care programme at the King's Fund signed an agreement with the Schwartz Center to pilot Rounds in the UK. As mentioned above, they were piloted in two UK hospitals (the Royal Free NHS Trust and Cheltenham and Gloucester NHS Trust) for one year beginning in 2009, with the support of the Kings Fund and these rounds continue to be delivered and are now self sustaining. Since the UK pilot approximately 31 further hospitals and hospices in the UK have implemented Rounds, or have plans to do so. The license agreement transferred from The King's Fund to the Point of Care Foundation when it was established in May 2013. Under the terms of the agreement NHS trusts and hospices have to meet certain criteria: demonstrable support from the trust's chief executive and board; identification of a skilled and willing facilitator(s); a senior doctor to champion the Rounds; dedicated administrative support; a commitment by the hospital to provide lunch for those who attend; and a multidisciplinary steering group. It is the responsibility of the steering group to identify teams to present a case to plan ahead the topics and cases to be presented, manage the advance publicity for the Rounds, and evaluate each month, by analysing the feedback sheets given to all attendees. The Point of Care Foundation provides advice and support for the first two years, with a particular emphasis on training and coaching the Rounds facilitators. Once the Rounds are established it is expected that they will run indefinitely, embedded into the routine of the hospital or hospice.

Schwartz Rounds were identified in the Francis report (2013), and in the UK government's response to that report (DH 2013) as an intervention to bring staff together and with a positive impact on staff and on compassionate care. To date little is known about the organisations that provide Rounds, or a detailed understanding of attendance patterns etc. In May 2013 Dr Dan Poulter, Parliamentary Under Secretary of State at the Department of Health, announced funding for expansion of Rounds across the NHS to organizations wishing to run them. However, it is important to note that Rounds are not prescribed or in any way mandatory (quite the reverse) and roll-out to all NHS organisations is not therefore inevitable.

The US and UK evaluation of Rounds (Lown and Manning 2010; Goodrich 2011) show positive benefits, but neither evaluation is particularly robust. In the UK only two pilot organisations were evaluated. At this point in time, when uptake of the Rounds is expanding rapidly in the UK, there is an urgent need to understand whether and how they confer benefit, to whom and it which contexts, so that their value, or otherwise, can be better gauged and their implementation tailored locally to optimise the benefits for patients and for staff. We are therefore proposing a multi-method evaluation study, using the principles of realist evaluation, as we believe this is the methodological approach best placed to meet those needs. Few interventions exist to support staff with the emotional aspects of providing patient care and to sustain compassion in practice, and even fewer have been evaluated. This evaluation will provide much needed robust evidence for the NHS and other care providers regarding the effectiveness of Rounds as an intervention to support staff post-Francis and thereby enhance the quality of patient care.

Summary of Research

Please provide an expert summary of the project plan of investigation plus any additional points required to support statements made in the above sections, and include any key references required to justify the points made (e.g. in the use of particular outcome measures or methods of analysis).

Following the Francis inquiry, which highlighted major shortfalls in provision of care to patients, there is a widely acknowledged need to find ways to better support staff to deliver compassionate patient care. Schwartz Center Rounds (Rounds) have been recommended as an organisational intervention to enhance the quality of patient care by providing emotional support to staff members through reflection and facilitated group discussion (Francis 2013; DH 2013). Rounds are regular facilitated meetings where healthcare staff can explore the emotional and social challenges of providing compassionate patient care in a safe, non-challenging environment.

They were developed in the US but are rapidly spreading in the UK (23 hospitals and 8 hospices have already adopted them, and this is expected to increase to 40+ providers by 2014).

Rounds may benefit staff by providing support and reducing stress relating to the emotional aspects of providing patient care, which in turn may help them to deliver high quality compassionate patient care. Evidence of benefit has been reported in small-scale evaluations, with reliance upon relatively weak design, but has yet to be determined in robust studies. Given the rapid uptake and growing interest in Rounds in the UK further research is now needed to determine what mechanisms affect their uptake and successful implementation at the organisational level, as well as determine their impact on individual staff wellbeing, the culture of teams and the wider organisation in support of delivering compassionate care.

We propose to undertake a longitudinal evaluation of Rounds, using mixed methods and underpinned by the principles of realist evaluation, in order to determine what works for whom, and in what circumstances, focusing on the impact of Rounds on staff well-being and staff capacity to deliver compassionate patient care.

RESEARCH QUESTION: How does participation in Rounds affect staff wellbeing at work, social support for staff and improved relationships between staff and patients including compassion?

AIMS:

i) To investigate and establish contexts within which and mechanisms whereby Rounds influence staff wellbeing at work and social support
ii) To identify and evaluate any changes that take place in relationships between staff who attend Rounds and their patients and colleagues
iii) To identify and consider any wider changes that may be felt in teams or across the wider organisation in relation to the quality of patient care and staff experience following the introduction of Rounds, and to suggest whether, and if so how, these may be linked.

We will meet these aims in two phases of work:
In **Phase 1** we will undertake a critical scoping review of the reflective learning literature providing a critical review of the alternatives to Rounds and their evidence base; undertake Rounds Provider Mapping & calculate the costs of implementing and running Rounds: profile of all 31 / 40+ Rounds provider organisations and reasons for adoption of Rounds (interviews with key Rounds champions).

In **Phase 2** we will undertake ten organisational case studies (sampled from Phase 1 for maximum variation and to include new providers) in which will we conduct a) a staff survey and b) ethnographic field work.

Phase 2a) Staff survey: we will conduct a longitudinal survey (2 time points) with a total of 800 Rounds attenders plus 2500 controls to include regular attendees, irregular attendees, drop-outs and non-attenders, so we can look at the relationship between Rounds attendance and changes in staff wellbeing at work, social support and relationships with staff and patients.

Phase 2b) Ethnographic Field work: we will undertake ethnographic observation of Rounds, team preparation meetings and facilitator training and interview a range of staff in 10 Rounds organisations (organisational case studies), including attenders, non-attenders and managers.

Finally we will examine all the data from Phases 1& 2 and hold events/ workshops (in the ten case study sites), with Rounds presenters, participants and stakeholders to present and check research findings with them and ask for feedback.

The research findings will result in recommendations which we will share widely (including UK healthcare providers; healthcare managers and commissioners; Rounds providers; Point of Care Foundation; Schwartz Center Boston & wider public and academic community).

OUTPUTS

1. A review of evidence base to determine mechanisms by which Rounds may ‘work’ and a review of other forms of reflective learning providing a critical review of the alternatives and their evidence base.
2. Descriptive profiles of current Rounds provider organisations including reasons for adoption and associated costs.
3. Relationship of Rounds attendance to self-reported changes in staff wellbeing, social support and behaviour towards patients and colleagues

4. In-depth understanding of the process of Rounds and the mechanisms and contexts in which they may (or may not) be (i) effective for staff and (ii) impact on patient care
5. An understanding of any wider changes that may be felt in teams or across the wider organisation in terms of quality of patient care, and staff experience.

Background and Rationale

Poor quality patient care in hospitals has been highlighted by the Francis report, following the public inquiry into Mid Staffordshire hospital (Francis 2013) and previously by others (Health Service Ombudsman 2011; CQC 2011; Commission on Dignity in Care 2012). The report identified an apparent indifference to suffering, lack of caring, and questioned the adequacy of current systems to support provision of compassionate patient-centred care. There has long been concern about the demands placed on staff in healthcare and the effects of these on the health and wellbeing of staff (Karasek 1979; Cox and Griffiths 1995). Medical and nursing staff are known to have high levels of stress (Payne and Firth-Cozens 1987; Mimura and Grifiths 2003), burnout (Maslach and Jackson 1982; Schaufeli et al 1993) and psychological morbidity (Taylor et al 2005; Wall et al 1997; McManus et al 2002). Staff wellbeing impacts directly on patient-care (Taylor et al 2007; Maben et al 2012a). The way in which healthcare-staff experience their job impacts on: individual performance as professionals, including for example, the number of medical errors made; patients' experience and healthcare outcomes, including rates of patient mortality; and the productivity and performance of organisations as a whole (West 2004). It also affects staff's ability to show empathy and to show compassion to patients and their carers (Maben et al 2012). We know that *"really relating to patients takes courage, humility and compassion, requires constant renewal by practitioners and recognition, re-enforcement and support from colleagues and managers. It cannot be taken for granted"*(Maben et al 2010). The Francis report (2013) calls for culture change so that frontline staff are encouraged and supported to provide compassionate care to their patients and cites Rounds as a possible intervention to facilitate staff support.

Health care staff work in highly pressurised environments and their work is complex, intense and emotionally challenging. This has an impact on staff well-being, which in turn affects staffs' ability to compassionately care for patients (Maben et al 2012; Goodrich and Cornwell 2008). Our own previous research on staff wellbeing and its links to patient experience has shown a clear relationship between the wellbeing of staff and patients' experiences of care: individual employee wellbeing is an antecedent, rather than a consequence, of patient care performance (Maben et al 2012a). Similarly, the Boorman review of staff health and wellbeing in the NHS found that 80% of staff felt their health and wellbeing impacted on their care for patients, but only 40% thought that their employer was proactively trying to do something to improve it (Boorman et al 2009). National NHS staff and patient surveys have shown a correlation between poor patient experience and poor staff experience in low performing trusts and the reverse- a correlation between good staff experience and good patient experience in high performing organizations (Raleigh et al 2009).

Research evidence to date, presents a compelling case for the need to protect staff health and wellbeing and focus on improving staff work experience, including staff social support and psychological wellbeing. There are a number of initiatives that provide support for staff and opportunities for reflection on practice, such as Restorative supervision (Wallbank and Woods 2012), a pilot in the NHS of 'Samaritans' type buddying scheme to support staff (Sawbridge and Hewison 2011) and methods of providing reflective space such as After Action Reviews (Walker et al 2012), Balint Groups in Primary care (Balint et al 1993), resilience training/workshops (Antonovsky 1987) and Action learning sets (Pedler 1997) as well as Schwartz Center Rounds. The range of reflective and supportive learning spaces will be scoped in our Phase 1 review providing a critical review of the alternatives and their evidence base.

In this study we use Paul Gilbert's (2009) definition of Compassion:
"The motivation to be caring for the purpose of alleviating distress and facilitate the flourishing and development of the target of the caring. The skills required are sensitivity; sympathy; empathy; distress tolerance and being non-judgmental to create feelings of warmth, kindness and support" (p.203).

Drawing on the theoretical literature, reflective spaces may be expected to produce benefit through the mechanisms of self disclosure and a potential rise in self compassion, which Gilbert (2010) has suggested is an important aspect of developing positive affect and compassion for others (Gilbert 2010). Self-disclosure, or the sharing of personal information with others through verbal communication, is an integral part of social interaction. Disclosure can provide an opportunity to express thoughts and feelings, develop a sense of self, and build intimacy within personal relationships (Derlega et al 1993). A growing literature suggests that the reaction of the confidant is one of the most important factors predicting whether disclosure will be beneficial or not. For example, in a longitudinal examination of disclosure of abortion, women who disclosed but felt that their

confidant was not fully supportive did not show benefits of disclosure in the form of lower psychological distress (Major et al 1990). Other studies have also shown participants do not experience the benefits of disclosure when confidant reactions are neutral or negative (Lepore et al 2000). These theories also fit with research evidence that demonstrates a link between social support at work (from managers and co-workers) and psychological wellbeing (Stansfeld et al 1998). To date, researchers have paid limited attention to the potential mediating mechanisms, or reasons *why*, disclosure can affect such a wide array of outcomes or have predominantly relied on an alleviation of inhibition mechanism. This process, borrowed from the literature on written disclosure (e.g. Lepore, 1997; Pennebaker 1995), suggests that individuals benefit from disclosure to the extent that they can cognitively or affectively process previously inhibited information. While this process has been demonstrated to apply in the context of verbal disclosure, it cannot explain the full range of effects caused by interpersonal forms of disclosure. Thus, further theorizing is needed to fully elucidate the mediating mechanisms whereby verbal disclosure can affect well-being (Chaudoir & Fisher 2010). As outlined above Rounds are a multidisciplinary facilitated fora where staff come together once a month to discuss challenging aspects of caring for patients: the emotional, social and ethical challenges associated with their work. Rounds are designed to provide staff with an opportunity to reflect on their experiences of delivering care, including both its rewards and frustrations – on what the Schwartz Center calls the 'human dimension of medicine'. Evidence from the Rounds evaluation in the USA and pilot in the UK also suggest that through a 'ripple effect' Rounds may also impact on teams and whole organisations changing conversations about care and through this care cultures (Sanghavi 2006; Lown and Manning 2010; Goodrich 2011;). Rounds are spreading rapidly through 'pull' from NHS organisations and hospices in the UK keen to support staff with the challenges of caring work, but to date evidence of their impact and mechanisms by which they work is limited and has yet to unpick the active ingredients and mechanisms through which Rounds operate in the USA (Sanghavi 2006; Lown and Manning 2010). The UK pilot was primarily testing feasibility and acceptability in the UK (Goodrich 2011).

This study will use a realist evaluation approach which is drawn from Pawson and Tilley's seminal work, Realistic Evaluation (1997). It is a type of theory-driven evaluation, an approach grounded in realism which asserts that both the material and the social worlds are 'real' and can have real effects; and supports an understanding of what causes change. The approach has implications for programme evaluation and suggests that programmes 'work' in different ways for different people (that is, programs can trigger different change mechanisms for different participants) and that the contexts in which programmes operate make a difference to the outcomes they achieve. Programmes 'work' by enabling participants to make different choices which often requires a change in participant's reasoning (e.g. values, beliefs, attitudes) and/or the resources (e.g. information, skills, material resources, support) they have available to them. This combination of 'reasoning and resources' is what enables the programme to 'work' - the programme 'mechanism' (Pawson and Tilley 2004). In this study we will examine what works for whom in which contexts by examining impact of Rounds on individual staff wellbeing, teams and reported patient care delivery at different levels within organisations. It will build upon the current evidence base regarding the relationship between staff and patient wellbeing, and will evaluate the uptake and impact of Rounds in a range of settings.

Evidence explaining why this research is needed now

We lack effective organisational level multi-professional interventions to support NHS staff to manage the human and emotional aspects of delivering care. The Francis report presents an extreme example of what can happen when support for staff is lacking and cites Rounds as an important intervention to support teams to deliver compassionate care (Francis 2013). The negative impact on wellbeing and patient care of jobs with high demand and low control (common in hospitals) is exacerbated when support for staff to undertake this difficult work is also lacking (Maben et al 2012a). High levels of stress and burnout among NHS staff affect their ability to provide high quality care (Maben et al 2010; 2012b) Stress among health care staff is greater than in the general working population and explains more than 25% of staff absence (Boorman 2009); while depression, anxiety, a loss of idealism and empathy are also reported by doctors and nurses (Reiss 2010; Harvey et al 2009). Burnout symptoms include a reduced sense of personal effectiveness, emotional exhaustion and depersonalisation which can limit compassion or, worse, produce cruelty in dealings with patients (Firth-Cozens and Cornwell 2009). Caring for ill or distressed patients may lead to staff needing to confront their own vulnerability. They may "withdraw" to protect themselves emotionally, retreating behind organisational barriers within the health care system (Menzies Lythe 1988). Having a supportive space to reflect, process and debrief difficult situations is important (Schon 1991; Pennebaker 2003. Rounds have the potential to provide this space. As mentioned earlier, a US evaluation suggests patient care improvements were evident for Rounds attendees and that there is a 'dose' effect: the greater number of Rounds attended, the higher the patient interaction survey score (Lown and Manning 2010). In the UK uptake of Rounds is currently increasing substantially with a 'pull' from organisations keen to support staff post Francis. The mention of Rounds by Robert Francis and the funding and endorsement by the Department of Health is also making them popular. An intervention that is spreading at

pace requires careful scrutiny and a robust evaluation to investigate and establish receptive contexts and establish the mechanisms by which Rounds are effective, in what contexts and for whom.

Aims and objectives

In this study we will examine if and how Rounds influence: staff wellbeing at work and social support; changes in relationships with colleagues and patients; 'ripple effects' in the wider teams and organisation in terms of compassionate care and patient care improvements.

RESEARCH QUESTION: How, in which contexts and for whom, does participation in Rounds affect staff wellbeing at work, social support for staff and improved relationships between staff and patients including compassion?

AIMS: i) To investigate and establish contexts within which and mechanisms whereby Rounds influence staff wellbeing at work and social support (ii) To identify and evaluate any changes that take place in relationships between staff who attend Rounds and their patients and colleagues (iii) To identify and consider any wider changes that may be felt in teams or across the wider organisation in relation to the quality of patient care and staff experience following the introduction of Rounds, and to suggest whether, and if so how, these may be linked.

OBJECTIVES

1. Review the evidence-base re reflection, group work and disclosure/discussion of emotional/challenging events for the mechanisms by which Rounds may work and scope the reflective learning literature and critically review the alternatives to Rounds and their evidence base.
2. Map the profiles of current UK Rounds provider organisations including reasons for (and time since) implementation ('pull'); attendance at Rounds; NHS Staff and in-patient survey results; staff absenteeism; Occupational Health function and use this data to inform sampling of ten case study sites for maximum variation.
3. Determine cost and resource implications by examining resources required to establish and sustain Rounds in provider organisations.
4. Evaluate in 10 different case study Rounds providers whether Rounds attendance impacts on NHS staff wellbeing at work, social support for staff and behaviour change towards patients and colleagues.
5. Examine staff experiences of attending, presenting and facilitating Rounds.
6. Conduct in-depth case studies of Rounds in 10 settings to examine how Rounds are operationalised and the mechanisms by which wellbeing and social support might be influenced (or not) by observation and interviews regarding (i) reasons for variance in attendance and dropout rates and attendees experiences; (ii) influence of variance in facilitation (e.g. in relation to content/style); (iii) topics presented and Round climates; (iv) any influence on team hierarchy and team work and on coping with stress; (v) factors influencing 'success' or otherwise of Rounds in organizations; (vi) wider 'ripple' effects felt in day-to-day practice and patient care interactions.
7. Make recommendations regarding the role of Rounds in healthcare provider staff support, to inform future practice: to Round providers; the Point of Care Foundation; the Schwartz Center for Compassionate Healthcare, Boston; patient and carer groups; the academic and management community; NIHR and the wider NHS.

Research Design and theoretical approach

This study is a mixed methods realist evaluation of Schwartz Center Rounds which draws on a number of theoretical foundations.

The realist evaluation approach seeks to get beyond a simple question 'do Schwartz Rounds 'work'? It seeks to understand better what works, for whom – which staff; which organisations; in what circumstances. This staff support innovation is being introduced into multiple contexts, and we seek to find out under what conditions this innovation will produce any change or impacts. In some organisations, some of the effects may be unwanted, in other cases wanted and more likely there will be a mixture of wanted and unwanted effects. Realistic evaluation is simply an application of this insight to the examination of new programmes and innovations. Its concern with understanding causal mechanisms and the conditions under which they are activated to produce specific outcomes is highly relevant for this study. Realist evaluation techniques recognise the interwoven variables that operate at different levels in organisations and in wider society, thus realist evaluation suits complex social

interventions. It acknowledges that intervention programmes and policy changes do not necessarily work for everyone, since people are different and are embedded in different contexts (Pawson and Tilley 1997).

Our approach to data collection and analysis will be to use a preliminary theoretical framework so that data analysis is a combination of induction (data-driven generalisation) and deduction (theory-driven exploration of hypotheses) (Pettigrew 1990) and the balance of these will be different in each Phase. For example in Phase 2a) our survey utilises tools based on our hypothesis that Rounds, as reflective spaces influence self-compassion; empathy; work engagement, social support and wellbeing of staff. In our Phase 2b) ethnographic field work in the ten organisational case studies we seek to understand at a deep level the kind of processes that are at work in rounds, how disclosure in Rounds is experienced by staff and how Rounds may influence wide changes in teams; the organisation and patient experience. Here we draw upon, the emotional contagion literature. Emotional contagion is defined as the flow of emotions from one person to another (Hatfield et al 1992; Totterdell, 2000; Totterdell et al 1998), with the receiver 'catching' the emotions the sender displays creating a ripple effect of emotions (Hennig-Thuran et al 2006) . Similarly, the moods and emotions of leaders, given their positions of power and influence within organizations, can influence the moods and behaviors of those with whom they work. Positive leader affect is associated with more positive affect among employees (Cherulnik et al 2001), enhanced group performance (George, 1995), and higher rates of prosocial behaviors among employees (George, 1990).
This study is therefore a theoretically-informed realist evaluation drawing on lessons from research on innovation adoption in health service organisations (Greenhalgh et al 2005) taking into account four key components:

1. wider NHS/societal context and wider context including an understanding of other interventions for staff
2. organisational (across different Rounds providers) and Rounds context
3. Rounds and how they are implemented (i.e. the innovation itself)
4. nature and quality of linkages between external stakeholders (e.g. POCF; Schwartz Center, Boston) and their relationships with Rounds providers, champions and committees.

The four components exist in dynamic relation to the system as a whole and our research is designed to capture these interactions as we explore how and why the processes and outcomes of Rounds implementation differ in the ten organisational case study services (figure 2- appendix A).

Data Collection

Phase 1: SCOPING PHASE (0-12 mths; Objectives 1-3)- Lead Catherine Foot and Cath Taylor

Phase 1 is the scoping phase, and is intended to meet objectives 1-3 of the project:

1. Review the evidence-base re reflection, group work and disclosure/discussion of emotional/challenging events for the mechanisms by which Rounds may work and scope the reflective learning literature and critically review the alternatives to Rounds and their evidence base.
2. Map the profiles of current UK Rounds provider organisations including reasons for (and time since) implementation ('pull'); attendance at Rounds; NHS Staff and in-patient survey results; staff absenteeism; Occupational Health function and use.
3. Determine cost and resource implications by examining resources required to establish and sustain Rounds in provider organisations.

Phase 1 seeks to answer specific research questions:

- How do Rounds compare with other forms of reflective spaces / staff support interventions to enhance compassion in the literature and how are they theorised to work?
- How many and what types of organisations are running Rounds and why were they set up?
- What are the resource implications or running Rounds in organisations?

It will comprise two main elements: a literature review; and mapping exercise that combines existing data with interviews to describe profiles of UK Rounds provider organisations, how their Rounds are run and organised and reasons for implementation and perspectives on impact.

Literature review

We will conduct a critical scoping literature review to determine:

- The evidence base for Schwartz Center Rounds including a review of theories regarding the mechanisms by which Rounds may work
- The evidence base for other staff wellbeing interventions including initiatives such as restorative supervision (Wallbank and Woods 2012) and methods such as Balint groups, (Balint et al 1997), resilience training/workshops (Antonovsky 1987) and action learning sets (Pedler 1997), to understand how Rounds contrast with other interventions providing staff support/ reflective space and providing a critical review of the alternatives and their evidence base.
- Any recent information on the uptake and impact of Rounds in the US (beyond Lown and Manning 2010).

In investigating the theoretical basis for Rounds and other staff wellbeing interventions, we will focus on the literature on the use of reflective spaces and learning, including the role of self-disclosure and discussion (Gilbert 2010) and social support in the workplace (Stansfield et al 1998). We wish to understand the mechanism through which Rounds might be expected to 'work', so we will also explore issues of disclosure, including the responses of listeners and we anticipate further theorising to fully elucidate the mediating mechanisms whereby verbal disclosure can affect well-being in situations such as Rounds, if indeed this is so.
The precise search terms and inclusion and exclusion criteria for the literature review will be determined by the project team with the advice of the advisory group and the Kings Fund information specialist. We will conduct an exhaustive literature search of available management, sociological and medical databases that index research relevant to the topics above. This will involve:

- Scoping searches to help identify appropriate keywords, synonyms, spelling variations etc.
- Searches using both free text and database-specific subject headings e.g. MeSH, Thesaurus terms.
- Using advanced Boolean, truncation, 'explode' and other search techniques.
- Search filters for certain publication types e.g. systematic reviews and meta-analyses and where possible grey literature.

We will supplement this with additional search strategies including reference list checking, contact with experts, and snowball searching, in recognition of the fact that protocol-driven literature searches in complex and qualitative evidence areas have been shown to be insufficient (Greenhalgh and Peacock 2005).

Inclusion and exclusion will be based on relevance to the topic. We will first review abstracts for relevance. The full text of papers to be included will then be retrieved and reviewed by a researcher. Methodological quality will be appraised using CASP but will be used for moderation rather than for inclusion and exclusion.

The literature review will be used to inform the development of the survey in Phase 2a) by reviewing the mechanisms by which Rounds work and the outcomes they may impact on. This will inform choice about measures that may be expected to best capture the mechanisms and outcomes. It will also inform the development of the interview schedule and observation plan in Phase 2b), and more broadly to situate the findings and conclusions of this study in the wider literature.

Mapping exercise

We will use a range of existing data sources to map the UK Rounds providers. These may include:

- Data held by The Point of Care Foundation (and verified by the Rounds providers) on time since implementation of Rounds (in months) and attendance numbers at Rounds.
- Selected items related to staff wellbeing and the provision of compassionate care from NHS staff and inpatient surveys
- Staff absenteeism rates
- Information (provided through written correspondence with the providers) on occupational health function and use
- Selected items on clinical quality and patient safety such as complaints and serious incidents.

We will seek to collect data from the three years prior to the introduction of the Rounds and for each and every year since up to the most recent data available.

We will also conduct a micro-costing exercise of the resource implications of introducing and sustaining Rounds. This will be conducted via written communication with the Rounds providers and will be limited to a measure of staff time (for Rounds champions and coordinators as well as for participants) and resources (room hire and refreshment fees if any).

We will then supplement this data by conducting one-on-one semi-structured telephone interviews in each Rounds provider with staff who have championed or led the implementation of Rounds in their organisation. These interviews will explore:

- Reasons for implementation
- Perspectives on the impact of Rounds
- Verifying the data items above

All interviews will be audio-recorded and transcribed. Transcripts will then be coded for analysis. Our coding scheme will be developed using a mixture of inductive and deductive reasoning. It will operate using a range of units of analysis pertinent to the information being sought. We will then conduct open coding, following the approach recommended by Strauss (1987). This coding scheme will have clearly defined and mutually exclusive analytical categories and systematic criteria for selection of data from the interview transcripts into those categories. The coded interview data will be analysed using NVIVO to identify thematic patterns and conclusions from the data.

Rounds Provider Profiles will then be drawn up combining the interview data with the quantitative data. These profiles will provide a national assessment of which organisations are using Rounds and why, how much it costs to implement them and what impact providers feel they have had. They will also be used to select a sample of ten providers for the case study phase.

Phase 2: Organisational Case studies (4-21 months) – Overall Lead Jill Maben

Sample: Ten providers will be purposively sampled from Phase 1 to provide maximum variation and information-rich cases (Patton 1990; Mason 2002). We have selected ten case studies to facilitate the deep, case-orientated analysis that is the hallmark of all qualitative enquiry, and that results in - by virtue of not being too small - a new and richly textured understanding of experience (Sandelowski 1995):p183. Maximum variation is theoretically driven to include aspects of Rounds implementation which we theorise will have an important effect on implementation and Rounds impact (size of institution and percentage of total staff who attend; established and new Rounds (Klein 1962;1964) and early and late adopters (Greenhalgh et al 2005); also a range of providers- acute and community trusts and hospice / mental health providers) - see figure 1 for our sample quota target list.

Figure 1: Sample quota target list (for sampling of 10 case studies)

- At least two large acute trusts with 5000 + staff
- At least two medium acute trusts with 2000 + staff
- At least two small institutions with up to 2000 staff
- At least two providers with approx. 25-50% of total staff attend Rounds
- At least two providers with and approx. 10-25% of total staff attend Rounds
- At least two providers with less than 10% of total staff attend Rounds
- At least two early adopters (within first year)
- At least two late adopters (within lifetime of project)
- At least three new Rounds providers (less than 3 months)[2]
- At least three established Rounds providers (more than 2 years)
- At least two hospice providers
- At least two community / mental health providers

[2] We aim to recruit these providers before the first Round, but this may not be in our control

Phase 2a): Longitudinal Survey of Staff (4-21 months; Objective 4) - lead Jeremy Dawson

Phase 2a collects longitudinal data from Rounds attendees and non-attendees (control), and is intended to meet objective 4 of the project:

4. Evaluate in 10 different case study Rounds providers whether Rounds attendance impacts on NHS staff wellbeing at work, social support for staff and behaviour change towards patients and colleagues.

Phase 2 seeks to answer the specific Research question:

- Is regular attendance at Rounds associated with greater improvements in staff wellbeing at work, social support for staff and reported positive behaviour change towards patients and colleagues?

Pilot phase (months 4-5)

An initial pilot phase in one provider identified in Phase 1 will be used to test both the proposed questionnaire (probable measures are described later), and the feasibility of the data collection methods. The pilot phase will use the methods proposed below, but in addition will include 10-12 follow-up cognitive interviews (Willis et al 1991; 1999) with a range of participants (varied professional group and seniority) to determine the feasibility of methods and the face validity of the measures. Incentives of £25 vouchers will be offered to cognitive interview participants. If the questionnaire is found to be too long, or any of the measures inappropriate, changes will be made to the questionnaires before being implemented in the ten case study sites.

Main Study (months 6-21): Study design and sample size

Within each provider, we will conduct a longitudinal survey of a stratified sample of staff. The longitudinal nature of the survey is necessary so that within-person effects can be identified; if only between-person effects were studied (e.g. with a cross-sectional study), it is likely that results would be heavily affected by the self-selection bias inherent in the design; attendance at Rounds is entirely voluntary and those who attend regularly are likely to be those who are more predisposed to find such interventions useful. Whilst it is impossible to completely rule out the effects of self-selection bias with our study (this would require a fully-randomised experimental design, which is not practical), the use of within-person differences eliminates the possibility of effects being due to baseline differences (e.g. those attending Rounds having better well-being generally), or sample-wide effects (e.g. differences in well-being across the NHS caused by other factors).

A quasi-experimental design will be used. There are two main study groups: staff regularly attending Rounds (defined as those who attend at least 50% of available Rounds in the study period), and staff not attending Rounds at all. The former group is the "intervention" group, while the non-attenders give a within-provider control group. A third group will also emerge – staff attending Rounds more occasionally than this, including those who drop out after one or two Rounds, or begin attending towards the end of the study period, or have attended Rounds previous to the evaluation but do not attend during the study period. This latter group will enable the examination of whether the level of attendance (number of Rounds attended) or patterns of attendance (e.g. stopping attendance after a certain period of time) are linked to changes in outcomes – the former being a form of dose effect (is more frequent attendance linked to greater improvements?), the latter being a dropout effect.

We will limit the intervention group to those who are attending Rounds for the first time. We know from POCF data that up to 40% of attendees are new attendees. It is important to note that we cannot know in advance who will be regular attenders and who will be occasional attenders. Therefore we will over-sample this group so that we are likely to get enough regular attenders included.

The primary outcome variable will be determined following the pilot work and scoping phase to ensure that an appropriate outcome is used. A precise sample size calculation will be conducted at this point, and therefore it is not possible to give a detailed sample size now. However, for illustration, we have estimated the sample size required to find a change in work engagement of 0.33 with power of 0.80. Using data from the NHS staff survey and from prior research by West et al. (2011), an increase of 0.33 in this measure is associated with a 0.5% drop in staff absence (representing more than one fewer day's sickness absence per person over a year), and may therefore be considered an important difference, although in standardised terms it represents a small-medium level change in individual engagement.

The total sample size required to detect this effect with 80% power in such a design (allowing for clustering effects) would be around 228, or 114 in each of the intervention and control groups. Therefore, allowing for a response rate/dropout rate of around 50% (see below), and allowing for the fact that we cannot know in advance who will become regular attenders, we will aim to survey an average of 50 new attenders per site in existing Rounds providers (n=7), and up to 150 attenders per site in the three new providers (800 in total). Recruitment will be supported by two researchers attending up to four Rounds in each site from the start of the survey period.

We note that the NHS staff survey has an average response rate of 55% (a 100+ item survey – our survey will have far fewer items, probably no more than 30), and that POCF data shows evaluation questionnaires following Rounds often have response rates of 70% or higher; we will also have researchers present to encourage response, unlike the NHS staff survey.

The control group (non-attenders) will be recruited via an online survey, conducted in the month before the first Round. Allowing for a lower response rate, drop-out and the fact that some respondents may subsequently attend Rounds we will sample 250 staff members per provider (2500 in total).

The survey will be repeated with the responders to the baseline survey (attenders and controls) after 8 months. This will allow sufficient time for the regular attenders to attend a minimum of two Rounds before the second administration (more in providers who have monthly Rounds). After the second administration the respondents will be classified into regular attenders, irregular attenders or non-attenders based on self-reported attendance information verified by attendance list review.

Inclusion criteria:

- (All groups) Staff employed by the provider who have the opportunity to attend Rounds
- (Regular attenders) Staff who attend at least 50% of Rounds between the two surveys (but for existing providers of Rounds have not attended before the first study period Round)
- (Irregular attenders) Staff who attend at least one Round but fewer than 50% between the two surveys (but for existing providers of Rounds have not attended before the first study period Round)
- (Non-attenders) Staff who have not attended a Round previously, and do not attend during the study period.

Exclusion criteria

- People not employed by the provider
- Staff who do not have the opportunity to attend Rounds (e.g. in providers where Rounds are limited to one part of the organisation only, or staff who do not work at times that Rounds operate)
- Staff who have attended Rounds previously, including with a previous employer

Data on Rounds attendance will be gathered from Rounds sign-in sheets, routinely collected in each organisation.

Survey administration
The baseline survey will be administered in two different ways for the two groups (attenders and non-attenders).

Attenders. At least two researchers will attend the first Round and distribute questionnaires to all attendees as they arrive and sign in (a separate sign-in sheet/desk will be used for new attendees to facilitate this). They will be encouraged (verbally and via a cover letter/information sheet) to complete the questionnaire before the formal start of the Round if possible, but if not to complete the questionnaire as soon after the round as practical. The questionnaire will be short enough that it can easily be completed in ten minutes, and participants will have the opportunity to return the completed questionnaire immediately (either on a paper version or alternatively post the completed questionnaire to the researchers using a pre-paid envelope. The cover letter/information sheet will make it clear that response to a further short questionnaire will be requested after eight months, and will be asked to choose between an online or postal questionnaire for this follow-up survey (online surveys will be recommended where possible to ensure costs are kept lower). Participants will be informed of the prize draw incentive (see below). A unique ID number will be attached to the questionnaire at sign in, to ensure the survey is anonymous but to allow the researcher to match ID's to appropriate email addresses or postal addresses for the follow-up survey, and to match data for analysis. The follow-up survey itself will have up to three reminders. Participants will also be told that if they have already completed the online survey targeting a comparison non-attending group (described below) that they do not need to complete the survey at the first Round itself.

Non-attenders. Up to a month before the first Round included in the evaluation, an online survey will be distributed to a random sample of up to 250 staff per site (or all employees if the provider is smaller than this). At baseline it will not be clear which of the respondents to this survey will qualify for the non-attenders group, but as with the attenders' survey, it will be made clear that a further response to a short online questionnaire will be requested after eight months. Only participants who respond at baseline will be included in the follow-up survey, which will include a question asking how many Rounds (if any) the respondent has attended. (Where possible this information will be validated against Rounds attendance records.) Participants will be informed of the prize draw incentive (see below). Each survey will have up to three reminders.

The questionnaire

The questionnaire itself will be kept short in order to maximise response rates. We will also offer a prize draw for eight vouchers per provider (£50 each) for control / attendee participants who complete both questionnaires to further incentivise response. The survey content will be finalised during phase 1, when preliminary findings from the literature review are known, and will be piloted in a Rounds provider not taking part in the main study before the start of the main data collection to ensure it can realistically be completed in 10 minutes, and that all questions are applicable for all likely respondents. The baseline version will begin with a question to ask whether participants have attended Rounds previously: if they have, they will be advised not to continue with the questionnaire. We anticipate that the survey is likely to include some or all of the following questions/ tools:

Validated tools to measure hypothesised benefits and potential harms:

- Psychological well-being (the GHQ-12; Goldberg, 1972: this is the primary outcome)
- A version of the Jefferson Physician Empathy scale (Hojat, 2001; likely to be short version used by Lown & Manning, 2010)
- Professional Quality of Life Elements Theory and Measurement (PROQOL, Stamm 2010) measuring compassion satisfaction and compassion fatigue http://www.proqol.org/Home_Page.php
- Short scales on social support (e.g. Haynes et al., 1999) and
- Work engagement (short version of the UWES, Schaufeli et al., 2006, as used in the NHS staff survey).

Questions developed specifically for the survey:

- Opportunity to attend Rounds
- Number of Rounds attended (follow-up survey only)
- Whether Rounds were attended with immediate co-workers or not (follow-up survey only)
- Whether attended Rounds in a previous organisation
- Whether the respondent was a presenter at a Round
- Perception of the usefulness of Rounds (follow-up survey only)
- Perceived adequacy of communication skills (e.g. Ramirez et al, 1996)

Objective data:

- Demographic & background information (including age, sex, occupational group, length of service) (baseline survey only)
- Number of days' sickness absence within previous six months.

We will use multilevel repeated measures analysis to detect any change in outcomes between the surveys for attenders compared with non-attenders (multilevel analysis will account for any effects of clustering by provider; repeated measures analysis will ensure that any sample bias due to lack of randomisation is kept to a minimum by examining within-participant differences). Demographic characteristics will be included as covariates to account for differences between factors such as age, sex and occupational group.

Multilevel regression analysis will be used to examine whether the level of attendance (for irregular attendees) and/or dropout is linked to change in any of the outcomes.

Phase 2b): Ethnographic field work in the organisational case studies (Months 4-21) (objectives 5 & 6) – Lead Jill Maben

In-depth ethnographic case studies underpinned by realist evaluation (Pawson and Tilley 1997) will examine how Rounds are operationalised and drawing upon the literature review in Phase 1 we will theorise the mechanisms by which they influence staff wellbeing and social support (or not) and patient care practices and gather data on this in the observation and interview data. This phase of the study will seek to answer objectives 5 and 6:

5. Examine staff experiences of attending, presenting and facilitating Rounds.

6. Conduct in-depth case studies of Rounds in 6 settings to examine how Rounds may 'work'; how are operationalised and the mechanisms by which wellbeing and social support might be influenced (or not) by observation and interviews regarding:

(i) reasons for variance in attendance and dropout rates and attendees experiences;
(ii) influence of variance in facilitation (e.g. in relation to content/style);
(iii) topics presented and Rounds climates;
(iv) any influence on team hierarchy and team work and on coping with stress;
(v) factors influencing 'success' or otherwise of Rounds in organizations;
(vi) wider organisational ('ripple') effects felt in day-to-day practice, in staff and patient care interactions. These may be felt by at least three different groups of people that might be affected - in the same way or different ways - by Rounds: 1)those who attend as audience 2)those who present cases at Rounds and the departmental teams they belong to (may include senior people) and 3)the Rounds Steering Committee members in each organisation.

Specific Research questions:

- How and in what circumstances do Rounds work, by what mechanisms are they reported to affect staff wellbeing, social support and compassion?
- What is the experience of attending and presenting at Rounds, and how does topic, other attendees, and facilitation affect this?
- What if any are the wider organisational effects felt by staff and patients?

Methods: In each case study:

1. **Observation:** we will use a combination of general and focussed ethnographic observation approaches in Rounds and with teams in practice of:
    - Rounds (n=3-6) to examine group dynamics; hierarchies; participant interaction
    - Presenter team planning meetings (n=3) to examine team working/topic selection
    - Presenter teams in practice settings (n=3) to examine any ripple effects beyond Rounds
    - Facilitator training (n=1-2) re: approach and emphasis given.

2. **Qualitative in depth interviews:** with
    - Facilitators of Rounds (n=1-2) re focus, experience and issues arising in Rounds
    - Rounds attendees; regular (n=5) irregular attendees (n=5); Rounds drop-outs (n=up to 5) and non-attenders (n=5) re reasons for attending Rounds (or not) and impact on their experiences with patients and any wider impact on culture and practices?
    - Presenters (n=5) to explore Rounds experiences, any actions taken and influence of Rounds on the culture of teams / wider organisation re support, roles and relationships or changes in wider practices attributable to Rounds- including patient communication and compassion.
    - Rounds Steering group members (n=3-5) and Senior stakeholders (board) and managers (n=5-10): re knowledge/support for Rounds; barriers and facilitators to attendance and reports of any 'ripple effects' / changes in wider practices attributable to Rounds- including patient communication and compassion.
    - External stakeholders – Schwartz Center Boston and POCF colleagues re relationships with Rounds providers, champions and committees.

Analysis: Qualitative data will be analysed for patterns in the data using a framework approach (Ritchie and Spencer 1994) drawing directly on the realistic evaluation framework to guide identification of key themes. Theoretical frameworks will be used to identify general lessons about implementation of the innovation (Rounds). Interviews will be digitally recorded and transcribed verbatim in preparation for analysis using a framework approach, a method which involves the systematic analysis of verbatim interview data within a thematic matrix using a framework approach (Ritchie and Spencer 1994) The key topics and issues emerging from the interviews will be identified through familiarisation with interview transcripts as well as reference to the original objectives and the topic guides used to conduct the interviews. A series of thematic charts will be developed and data from each transcript will be summarised under each theme. This will facilitate detailed exploration of the charted data, in order to map and understand the range of views and experiences in different themes and allowing comparison within and between cases to answer objectives 5 and 6.

Phase 3: Overall analysis: the analysis from phases 1& 2 will be synthesised to determine what works for whom in what circumstances in Rounds evaluation write up. Drawing on Greenhalgh et al's work (2009) one of the challenges is the balance between an emic versus etic position, a formative versus summative analysis, and (interpretive) illumination versus (normative) judgment. The realist evaluation guides this study in the Phase 2b0) in the 10 case studies – an emic, formative and interpretive analysis will allow us best to understand the process of Rounds implementation; and to determine what works for whom in what circumstances. We will draw upon the work of Happ et al (2006) to undertake a concurrent mixed analysis for complementarity and completeness. Data from each Phase will be analysed separately and then combined to provide a richer and more complete understanding of the process, implementation and impact of Rounds in a variety of sites. This, as Greenhalgh et al (2009) report, is not a linear nor simple process, but requires much discussion and interpretation and a rigorous approach to determine enabling and constraining factors in terms of Rounds implementation and impact.

Elements will be captured in film and in a managers' guide (see outputs). Where possible we will hold events in each case study Rounds provider bringing together presenters; Rounds attendees and stakeholders for validation of findings and feedback. This phase will produce recommendations as per objective 7:

> 7. Make recommendations regarding the role of Rounds in healthcare provider staff support, to inform future practice: to Round providers; the Point of Care Foundation; the Schwartz Center for Compassionate Healthcare, Boston; patient and carer groups; the academic and management community; NIHR and the wider NHS.

In our design we have deliberately chosen NOT to gather patient level data and agree with Cox et al (2007) that it is important to determine the best research design and methods for evaluation of organisational level work stress interventions. Rounds are aimed at supporting staff by supporting multi-disciplinary conversations about the difficult work with patients. It is anticipated that through supporting staff wellbeing there will be positive consequences for patient care, and we suggest that if we are able to demonstrate an impact on staff this will impact on patients but any direct attribution would be difficult. We therefore draw upon the existing literature associating health staff wellbeing with quality of patient care (Taylor et al, 2005; Harvey et al, 2009) and in particular Maben et al's HS&DR report (Patients' experiences of care and the influence of staff motivation, affect and wellbeing Maben et al 2012a) and papers (Maben et al 2012b) which provides evidence that good staff wellbeing is an antecedent of good patient care performance.

Dissemination and project outputs. Key outputs for the study will include:

1. 'Consequences for practice' Guide for managers: a representative from NHS Employers and the NHS Confederation will be invited to the advisory group to facilitate impact.

2. Rounds Film: With colleagues at the King's Fund and Point of Care Foundation we plan to create a succinct 10 minute Rounds film to detail aspects of the research to provide greater reach and impact for research findings including; Rounds in action; "talking heads" (positive and negative) of attendees; presenters; facilitators and drop outs/non-attendees. The purpose of the film is to show people what a Round is like and to hear from attendees and others involved. Where possible it will include key findings and lessons from the evaluation for implementation. Rounds are unlike other meetings which makes it hard for most people to imagine them. This will be available on King's College, Point of Care Foundation and King's Fund websites and YouTube and launched at the King's College London dissemination event. We will also explore the possibility of it being uploaded on NHS Employers and also NHS Choices websites.

3. **One day Rounds dissemination event:** will be held at Kings College Londonto present findings to participants and others interested in Rounds e.g. managers; policy makers; practitioners; NHS Employers. Targeted at an invited audience from policy and practice communities, and designed to stimulate debate and share learning and evidence about key issues re Rounds addressed within our work will include launching the film and 'Consequences for Practice Guide' for key audiences e.g. managers; policy makers; practitioners; NHS Employers and the Point of Care Foundation

4. **Papers, reports and other products** from this study will include:
(i) Peer reviewed academic journal articles (e.g. BMJ Quality and Safety; Health Services Research and Policy; Work Employment and Society;)
(ii) Health services professional Journals (HSJ etc.)
(iii) Summary briefings; e.g. Policy +
(iv) Final report

We will engage user groups with interests in staff stress and wellbeing such as the Royal Colleges, Deaneries, Royal Colleges of Nursing and Midwifery and Unison and with regional and national patient organisations and public engagement networks. Our dissemination plans include promoting and publicising the findings through these organisations by:

- Workshops to input to the research, gain immediate feedback and support dissemination
- Producing lay summaries of research
- Briefing documents for managers; commissioners and policy makers on findings and implications
- Engagement with policy makers at national level, particularly NHS England; Health Education England, LETBs and other agencies e.g. NHS Confederation, National Occupational Health Conference
- We will publish our protocol and findings in peer reviewed journals and present at relevant scientific meetings e.g. conferences for the researchers and policy makers

Links with the Boston 'Schwartz Center for Compassionate Healthcare' opens international routes to dissemination which the team will capitalise upon. The research team have a long and successful history of disseminating research results. The King's Fund have a strong reputation for delivering outputs that have significant impact on policy and service delivery as does the National Nursing Research Unit (NNRU), King's College London. NNRU disseminates to nurse directors, Occupational health clinicians and other managers via its Policy + publication, with a previous HS&DR study relevant to this project already published in this format: "Does staff wellbeing affect patient experiences of care?" Findings will also be shared on websites including the Point of Care Foundation ;King's Fund; National Nursing Research Unit /KCL; Institute of Work Psychology/University of Sheffield.

We will engage with staff (NHS Employers) and user groups (for example Patient Voices, and the Patients Association) at local and national level to identify suitable ways to report findings. Research team and Project Advisory Group members have excellent well established dissemination networks which we will utilise fully. We will feedback to case study Rounds providers in workshops. Other Rounds providers will be invited to the Rounds conference at King's College London where they will have an opportunity to review and comment on the film.

In terms of impact we anticipate the research will enhance the evidence base, and producing practical hands on knowledge about what works for staff in terms of support across different organisations, and the extent to which they can enhance compassionate relationships between staff and patients through providing staff support and promoting staff wellbeing. The research is also likely to increase knowledge and awareness of Rounds in the UK and potentially increase our knowledge of staff wellbeing in healthcare and the ability of such staff interventions to improve patient experiences of care.
We have established an advisory group involving patient representatives, key academics and stakeholder groups including NHS staff and managers, which represents an excellent network through which to disseminate findings and lessons. The Point of Care Programme (now Foundation) which brought Rounds to the UK is fully supportive and will provide support and access to Rounds sites, and provide a mechanism by which findings can be embedded in future Rounds implementations.

Plan of investigation (see also figure 3 flowchart in Appendix A)

Before project start: Months -3- 0

- Draft ethical approval for Phase 2a survey and Phase 2b ethnographic field work in case studies; submit ethical approval for Phase 1 access and interviews.
- Recruit Researchers at King's Fund, King's College London, and Sheffield.

Months 1- 3

- Researchers at King's and Kings Fund commence (Month 1) and Sheffield (Month 2)
- Project management- monthly meetings with co-applicants; Project Advisory Group meeting (PAG) month 3
- Phase 1 – Lit Review: review tools for questionnaire; commence wider literature searching and review, start interviews
- Phase 1 - Rounds mapping: make contact with all rounds providers; collect data from POCF and analyse to facilitate sampling for Phase 2.
- Ethics and R&D approvals: Finalise survey and submit for ethical approval; commence R & D process once Rounds sites sampled for Phase 2a determined.
- Phase 2a: Begin designing survey

- Phase 2b: Develop interview schedules, observation guides, begin sampling for Rounds sites and access.
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Months 4- 6

- Phase 1: Continue to review and analyse literature; continue interviews, gather costs data; finalise mapping and write up
- Phase 2: Finalise sampling for Rounds sites and gain access to Case study sites
- Phase 2a: Conduct pilot study, begin main study: commence access to case study sites and start baseline data collection
- Phase 2b: develop interview schedules, observation guides etc. begin fieldwork (month 6)
- Project management- monthly meetings with co-applicants, progress report to HS&DR

Months 7- 9

- Phase 1: Continue to review and analyse literature; finalise costs data and write up
- Phase 2a: Continue access to research sites and baseline (time 1) data collection
- Phase 2b: Data collection sites 1 -4 and commence access to sites 5-8
- Project management- monthly meetings with co-applicants; Second PAG.

Months 10-12

- Phase 1: Finalise literature review and write up- Phase 1 complete
- Phase 2a: Data collection and analysis of baseline surveys
- Phase 2b: Complete data collection sites 1 -4 and commence data collection sites 5-8
- Project management- monthly meetings with co-applicants, progress report to HS&DR.

Months 13-15

- Phase 1: write paper for publication from phase 1 literature review and mapping
- Phase 2a: Data Collection of time 2 surveys
- Phase 2b: Analyse sites 1 -4; continue data collection sites 5-8 and commence data collection sites 9 and 10; workshops sites 1 -4.
- Project management- monthly meetings with co-applicants, third PAG.

Months 16-18

- Phase 2a: Completion of data Collection and analysis of time 2 surveys
- Phase 2b: Analyse sites 5 -8; continue data collection sites 9-10; workshops sites 5-8 Project management- monthly meetings with co-applicants, progress report to HS&DR

Months 19-21

- Phase 2a: Complete and finalise survey analysis and begin write up
- Phase 2b: Complete data collection sites 9 and 10 and commence analysis of these case studies
- Project management- monthly meetings with co-applicants, fourth PAG.

Months 21-24

- Phase 2a: Complete survey write up for final report
- Phase 2b: Overall case study analysis including cross case analysis; workshops sites 9 and 10
- Final report: commence drafting of final report and management guide
- Plan dissemination
- Film: commence filming, editing and create film
- Project management- monthly meetings with co-applicants, progress report to HS&DR
- Film: begin access for filming

Months 25-27

- Project management- monthly meetings with co-applicants, fifth PAG.
- Final report: final drafting of final report and management guide and submission to HS&DR
- Dissemination event-Plan / launch of film

Project management

The project will be managed by Professor Jill Maben (JM) who will co-ordinate management of the research team including researchers at Sheffield and the King's Fund. She will direct fieldwork and analyses of the data and will be responsible for delivery of the project and final report on time and to budget. Professor Maben will lead the 'core' project senior team comprising Dr Jeremy Dawson (JD); Dr Catherine Foot (CF); Dr Cath Taylor and Dr Caroline Shuldham, who will meet monthly inviting other members of the project team (King's Research fellow; Sheffield Research Associate and King's Fund Research Fellow) as required. The two King's Researchers are full-time for the whole duration of the study (27 months) and will support Phases 1 and 2a as required, supporting the literature review for example in Phase 1 and supporting survey data collection in Phase

2a. The KCL Research Fellow (Grade 7 post) will lead the fieldwork (Phase 2b) in the ten case studies with the support of the KCL Research Associate (Grade 6 post)(leading data collection in 5 case studies each) and will be line managed by Professor Maben. The Sheffield Research Associate will be employed full time for 23 months to lead the data collection, analysis and write up Phase 2a (survey) supervised and line managed by Dr Dawson (lead Phase 2). The King's Fund Research Fellow will undertake the mapping element of Phase 1 and cost analysis supervised and supported by Dr Foot (lead Phase 1), with analysis conducted by a Kings Fund statistician and additional support if required from the Sheffield Research Associate. Dr Taylor will lead the literature review with support from the King's Fund and King's College London researchers. The leads (JM;CF; JD; CT) will direct and co-ordinate the work of the researchers in weekly or bi-weekly meetings reporting to the PI (JM) in the monthly meetings outlined above.

Dr Taylor and Dr Shuldham will provide input and support across both phases of the project as required and directed by Professor Maben and will contribute to the monthly meetings. Dr Taylor's expertise in NHS teamwork and doctors' stress and wellbeing will be important in all Phases of the research and Dr Shuldham's management and leadership expertise in a Rounds provider will be invaluable throughout the study. The advisory group (see below) which includes four patients will meet six monthly to advise the project team on all aspects of the work.

Approval by ethics committees

We believe this proposal will require NHS research Ethical approval, but believe we can achieve an expedited and proportionate review as we are undertaking research on NHS staff only (not patients). The Research will also require R & D approvals in the relevant trusts. Phase 1 ethics and R & D approval (for access and interviews) will be gained before the study commences. We plan to apply for NHS Research ethics approval for Phase 1as soon as we hear if we are successful. We are planning to review the tools for the Phase 2a questionnaire during our review of the literature in Phase 1 but will submit for Phases 2a and b ethical approval within the first 3 months of the project if acceptable to the HS & DR board. Issues of anonymity, confidentiality and informed consent will be addressed in the recruitment of all participants, data collection processes and data storage. The principles of beneficence and non-malfeasance will be adhered to. The team is experienced in NHS research and Research ethics applications, including recruitment, access and data collection such as observation of practice, interviews and questionnaire design. Professor Maben has successfully gained approval for surveys and case study field work in previous HS&DR projects and was vice chair of the King's College London nursing and psychiatry ethics committee for several years and is thus experienced in obtaining ethical approval.

Patient and Public Involvement

We will actively involve patients through membership of the Project Advisory Group (PAG) in order to improve the quality of the research and relevance of the study to NHS users and to support our dissemination activities. Four patients who have previously had input into this application (see below) have agreed to join the PAG and alongside other group members they will be asked to advise on data collection, comment upon and help us interpret the findings emerging from the research, and help us with dissemination through links with their local networks. This includes one member (Havi Carel) who is an experienced patient representative and Senior Lecturer in Philosophy who has spoken at the King's Fund and presented at Schwartz Centre Rounds. Collectively their contribution has and will be highly valued in relation to highlighting the benefits to patients of Rounds. The PAG will meet biannually and patient members of the PAG will be offered support for their role, payment of out-of-pocket expenses and a day-rate for attendance at meetings (in accordance with good practice as recommended by INVOLVE). We would also be delighted to feedback to the patients and public in local forums at the local study sites where they exist. The four patients who have commented on drafts of this proposal and discussed it in a teleconference are:

- Kathryn Baurley: a biology graduate, mother and patient with Marfan syndrome. Participated in a project conference call and fed back on a draft of the proposal.
- Tal Golesworthy: a Chartered Engineer with 30 years in combustion R&D and a patient with Marfan Syndrome. Participated in a project conference call and fed back on two drafts of the proposal.
- Christine Chapman: a patient and former NHS manager commented on two drafts of the proposal suggesting dissemination routes; study design issues; patient participation in Rounds (many SCR meetings have invited patients); and was interested in capturing actions that emerged from Rounds. Christine is a Patient Governor at an NHS Foundation Trust, a patient and public reviewer for the National Institute of Health Research (NIHR) and a Public Member of the EME Prioritisation Group of NETSCC.

- Havi Carel: Senior Lecturer (Philosophy) and patient: Commented on drafts combining her rich theoretical insights with experiential knowledge of ill-health.

These patients understand well the challenges staff face and believe post Francis that interventions to support staff which have the potential to impact on patients were important to study.

Expertise and justification of support required

The team is uniquely placed for this evaluation, with excellent access and team expertise, and we have worked together in various combinations over a number of years. We are an experienced team with multi-clinical/disciplinary perspectives, uniquely placed to undertake this work (supported by Schwartz Center, Boston & POCF). JM is an experienced PI and has led and successfully managed two other HS&DR mixed-method studies. We have expertise in medicine; nursing; sociology; anthropology; statistics; psychology; and have undertaken research on staff wellbeing; work engagement; compassion; teamwork; stress and policy analysis.

CO-APPLICANTS:

Jill Maben (JM) (KCL)(PI & Lead Phase 2b) 20% FTE: Nurse and social scientist. Experienced researcher and manager of national studies; Expertise in staff wellbeing research and its links to patient care experience. Two previous NIHR HS&DR grants.

Cath Taylor (CT) (KCL)(co-Lead Phase 1 and Input Phase 2) 15% FTE: Senior lecturer (psychology) Management of national studies; Mixed methods expertise. Research areas include NHS teamwork and doctors' stress and wellbeing.

Caroline Shuldham *(Royal Brompton and Hare field NHS Trust)*5% FTE*:* Director of Nursing and Clinical Governance. Senior executive in trust running Rounds. Has experience of being a co-applicant on previous HS&DR project.

Jeremy Dawson (JD) (Sheffield)(Lead Phase 2a) 20% FTE: Statistician and Reader. Led large-scale projects regarding management of NHS staff (team working, staff engagement and well-being and links with patient outcomes). Ran NHS national staff survey between 2003 and 2007.

Catherine Foot (CF) (Kings Fund)(Co-Lead Phase 1) 15% FTE for year 1 and 5% thereafter: Assistant Director Policy. Currently managing a programme examining the measurement and reporting of quality and outcomes information.

COLLABORATORS: Joanna Goodrich Rounds Programme Manager & Head of R&D, POCF (5% FTE); Professor Glenn Robert (2.5%); organisational sociology expertise to advise on case studies; Professor Michael West and Jenny Firth Cozens (5 days) and Barbara Wren (3 days) to advise on specific aspects across the project.

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