

**Collaboration For Leadership
in Applied Health Research
and Care Greater Manchester**



**National Institute for
Health Research**

CLAHRC GM

**OUR WORK
OUR IMPACT**

Editorial
Jim Pendrill
jim.pendrill@manchester.ac.uk

Collaboration for Leadership in
Applied Health Research and Care
Greater Manchester (CLAHRC GM)
www.clahrc-gm.nihr.ac.uk
+44 (0) 161 206 8551
clahrc@srft.nhs.uk
🐦 @CLAHRC_GM

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MAKING A DIFFERENCE



Working at the boundary between health and social care and academia is getting more difficult, as resources - both financial and human - become increasingly stretched. The fact that within this environment we've been able to develop what we do and grow, has been a major achievement.

COLLABORATION

CLAHRC GM is a collaboration of people from different backgrounds and sectors working together with a common vision of generating new knowledge and applying it in practice.

This review of our work, which shares the impact we've had on patient groups and services we've worked with, should make us look back with pride on what we have achieved collectively.

We are a great team of people which includes academics at various levels from research associates through to professors and administrators, as well as NHS staff.

Together we have shown tenacity and determination to succeed. Working at the boundary between health and social care and academia is getting more difficult as resources, both financial and human, become increasingly stretched. The fact that within this environment we've been able to develop what we do, and grow, has been a major achievement.

As a collaboration, we're pleased to share our learning from a number of key programme areas in this review. We hope that our current partners and other organisations can also benefit from this learning, particularly in terms of how we've collaborated on projects, as well as what the projects have achieved.

We describe each of these programme areas, highlighting how we've approached focusing on innovation through research and, crucially, how we've turned evidence into practice.

Each programme also features a personal perspective from its academic lead describing their involvement and how the programme will help to impact service delivery and patient care in the future.

I hope you are all as proud as I am of our fantastic collaboration.

Prof. Ruth Boaden
Director, CLAHRC Greater Manchester

Organising health care



There is an ongoing drive to transform the NHS with improved coordination and integration of care to better meet the needs of the population and address the growing, and increasingly unsustainable, pressures it faces.

We aim to inform and support this by:

- conducting rigorous and research-informed evaluations which shed light on the implementation and impact of change initiatives across health and social care;
- providing commissioners and providers with evidence to support decision-making to deliver effective and sustainable future service design and configuration;
- supporting partner organisations to generate and evaluate innovative projects which seek to better integrate primary care with other parts of the health and social care system, with the potential to make a real difference.

Innovation through Research

Given the lack of a clear understanding of the current workforce landscape, or the associated challenges facing Greater Manchester (GM) general practices, we have been working with the Greater Manchester Health and Social Care Partnership, as well as Salford Clinical Commissioning Group (CCG), to investigate long-term workforce challenges in general practice across the region.

To address the gaps in current knowledge we have been:

- assessing the composition of the general practice workforce and how this varies across GM;
- identifying key factors that are affecting the recruitment and retention of general practice staff;
- exploring key issues affecting the introduction and embedding of new 'non-medical' roles into GM general practice;
- sharing learning about addressing workforce challenges across the region to support providers/CCGs in future workforce planning.

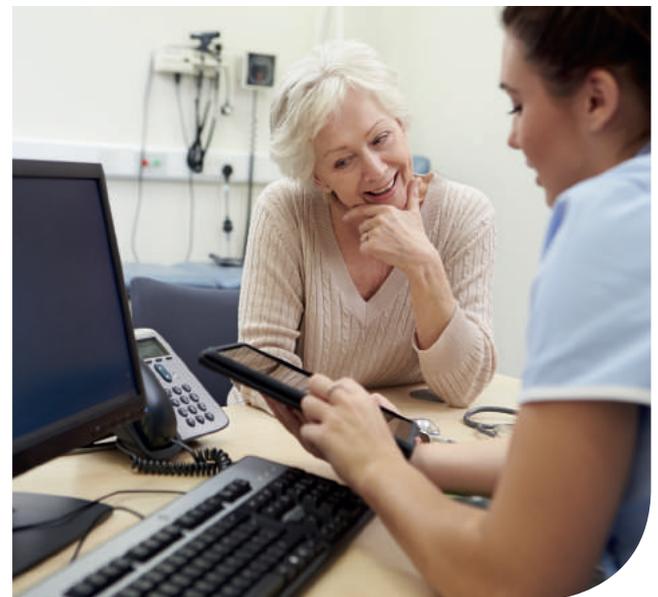
The project focused initially on a baseline mapping exercise of the current workforce landscape across GM CCGs, drawing on data captured through existing tools, as well as additional data gathered by the project team.

The next stage of the project was to focus on the challenges of recruiting and retaining GPs within practices in GM, as well as identifying the barriers to and facilitators of the successful uptake and integration of new roles.

As part of the final stage, the learning generated from this work is now being fed back to key primary care stakeholders, including general practices, CCGs, and workforce leads, through facilitated workshops and network meetings.



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Evidence into Practice

A landmark study has been our evaluation of the roll-out of 7-day access to primary care across GM, building on an earlier study of the piloting of extended access in six demonstrator communities in GM, with our findings helping to inform ongoing refinement of services.

The study looked at the implementation, provision and impact of 7-day access in seven CCG areas across GM. This evaluation has contributed both locally - informing the initial piloting and subsequent roll-out of 7-day access to the four million residents of GM - and also nationally to the evaluation of NHS England's £100m GP Access Fund programme.

These activities have collectively ensured that decision-making by commissioners about service models of 7-day access across the country, and the process by which such models are implemented and sustained, can be informed by a high-quality and reliable evidence base.



The study looked at the implementation, provision and impact of 7-day access in seven CCG areas across GM.

Our key findings included:

- 50,000 extra appointments were provided across the 7 CCG areas during the course of one year, with wide variation in provision between areas
- Each area chose to implement 7-day access in a different way, reflecting local primary care strategy, anticipated demand and other local conditions
- The overall number of people not attending their appointments was higher than for core hours, although this varied between areas
- The average user of the service was relatively young with 70% aged under 50. Women were more likely to use the service than men
- Weekday appointments were still more popular than weekends, but this varied by area with some having strong take-up at weekends and one achieving nearly 100% use on Sundays by the end of the year
- The way in which the service was publicised in each area significantly affected demand for 7-day access
- Demand was affected in many areas by a 'referral moderator'. For instance where patients relied on GP practices to highlight the service the conduct of practice staff was likely to have moderated demand
- Patients registered at the hub practice were more likely to use the service than other patients, but the size of this effect varied by area and by hub
- The evaluation found some evidence of a link between 7-day access and A&E attendances with reductions in self-referrals for minor ailments



VIEWPOINT

Prof. Damian Hodgson looks at how our research is helping tackle the huge challenges facing the NHS.

Providing care for an ageing population living with increasingly complex health needs, at a time of a corresponding shortage of GPs and nursing staff,

represents a huge challenge for the NHS.

Against this backdrop, the Primary Care Workforce Commission recently recommended a complete re-design of primary care, with effective multi-disciplinary teams supported by appropriate technology, and active collaboration within and across organisational boundaries.

Key priorities were the recruitment and retention of GPs and nurses, along with the integration of other health professionals into the primary care workforce to redistribute the workload.

Demand driven research

These ideas have formed the basis of much of our research over the past few years, exemplified by our major analysis of [7-day access to primary care across Manchester](#), and also by our investigation of the long-term workforce challenges in general practice across the region.

These studies, including our work with Salford CCG, are also perfect examples of demand-driven research where the NHS actively seeks research-informed evidence to inform its policies.

For instance the challenges of keeping and attracting GPs is certainly one of the most pressing issues of our time. Part of the answer has been a drive to take workload pressure off GPs by

having more specialist staff based in clinics such as pharmacists, advanced nurse practitioners, paramedics and physiotherapists. These general practice teams offer new possibilities, but also bring new challenges, compared to the old days of a GP with a sole receptionist sitting behind the desk.

Management skills

In theory this initiative sounds like good news for GPs. But an often overlooked fact is that GPs then need all the necessary management skills to manage all these other people in the health centre.

At its most basic, someone has to work out how all these people fit together in a clinic environment. Who makes those decisions? Who should be employed? And who carries the risk?

The evidence on the success of this new way of working is, at the moment, somewhat conflicting. In some locations this new model appears to work well, but in others it doesn't, and many GPs are concerned about what this might mean for their relationships with patients. The debate is far more complex than simply about replacing GP roles.

Another question is who exactly should be working in primary care in the first place. This might sound a rather odd question, but isn't. Even measuring how many people work in primary care, and what they do, is already very difficult.

GM experience

These questions take on even more pertinence when you look at what is happening on the ground in GM against the backdrop of both devolution and the continued integration of health and social care services.

For instance the Greater Manchester Health and Social Care Partnership has a five-year plan putting primary care at the heart of new neighbourhood-based integrated care teams in the community. But it also recognises that the delivery of health and social care across organisational boundaries will require changes in how the future workforce is developed and sustained.

Against this backdrop we at CLAHRC GM are committed to ensuring the key decisions made in policy and practice are informed by world-class, engaged, and responsive research.

Prof. Damian Hodgson is Professor of Organisational Analysis at Alliance Manchester Business School.



General practice teams offer new possibilities, but also bring new challenges, compared to the old days of a GP with a sole receptionist sitting behind the desk

Wound care



Projects within our wound care programme focus on enhancing the quality of care and outcomes for people with complex wounds such as leg, foot and pressure ulcers. In collaboration with a wide range of stakeholders we seek to understand how wound care is delivered in NHS community services and promote the development and use of evidence-based practice.

The objectives of our wound care programme are to:

- build an active and collaborative wound care research and implementation network across Greater Manchester and East Lancashire;
- identify local wound care uncertainties, priorities and current standards of care, and use these to develop and deliver a programme of community-based, world-leading wound research;
- support the implementation of wound care evidence into clinical practice and health service delivery;
- study the processes associated with the implementation of wound care research evidence in practice.

Innovation through Research

Dr Jacqueline Lavallee looks at whether pressure ulcer prevention can be improved in nursing homes.

Elderly nursing home residents are at particular risk of developing pressure ulcers, where the skin and underlying tissues become damaged due to immobility and prolonged pressure. In severe cases large, open wounds can develop as a result of this prolonged pressure.

While guidelines for the prevention of pressure ulcers exist, their implementation can be sub-optimal and our discussions with nurses have showed that more research is needed in this whole area.

As a starting point we set out to design a specific 'care bundle' for pressure ulcer prevention in a nursing home setting. A care bundle is a set of research-informed practices used to facilitate the implementation of evidence into practice. Care bundles are already used in hospital settings for the prevention of conditions such as sepsis and pneumonia.



Non-acute setting

As part of her [PhD \(now completed\)](#), Jacqueline set out to co-design and assess a care bundle for ulcer prevention, seeking to find out whether such an approach could be of benefit in a non-acute healthcare setting.

She firstly conducted a systematic review of existing literature to determine the effects of care bundles generally on patient outcomes, and then interviewed nursing home care staff and NHS community-based nurses to explore the context of, and the barriers and facilitators to, pressure ulcer prevention in nursing homes. Based on these findings Jacqueline then co-designed a pressure ulcer prevention care bundle with nursing home staff, community nurses and tissue viability specialists.



What we found was that staff really liked our approach and the model.

Findings

Jacqueline's research suggested that it is possible to co-design and implement a pressure ulcer prevention care bundle intervention in the nursing home setting.

As she explains: "What we found was that staff really liked our approach and the model. There was a strong feeling that it could help with continuity of care for residents and make that care more comprehensive. Such continuity can be particularly important in a nursing home setting given that staffing can be quite transient."

That said, Jacqueline says that pressure ulcer prevention in nursing home residents is complex and can be influenced by several factors. As such, further research is now necessary to assess whether the care bundle intervention is effective. "We need to explore care bundles more to see how they can work. We are currently working with a number of CCGs to see if the care bundle can be trialled more widely."

Digital technology in community wound care

Jacqueline is also working on a study exploring the introduction of a new technology, [3D camera software](#), into the NHS for use by community nurses. She adds: "The aim of this study is to understand the process of introducing this new technology into routine wound care practice."

Her work is complemented by parallel exploration into the use of electronic patient wound care data collected in the community, and as part of this work we have developed a community wound data set.



We are using audit and feedback mechanisms to deliver improvements in current woundcare practices.



Evidence into Practice

Our ILUMIN study is a tangible example of how our research can make an impact on the ground.

Significant opportunities for delivering better value wound care exist across the NHS. Currently we are focused on developing strategies to identify, assess and disinvest from products and practices supported by little or no evidence, and to enhance the uptake of those that are.

One such example is our [Leg Ulcer Quality Improvement \(ILUMIN\) Programme](#) that involves the CLAHRC GM team working closely with community nurses across GM and East Lancashire to support the implementation of some changes to processes and practice that will enhance the quality and value of care delivered.

ILUMIN was developed after our large wound survey highlighted variation in the use of first line, evidence-based treatment for people with leg ulcers. We took three key quality standards focused on leg ulcer assessment and treatment and worked with local NHS trusts to improve data collection around these. The data was then incorporated into an audit and feedback process with the aim of encouraging improvements on the ground. This work is ongoing and now being evaluated.

The objectives of ILUMIN are to:

- increase measurement and recording of ankle-brachial pressure index (ABPI) by appropriately trained professionals for all patients with a leg ulcer;
- increase the use (and recording of the offer) of compression as an effective first line treatment for patients with venous leg ulcers and/or mixed aetiology leg ulcers, provided significant peripheral vascular disease has been ruled out;
- increase use (and recording of the offer) of 2-layer compression hosiery (where suitable) as an effective and cost-effective alternative to 4-layer compression bandages for patients with venous leg ulcers and/or mixed aetiology leg ulcers.



VIEWPOINT

Prof. Dame Nicky Cullum explains how significant opportunities for delivering better value wound care exist across the NHS.

The management of complex wounds is a significant, yet often neglected, area of care and expenditure in the UK. At any one time around

100,000 people in the UK have one or more complex wounds. Complex wounds, such as foot, leg and pressure ulcers, typically occur in older people and are themselves caused by other long-term conditions such as diabetes or venous disease while pressure ulcers are largely due to health-related immobility.

Context of community wound care

Our research has highlighted large variations in care and clinical practices across wound care services in the north of England. This includes the underuse of evidence-based practices such as compression, and overuse of those of low or no known clinical benefit such as antimicrobial dressings.



Our research has highlighted large variations in care and clinical practices across wound care services in the north of England.

Understanding, and reducing unwarranted variations is key to improving care and our data is suggestive of some gaps in skills and knowledge among community nurses. We know optimal assessment and treatment makes a real difference, but the last decade has seen a massive decrease in the numbers of nurses specially trained for working in the community setting.

At the same time a lot of people with expertise in wound care have been lost from the system. CPD (Continual Professional Development) funding for nurses via Health Education England has also been cut, making it harder to ensure that the existing workforce develops and maintains wound care related (and other) skills.

National strategy

This lack of priority and investment in community services has been highlighted in the House of Lords and, given the amount of time spent by community nurses on wound care and NHS expenditure on wound care products, calls made for a national wound care strategy to improve standards of care. This is now being taken forward by NHS England and we are working closely with them, helping to provide the evidence as they develop a national strategy for wound care in the NHS.

Counterproductive

Given that significant national investment in training and staffing is required, the cuts which have occurred in community nursing seem counterproductive. Our research aims to understand the current issues in wound care and to highlight areas where we can act with the aim of improving outcomes for people with complex wounds.

Prof. Dame Nicky Cullum is Professor of Nursing and Head of the Division of Nursing, Midwifery & Social Work in the School of Health Sciences.

End-of-life care



Our programme aims to support high quality end-of-life care in the community, prevent unnecessary hospital admissions, and facilitate appropriate hospital discharges. To achieve this vision we're working with a number of local NHS and national charity provider organisations.

The objectives of our programme are to:

- develop collaborative research and networks comprising clinicians such as nurses and GPs, patients and carers, NHS managers and commissioners, and university-based academics;
- improve end-of-life care pathways through the implementation of good research evidence;
- develop new streams of research responsive to the needs of the local NHS;
- develop new knowledge about how research findings can be implemented into practice in community services;
- improve support for family carers both as co-workers and clients as part of the end-of-life care provided within acute and community settings.

Innovation through Research

Family carers of people with cancer provide almost 70 hours of care a week to look after their relatives in the last three months of life. They are also between five and seven times more likely to have mental health problems than the general population.

These are a couple of the key findings of a [Dimbleby Cancer Care funded study](#) led by Prof. Gunn Grande and supported by CLAHRC GM. It was the first national level study which sought to identify the extent of the contributions and costs associated with family caregiving for people with cancer towards the end-of-life.

The findings emphasize the vast amount of time that family carers provide to support and care for their loved ones during their final months of life, whilst also demonstrating the strain that providing such support can have on their mental wellbeing.

Knowledge

In order for patients and carers to obtain good quality end-of-life care and support, it's essential that health service professionals have the appropriate knowledge and skills to be able to provide such care.

Supporting this we've worked with Macmillan Cancer Care, as part of the Manchester Cancer Improvement



Partnership, to survey the Manchester health and social care workforce to understand the current levels of training, knowledge and skills to deliver person centred end-of-life care, and to assist with the development and delivery of appropriate training.

We've also taken this one step further, and are currently working with a number of local hospital and community providers to help them understand the specific end-of-life training and development needs of their staff, and design and deliver bespoke training.

Organisation

Ensuring that family carers are supported in their caregiving role also requires changes in how healthcare organisations work with carers.



It is clear from this research that ongoing support for carers is very much needed and would prevent a breakdown in caregiving and may ultimately, in the long term, produce cost savings for the NHS.

JONATHAN DIMBLEBY
Dimbleby Cancer Care

A project in association with the University of Cambridge and Hospice UK, and co-led by CLAHRC GM, has been examining the organisational structures and procedures that need to be in place to identify, assess and support carers during end-of-life care.

Through a series of interviews and focus groups with informed practitioners, stakeholder consultations, and a survey, we've been able to propose ten key recommendations in relation to carer assessment and support. They outline the need for:

- Consistent identification of carers within the care setting
- Demographic and contextual data on who the carer is and their situation
- A protocol for assessing carers and responding to the assessment
- A recording system for carer information, separate from patient data
- A process for training practitioners
- Available time/workload capacity
- Support from senior managers
- Role models/champions
- Pathways for communication
- Procedures for monitoring/auditing processes and outcomes of carer assessment and support

Ensuring the above are in place and present will help organisations achieve the policy ambition of 'comprehensive, person centred assessment and support for carers'.



CSNAT enables a holistic and systematic process of assessment and support that is carer-led and tailored to carers' individual needs.

Evidence into Practice

The Carer Support Needs Assessment Tool (CSNAT) research team has won a major national research award for impact on practice.

The CSNAT intervention comprises two components. Firstly, an evidence-based, comprehensive support needs assessment tool, and secondly a defined five stage person-centred process. Together this enables a holistic and systematic process of assessment and support that is carer-led and tailored to carers' individual needs.

The collective research studies around CSNAT represent a robust programme of work which has involved more than 1500 carers and 500 practitioners, while the programme has also delivered training to more than 90 healthcare organisations.

CSNAT was originally developed for carers of people at end-of-life, predominantly from cancer, but we're supporting the exploration of the use of CSNAT for carers of people with other life-limiting conditions such as stroke (in association with the OSCARSS team overleaf), dementia and motor neurone disease (in association with the Motor Neurone Disease Association).

We're also working in collaboration with local hospital and community providers to understand if the CSNAT can be used as part of the transition from hospital to community care.

National and international roll-out

The underfunding of the NHS, and the time and resource pressures that healthcare professionals face, is increasingly in the public eye. As such the time which is available to attend set training and be away from clinical practice can be difficult to guarantee.

To allow increased national, and international, accessibility to the training programme for the CSNAT intervention, CLAHRC GM has supported the development of an online training and implementation toolkit for the use of CSNAT.

Our early work identified that it was feasible to deliver existing face-to-face training online, so we have created a tailored online training package which not only provides initial training materials, but also resources for leadership teams to implement change and train up further practitioners according to the requirements of their organisation.

Award

The work of the CSNAT team recently received a national award given for the publication of practice-changing research within the NIHR (National Institute for Health Research) portfolio. The award was announced at the NIHR Charities Consortium Conference for Hospice and Community-based Research.

As well as Prof. Grande from CLAHRC GM, the CSNAT team comprises Dr Gail Ewing at the Centre for Family Research at the University of Cambridge, and Dr Janet Diffin at Queens University Belfast.



VIEWPOINT

Prof. Gunn Grande says it is becoming increasingly important to recognise carers as a vital resource in end-of-life care.

Family carers provide substantial support and care for people nearing the end-of-life and are central to making end-of-life care in the community

possible, in line with patient preferences.

However, carers suffer considerable impact on their own health during caregiving and our research is the first to gain national data on the scale of carers' contributions and personal costs.

For instance we found that carers on average gave 70 hours of care and support a week to people dying from cancer in their final months of life. At the same time 83% reported psychological distress at levels where further clinical investigation is recommended and where, for instance, their ability to concentrate, make decisions and deal with problems may be affected. Clinical distress at this scale is likely to represent a considerable public health problem, particularly given that an estimated 500,000 carers provide end-of-life care in the UK each year.

Better support

If we can ensure that carers are better supported we are likely to reduce some of the more extreme stresses of caregiving, so that carers are more able to carry on their valuable work without being 'broken' by the experience.

An important aim of our work over the past decade, together with Dr Gail Ewing at the University of Cambridge, has therefore been to help ensure that person-centred assessment and support for carers becomes part of regular end-of-life healthcare practice.

For instance we have worked closely with carers to develop a CSNAT that captures what matters to them. This covers

support to enable carers to support the patient as 'co-workers', and support to look after their own wellbeing as 'clients'.

We have also built the CSNAT into a five-step CSNAT Approach to help practitioners take a more comprehensive, person-centred approach to assessing and supporting carers, and better tailor their input to what carers themselves feel they need.

We tested this in feasibility studies and two trials, and found it improved outcomes for carers and was seen to be valuable by carers and practitioners alike.

Change in practice

There is a big gap between developing something that works and implementing it into practice. However, our work with numerous healthcare services highlighted that regular, carer-centred support for carers takes a change in practice. Practitioners need training to take on board a new way of working and their organisations need to plan for, and implement, change at organisation level.

Work with CLAHRC GM has helped us develop our initial training into a comprehensive [online CSNAT training and implementation toolkit](#) to enable national and international implementation of CSNAT assessment and support.

We have also produced national recommendations for the building blocks that need to be in place for general implementation of carer assessment and support, supported by CLAHRC GM and Hospice UK. A national survey of Hospice UK members is currently enabling us to identify gaps between recommendations and what hospices provide, to improve hospice care.

Vital resource

In the light of the projected increases in the number of deaths, years of dependency in later life, and reliance on carers over the next decades, it is becoming increasingly important to recognise carers as a vital resource in end-of-life care, support them in their role, and ameliorate the impact from caregiving,

Most of us will support a family member or friend towards the end-of-life or eventually receive such support ourselves. To support carers we need to rethink where carers fit within healthcare provision, and integrate engagement with carers into the healthcare system.

Ultimately, this is likely to benefit patient care, support care in the community, and prevent unwanted acute hospital admissions.

Prof. Gunn Grande is a Professor of Palliative Care.



To support carers we need to rethink where carers fit within healthcare provision, and integrate engagement with carers into the healthcare system.

Stroke



Projects within this programme focus on enhancing quality and coordination of care and outcomes for people affected by stroke, including stroke survivors, their carers and families.

Working in partnership with the Stroke Association we aim to do this by:

- collaborating with stroke survivors, carers, their families, service providers, commissioners and researchers to identify key priority areas for research;
- developing and delivering high quality research studies in the area of longer-term support and care, to ensure that service provision is based on the best available evidence and delivers optimal outcomes;
- supporting the spread and sustainability of evidence-based interventions in routine practice.

Innovation through Research

Although the Care Act gives local authorities a responsibility to assess a carer's need for support, there is little guidance for providers on what that assessment should look like or who should provide it.

These 'gaps' informed the development of [OSCARSS \(Organising Support for Carers of Stroke Survivors\)](#), a study evaluating the effectiveness of approaches to identify and support the needs of informal carers of stroke survivors, the costs of this approach, and its potential sustainability and scalability nationally and internationally.

The value of informal care

Stroke is a lifelong condition. Survivors experience loss of abilities and independence, and can become concerned about how their condition affects their partners and family members who often take on the role of informal caregiver. Nationally the value of informal stroke care is worth up to £2.5bn a year, but this can come at a great personal cost to carers, threatening their physical health, family and social networks, finances and emotional wellbeing. It is important that informal carers have their health and wellbeing needs identified and supported.

Study

We have worked in partnership with stroke carers and other experts to adapt an existing carer-led approach, making it appropriate and acceptable for carers of stroke survivors. Over the past two years this adapted approach has been trialled within services provided by the Stroke Association across England and Northern Ireland, collecting questionnaire and interview data from more than 400 carers.

OSCARSS is one of very few large stroke studies to focus on meeting the needs of carers. Results from the trial are eagerly awaited by the international stroke community and will be revealed at the European Stroke Organisation Conference (ESOC) in Milan in May 2019.

Research User Group

As part of the study we established an OSCARSS Research User Group (RUG). This group includes members with experience of caring for a family member who has had a stroke. The group meets regularly, supporting all aspects of the development, design and roll-out of the study.

Setting up the carer user group has had an extremely positive impact for members themselves. As well as increasing their confidence, some members have gone on to participate in delivering teaching and workshops, training the future NHS workforce. Members have also been involved in engagement events and conferences to publicise the study, including the UK Stroke Forum 2017 and the International Perspectives on Evaluation of PPI 2018.

Impact

OSCARSS is still an active study collecting outcome data and the true impact will depend on the findings, namely whether or not the evaluated carer support intervention is more clinically and cost effective than usual care.

In anticipation of a positive finding in May 2019 we will be ready with a costed service specification and staff training package for scalability nationwide by the Stroke Association and other providers. In the interim OSCARSS' impact has been in the methods we've co-developed, partnering with a national service support organisation and locally with stroke carers, and we also recently presented at the World Stroke Congress in Montreal.

Connected Health Cities

Another project, in partnership with [Greater Manchester Connected Health Cities](#) and led by Dr Adrian Parry Jones, aims to improve outcomes for people affected by stroke. The project comprises three workstreams encompassing the complete care pathway; from suspected onset, through to management, and follow up after discharge to primary care. We have been collaborating with the North West Ambulance Service to improve identification of stroke and reduce the number of stroke 'mimics' (people who have not had a stroke but are initially thought to have had one) from entering the stroke pathway.

Developing people

[PhD student Verity Longley](#), a qualified occupational therapist with a background in psychology and stroke research, has raised the profile of CLAHRC GM work with her studies around stroke care.

Her PhD topic 'Understanding the impact of pre-existing dementia on stroke rehabilitation' was motivated by the observation that dementia or pre-stroke cognitive difficulties are associated with poorer functional outcomes after stroke.

In particular it is unclear whether this is due to lack of access to, or inequality in, stroke rehabilitation received.

Verity used a range of studies to understand clinicians' decision-making when referring/admitting patients for rehabilitation and whether there is a difference in the amount of physiotherapy, occupational, and speech and language therapy received by patients with and without pre-existing dementia.

Evidence into Practice

The National Stroke Strategy says that all stroke survivors and their carers should receive regular reviews of their health and social care needs, including a review six months after they have left hospital. This ensures that survivors and their carers continue to feel supported in the long-term after a stroke and enables them to access the further specialist advice, support, information and rehabilitation that they need.

In response to this we developed the Greater Manchester Stroke Assessment Tool (GM-SAT) - in partnership with service users, NHS commissioners and providers, and the Stroke Association - for use in six month stroke reviews.

We piloted and evaluated this in a number of different ways, ultimately leading to its widespread implementation. The GM-SAT was originally designed for use in the community, however healthcare professionals suggested that the tool was not suitable for use with stroke survivors living in care homes, as they may have different needs to those who live in the community. In response to this feedback we worked with healthcare professionals to develop a modified version of the GM-SAT.

This has helped us to understand how six month reviews are planned, delivered and communicated to help improve the support offered, and has led to a modified better version of the GM-SAT which was due to launch at the UK Stroke Forum in December.

Care needs

GM-SAT encompasses a wide range of potential post-stroke care needs, from medication management and secondary prevention, through to mood and fatigue. We have been working with patients, carers and professionals from across the stroke pathway to identify the common, long-term problems people experience after a stroke.

As well as working in partnership with the Stroke Association for many years, we worked with several NHS Trusts including Pennine Care and Manchester University. Meanwhile we will continue to raise awareness and support implementation of the tool to improve quality of care and outcomes for stroke survivors.

Impact

The use of GM-SAT has continuously increased over time:

- It is now used by the Stroke Association across England and beyond, delivering six month post-stroke reviews for stroke survivors across 42 services
- The number of reviews using GM-SAT has steadily increased over the years, with 17,000 reviews conducted by the Stroke Association to date
- It is the only assessment tool to be referenced by the National Institute for Health and Care Excellence (NICE) Quality Standard for Stroke in adults as potentially helpful in the delivery of routine post stroke reviews
- It is cited by the British Association of Stroke Physicians' clinical standards for six month reviews, while a national audit of service provision by the University of Nottingham found the GM-SAT to be the assessment tool most commonly used for six month post-stroke reviews nationwide
- It has been integrated into the primary and secondary care patient record systems across the Yorkshire and Humber region

As one community stroke co-ordinator at the Stroke Association sums up: "We find the GM-SAT brilliant to use and use it to recognise and plug the gaps that people have. It's not just patients who appreciate the tool, the feedback from all our stroke coordinators is that GM-SAT is very easy to use. It's simple and has put a structure and framework around what they were doing already."



It's not just patients who appreciate the tool, the feedback from all our stroke coordinators is that GM-SAT is very easy to use.



VIEWPOINT

Prof. Audrey Bowen outlines how CLAHRC GM is playing a crucial role in helping shape care services for people who have suffered a stroke.

Unprecedented improvements in pre-hospital and acute hospital treatment have led to many more people surviving their stroke and

living for many decades. This is a tremendous achievement for health sciences however 'a life worth saving has to be a life worth living'. This is a belief that CLAHRC GM shares with our partner the Stroke Association. Our work promotes well-being and resilience for all those affected by stroke, including the families and loved ones of those who survive and who often perform essential caring responsibilities.

Patient and carer-centred

Our research is patient and carer-centred. This is reflected in the way that we agree our priorities, our study methods and our collection and interpretation of data for implementation into practice.

We don't just consult with, we actively collaborate with stroke survivors and carers. We respect our different

contributions and learn from each other. We aim to generate robust research evidence that will convince stroke service commissioners and policy-makers, but this is also by and with, rather than for or about, those with lived experience of the effects of this life-altering, lifelong condition.

OSCARSS

One example is the work we are currently completing on OSCARSS. Our ideas about a study to evaluate the most acceptable, effective and affordable way of supporting informal carers have been shaped - and sometimes battered about - by an advisory group of carers who have worked with us from the very start of the project.

It is exciting and rewarding for us to play a part in improving future stroke and carer services in this way, and we are looking forward to the impact this will have once we have the big reveal of the trial results in Milan in May 2019.

Prof. Audrey Bowen is the Stroke Association's John Marshall Memorial Professor of Neuropsychological Rehabilitation.



Kidney health

Interface

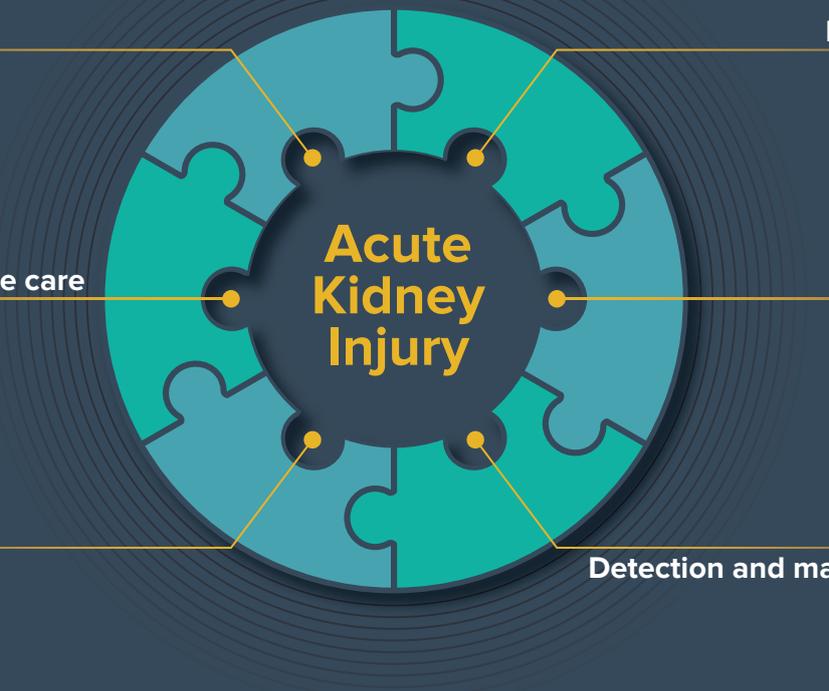
Prevention

Post discharge care

Interface

Interface

Detection and management



**Acute
Kidney
Injury**



Our kidney health programme consists of several closely aligned research and implementation projects which aim to develop and evaluate a whole systems approach to improve the prevention, detection and management of acute kidney injury (AKI).

The key principles underlying the programme are to:

- develop evidence-based interventions grounded in an in-depth understanding of routine clinical practice and everyday work;
- maximise the utility of AKI as a driver of quality and safety whilst minimising the treatment burden for patients and reducing unnecessary clinician workload;
- use AKI as a lens to support system resilience through collaborative working across the interfaces of care;
- build relationships with key regional and national organisations to support delivery of projects and best practice clinical care;
- increase understanding and involvement of professionals, and the general public, to raise the profile of kidney health.

Innovation through Research

AKI is associated with up to one in five unplanned hospital admissions, while illness complicated by AKI costs around 1% of the total NHS budget.

AKI is also associated with poor health outcomes in terms of high rates of mortality (it is estimated to cost 100,000 lives a year), development or progression of chronic kidney disease (CKD), and rehospitalisation. It is against this backdrop that our work is playing a key role in helping to address these huge challenges.



Bury improvement work

In partnership with [Bury CCG](#) we conducted a project supporting the delivery of care for individuals who have had a hospital admission complicated by AKI.

The project, which involved all practices across Bury CCG, had two strands. Firstly, through a local Quality in Practice Contract, practices were incentivised to participate in multi-disciplinary education, engage in audit and feedback, and develop a practice level action plan to improve post-AKI care.

Then during the evaluation phase we conducted research comprising of: a quantitative analysis of processes of care; a health economics evaluation to investigate the impact of the improvement intervention; and a qualitative evaluation to understand AKI-related working practises in primary care.

Benefits

To date we have demonstrated that practices have engaged with a national recommendation to improve diagnostic coding of AKI. We have also shown that increased coding of AKI in primary care is associated with improvements in processes of care including medication reviews, monitoring of kidney function, and communication with patients.

This has had a positive impact on associated processes of care, and the learning from the project now provides a platform for ongoing AKI-related work regionally and nationally, making a significant contribution to the current limited evidence base. Our work has also been widely highlighted at national conferences, including at the Diabetes UK Professional Conference Workshop.

Manchester work

We have also been working with GP practices across the [Manchester Health and Care Commissioning \(MHCC\)](#) locality, facilitating communication with AKI leads at Manchester University Hospital NHS Foundation Trust, where we explored the challenges around the management of patients with AKI.

The aim was to develop relationships between the teams and share important information to inform improvement, with a particular focus on improving the interface between secondary and primary care.



Learning from the project now provides a platform for ongoing AKI-related work regionally and nationally, making a significant contribution to the current limited evidence base.

Evidence into Practice

Data from both Bury CCG and MHCC has fed directly into our work with the Royal College of General Practitioners (RCGP), informing the design and content of the new AKI Quality Improvement Toolkit for GPs and healthcare professionals.

Our work on the toolkit highlighted the challenges that primary care teams face when patients return from hospital post-AKI without timely, relevant discharge information. In particular the project has revealed the practicalities and challenges of the patient pathway, and the difficulties faced when patients and information cross between organisations and between multiple professional groups.

Toolkit

The [toolkit](#) provides resources including national guidance, case studies, and shared learning about quality and safety issues to improve recognition, response and management of AKI in general practice.

By focusing on AKI there are also opportunities to improve medication management, deliver safer transitions of care, and improve safety for vulnerable patients and their carers.

Development of the toolkit, which is grounded in an in-depth understanding of routine clinical practice, was led by Dr Tom Blakeman from CLAHRC GM. The RCGP AKI Quality Improvement project is an ongoing partnership between CLAHRC GM, Think Kidneys, North East & North Cumbria AHSN (Academic Health Science Network), Kent Surrey Sussex AHSN, NIHR GM Patient Safety Translational Research Centre, Healthcare Improvement Scotland, and NHS Education for Scotland.

The RCGP project builds on Dr Blakeman's role in leading the development of national Think Kidneys guidance and resources for primary care. Since publication in April 2016 they have been accessed over 7,000 times. Also developed from his CLAHRC GM role, the BMJ e-Learning module was published in August 2016. More than 4,000 clinicians have taken the module and it continues to receive a 5* rating.

What next?

Following the Bury post-AKI care project a key next step is to understand and map variation in post-AKI care regionally and nationally and in doing so, provide a platform for the development, implementation and evaluation of improvement initiatives.

To achieve this we have been awarded funding through the NIHR School for Primary Care Research to design and evaluate a health informatics intervention to enhance timely feedback of data to support system change in the delivery of care for this high risk patient population. We have also agreed with NICE (National Institute for Health and Care Excellence) to collaborate on this national priority.

We have also recently led a workshop at the annual RCGP conference focused on embedding systems thinking as an approach to understand and improve routine care.



Our work on the toolkit highlighted the challenges that primary care teams face when patients return from hospital post-AKI without timely, relevant discharge information.



VIEWPOINT

Recognising and responding to acute kidney injury is a key priority for the NHS, says Dr Tom Blakeman.

AKI is a major marker of patient safety and illness severity. As a practicing GP myself, I see first-hand how illness complicated by AKI is associated with poor health

outcomes in terms of high rates of rehospitalisation, development or progression of CKD, and mortality.

Against this backdrop, improving the recognition and response to AKI is a key priority not just for NHS England but also across the world in terms of improving patient safety and health outcomes.

Also, as a clinical syndrome, AKI offers a lens to learn and improve care delivery and patient safety for people with a range of conditions, particularly those taking multiple medicines and living with complex health and social care needs.

Vision

The vision behind the CLAHRC GM work is to make kidney health meaningful to the public, to patients and to health practitioners, particularly in primary care.

Our wide range of live research projects are very much aligned with national initiatives and with priorities being set out by NHS England. Indeed, a key aspect of our work is to develop enduring partnerships. That involves meeting people in different settings and working together to define and identify key priorities and then build something up from an understanding of everyday practice.

The development of our AKI toolkit with the RCGP, mentioned earlier, is a key example. We identified that there was a collective need to find approaches that would maximise

the utility of detecting AKI whilst at the same time minimise the potential of treatment burden for patients and carers, as well as unnecessary workload for clinicians.

Our research

To date, national AKI initiatives have largely focused on tackling the harm associated with AKI in secondary care. Instead a key aim for our Kidney Health Programme has been to develop, implement and evaluate interventions to improve the prevention, detection and management of AKI in primary care, and across the interface with secondary care.

Meanwhile we are extremely excited about future work around AKI. For instance, following the successful delivery of the [RCGP toolkit](#), further funding has been awarded to conduct a consensus study to develop guidance to support more tailored and personalised care for people who have experienced an episode of illness complicated by AKI.

Funding has also been secured to implement Quality Improvement methods into routine practice in order to both improve patient safety in primary care, and mitigate safety risks that are common to multiple clinical problems beyond simply AKI.

This all goes to show that the UK is undoubtedly ahead of the game, trialling out new initiatives to improve care of AKI among the general population, with studies grounded in an understanding of routine clinical practice.

Dr Tom Blakeman is GP clinical-academic lead for the CLAHRC GM kidney health programme. He is also the clinical champion for acute kidney injury at the Royal College of General Practitioners.



Our wide range of live research projects are very much aligned with national initiatives and with priorities being set out by NHS England.

Remote Monitoring in Rheumatoid Arthritis (REMORA)



Rheumatoid arthritis (RA) is a long term condition affecting about 400,000 people in the UK which leads to joint pain, fatigue and disability. Treatment decisions are made at short clinic visits every six months or so, where remembering past symptoms can be difficult.

One answer to this problem is the increasing availability of digital technology and its ability to collect real time patient-generated data to inform and enhance clinical care and self-management for long term conditions such

as RA. High levels of smartphone ownership makes this method of collecting patient-generated data particularly appealing.

Until now frequent patient-generated data from mobile phone apps has not been linked into electronic health records (EHR) due to technology, privacy and governance issues. However a major CLAHRC GM study has proved that the development of such an app for RA, and making this data accessible at consultant appointments, has a multitude of benefits.

Innovation through Research

The Remote Monitoring of Rheumatoid Arthritis (REMORA) study aimed to improve the clinical consultation for patients with RA.



All participants were asked to suggest useful content for the app, as well as guiding its structure and functionality.



By co-designing an app with patients to track changes in their disease activity, patients and clinicians alike could view and discuss the app data during consultations. Crucially, data from the app was integrated into EHRs in the NHS to inform consultations.

System

The first stage of the programme (Round 1) saw the app designed and built in close consultation with stakeholders. The study team recruited and interviewed 26 patients with RA to co-design the app and views were also sought from clinicians, UK researchers with expertise relevant to the study, and IT development staff based at our partner, Salford Royal NHS Foundation Trust.

All participants were asked to suggest useful content for the app, as well as guiding its structure and functionality, ensuring the app would be useful for all of these groups.

Round 2 of testing consisted of eight patients with RA using the [REMORA app](#) to complete daily, weekly, and monthly questionnaires about their disease activity over the course of one month. The app testing began following an initial hospital outpatient consultation, and concluded one month later with a second consultation where the app data was available in the EHR.

This allowed the team to test how well the data flowed from the app to then record and fix any bugs. The data collection was followed-up with a post-testing interview so that participant experiences and recommendations for improvements could be recorded and any necessary app updates undertaken.

Real world setting

The Round 3 testing phase was designed to more closely mimic real-world settings. Twenty patients each tested the REMORA app over three months to reflect a realistic gap between potential outpatient appointment dates.

Like the testing in Round 2, clinic appointments were held before and after the data had been collected. Interviews were then conducted with study participants, clinicians and other stakeholder groups to seek their views on the benefits and challenges of remote monitoring and the integration of daily patient-generated data into the EHR.

Feedback

In addition to our work with our patient participants, another patient and public involvement group was established at the project outset with the purpose of informing, supporting, and contributing to the progress of study activities throughout its entire course.

The group met once a month during the course of the study to hear presentations and feedback from all members of the study team and our partner organisations. The group provided critical feedback across all elements of the study and was able to contribute to the development of project documentation, co-designing (creating and changing content) for the REMORA app, as well as supporting participant and patient engagement, dissemination of findings, and discussing the potential benefits and limitations of REMORA.



Some patients continued to use the app beyond the study period as they found it so useful.

Evidence into Practice

REMORA allowed patients to complete up to 85 daily, 13 weekly, and three monthly question sets. As a result there was a large amount of data collected for each patient, which allowed for much more informed decision making during consultations.

In total 26 patients and two clinicians were interviewed for this three-month testing period. Overall, patients found REMORA acceptable and usable, with most enjoying using the app. Furthermore they appreciated that questions looked beyond the purely physical symptoms and included emotional and physical aspects that often seem to be hidden parts of their condition.

There were also high levels of patient engagement with the app throughout the 85 day study, with patients recording daily data on a median of 73 of 85 days. Weekly data was also recorded a median of 11 of 13 weeks during the test period and all patients reported monthly data at least once. Indeed, some patients continued to use the app beyond the study period as they found it so useful.

Clinicians also noted that interpreting the graphical outputs of REMORA during consultations was quick and easy. This enabled them to see a clear picture over time, highlighting areas of importance, such as short-lived disease flares (some of which had been forgotten by the patients) which they could then further discuss with the patient.

Feedback suggested some patients continued to collect their own similar data after the app had been removed, aiding their future consultations.

Key messages

A number of key messages emerged from the REMORA study:

- Patients and clinicians all found the app usable and beneficial to the monitoring and management of their RA
- It demonstrated that patient generated symptom data can be effectively recorded via an app and integrated into EHR
- The study had high levels of engagement among patients and clinicians, with both viewing the presence of graphs and other app data during consultations very positively
- The clinical consultations demonstrated that data collected via the REMORA app could significantly improve shared decision making and support self-care for patients
- Co-designing the app with patients, plus input from IT specialists, researchers, clinical staff, and the public created a meaningful and appropriate tool that captured all the necessary information



VIEWPOINT

The benefits of the REMORA study show that the time has come for more widespread uptake of healthcare apps integrated into the NHS, says Prof. Will Dixon.

Just recently the government unveiled a new NHS mobile app that will allow users to book appointments with their

GP, order repeat prescriptions, and see their medical files held by the surgery. Although patients can already carry out online many of the functions the app offers, the government believes having them available via a smartphone will make them more attractive.

This is the just the latest example of how mobile technology is set to play an increasing role in our healthcare system. For instance more than 15 million people in the UK have a long-term condition (LTC) which accounts for £7 out of every £10 spent by the NHS. Yet people living with LTCs spend less than 1% of their time in contact with healthcare professionals, meaning they have to manage their own health, and doctors have limited sight of how their patients are doing day-to-day.

Against this backdrop the NHS recognises the opportunities that technology can bring to LTCs in terms of supporting self-management, informing clinical decision-making through remote monitoring, and transforming care delivery.

Barriers

So with seven in ten people owning a smartphone, and now more than 165,000 health apps available, what's stopping this digital transformation? In short, patient-generated data from apps are not yet integrated into the NHS due to multiple challenges including patient and healthcare professional concerns, technical issues, and privacy and security issues.

For instance our REMORA study highlighted the need for a high standard of IT capability within a Trust or organisation aiming to incorporate remote monitoring. It also revealed significant challenges that face the integration of remote monitoring data into healthcare systems, such as the compatibility between IT systems across organisations and the willingness of staff and patients to adapt to these new technologies.

Potential

REMORA demonstrated the terrific potential of healthcare apps. It delivered proof-of-concept that remote monitoring in RA using smartphones was beneficial for patients and clinicians. One patient remarked to us that the study was

“a brilliant thing” and they couldn’t wait until it was widely available. Others cited how the use of electronic graphs in clinic made it easier for a “shared conversation”, while pain flares otherwise forgotten became visible.

Crucially, the app has the potential to facilitate patients not having to attend as frequent appointments if their condition is under control, or conversely allow clinical teams to bring them in if they appear to be deteriorating remotely.



One patient remarked to us that the study was “a brilliant thing” and they couldn’t wait until it was widely available.

Next steps

So what next? For the REMORA project it will be about investigating how remote monitoring could be used on a larger scale and how it can be adopted within the NHS as part of usual clinical care across other disease areas and other locations.

Indeed plans for REMORA2 are well underway with the aim of further developing the REMORA app into new areas across GM. It will seek to demonstrate the benefits for self-management, clinical care and research in a wider RA population, as well as expand the smartphone app to support long-term engagement and to enable future digital interventions. Crucially, REMORA2 will also design and build a patient data repository and connecting infrastructure as a blueprint for integration of patient generated data into NHS records.

Prof. Will Dixon is chair in Digital Epidemiology at the University of Manchester and also Director of the Arthritis Research UK Centre for Epidemiology.

Research capacity building



Research capacity building refers to developing and strengthening the skills and abilities of individuals to conduct and implement high quality research. The purpose is to develop individual and organisational research capability, and apply this to clinical issues and challenges.

We support our partners through a range of programmes:

- An annual programme of research workshops and events to support continuous professional development
- A 30-day taster research internship programme
- Postgraduate research degree and fellowship opportunities

These opportunities have been taken up by a wide range of partners who wish to support their staff with developing research skills and initiatives that will ultimately benefit patients and service users.

All of the programmes align with our core objectives and vision of delivering high-quality research which improves healthcare and has an impact in Greater Manchester and beyond.

Innovation through Research

At a service level, having healthcare professionals who are involved in research may have a positive influence on the processes of patient care. At a societal level, there are a range of benefits with clinicians engaging in research, such as, the potential of more successful translation and impact of research findings into clinical practice, which may improve clinical care and patient outcomes.

To understand how research capacity is developed in organisations, we are investigating the process of learning and development in nurses, midwives and allied health professions (AHPs) who undertake either a Clinical Academic Pathways (CAP) programme, or our research internship programme. We have so far supported 20 interns through three cohorts and plan to deliver a further cohort later this year.

Recruits to the CAP programme spend 60% of their time in clinical practice and the remainder studying for a Masters in Clinical Research (MRs). Research interns, who come from a number of our partners, spend 30 days over nine months conducting a manageable project such as a literature review or small-scale service evaluation.

For both programmes the objective of our research is to investigate:

- the impact on their research knowledge and skills;
- their learning strategies;
- how they utilize research in clinical practice;
- the impact of capacity building activities on their career development.

PhD students

We also have eight fully-funded PhD students, including three funded through the NIHR Research Capacity in Dementia Care Programme. Some of our students have already published their work and several have now completed and been awarded their PhDs. Their work covers a range of different topics including:

- supporting family carers of people living with dementia towards the end of life;
- optimising population access to GPs;
- supporting family caregivers in the delivery of practical care at home;
- implementing a pressure ulcer prevention care bundle in nursing homes.



I completed a CLAHRC GM postdoctoral fellowship in 2017 and my connection with CLAHRC GM has not just been a personal journey for me but opened up a collaboration that is still ongoing. The support received, and the people I have been able to connect with, has helped me develop as a researcher and encourage others to participate in CLAHRC GM activities. Having mentored other people now on their own journeys is extremely rewarding and will help create the research culture we strive for across the NHS.

DR HELEN HURST

Consultant Nurse, Trafford General Hospital

Evidence into Practice

Internship programme

Our programme has had real and lasting impact for our students:

“The internship has helped me invaluablely in a number of ways. From the perspective of skills development, I have been able to work on my academic writing which has improved dramatically. As part of this work, I also presented as part of the Mental Health Research Group at an international conference in Indonesia.”

Barnaby Rumbold

Registered mental health nurse and CLAHRC GM Intern

“One of the most valuable aspects of the internship is being supported in building relationships with a plethora of experts and a network of relevant resources. This has been both inspiring and invaluable for my professional development.”

Dore Young

Musculoskeletal physiotherapist and CLAHRC GM Intern

Masters students

We have also funded six part-time Masters in Clinical Research students. These students spend 60% of their time in clinical practice and 40% on the programme studying for a Masters in Clinical Research. The students’ clinical roles cover a wide range of areas from wound care to end-of-life care and three of the master’s students have progressed from the internship programme. To examine the split clinical academic role we are conducting a study to explore the experience of students.

Evaluation

Alongside formal qualifications, we have also delivered evaluation workshops for a great number of our external stakeholders. The workshops are aimed at professionals who are interested in learning about how to conduct evaluations. The sessions focus on how to plan, deliver and evaluate implementation programmes.

Toolkits

Rheumatology registrar, Dr Charlotte Sharp, is currently completing a PhD on the subject of knowledge mobilisation, in particular looking at the use of toolkits and other products from healthcare research.



She spent the first year of her studies interviewing academics, research fellows and healthcare managers as she sought to understand stakeholder perspectives on toolkits. During her second year she has been conducting case studies of specific research projects

which are developing products which aim to get research into practice, observing project meetings and interviewing researchers and clinicians linked to these projects.

Charlotte says: “Toolkits have become very popular among applied healthcare researchers, particularly in the wake of the impact agenda. I set out to find out what drives the production of toolkits and whether they are useful and

worth the time, money and effort. Also, I’ve been looking at whether the creation of toolkits needs to be part of a broader strategy.”

She says the motivation for taking the PhD was that she had always been interested in leadership and management in health services.

“My studies are exposing me to the broad range of CLAHRC GM programmes, and from a personal point of view the PhD has already been incredibly rewarding. For instance I have developed my skills in writing papers and literature reviewing, and have learnt a huge number of generic skills that I will be able to use both within academia and the NHS.”

Charlotte has already presented her initial findings at the Organisational Behaviour in Health Care Conference, and to policymakers from the Department of Health.



VIEWPOINT

Our programmes are having real impact on the frontline of the NHS, says Dr Jane Griffiths.

Our internship programme has been a huge success, far greater than we anticipated. We are constantly impressed by how much our interns

achieve in a relatively short period of time and with quite limited resources. Instead of just dipping their toes into research, most opt for full immersion.

The programme is beneficial to anyone with an interest in research who has a question from practice they would like to explore. The interns start with an intensive workshop that introduces them to the world of health services research, including an introduction to research and evaluation methods. By the end of this workshop, they have a clear question and plan for how they will answer it.

Most decide to do a literature review and an evaluation of some aspect of their service. They then present their progress at a second workshop half way through the programme and again at the end.



The impact of their work is immediate. They select a topic, review the evidence, conduct a small scale evaluation, and implement the findings.

Our interns report that when they start the programme the research seems ‘other worldly’ and beyond their reach. But by the end they are far more confident in literature searching, critiquing research and using it in practice, conducting an evaluation, disseminating it, and networking within and outside their organisations.

NHS challenges

How does this align with the challenges that the NHS faces and how does it have impact on the front line?

Well, as our interns are from practice their questions directly relate to current challenges within the NHS and also to our CLAHRC GM programmes. The impact of their work is immediate. They select a topic, review the evidence, conduct a small scale evaluation, and implement the findings.

We are currently working with Manchester University NHS Foundation Trust and our interns are employed by them. This has been very successful because they are a cohesive group, with excellent support from our NHS colleagues. It is a model that we will be emulating with other partners and co-funders in the future as we are also keen to develop a programme for service managers to help change the research culture in organisations.

Skills

In addition to research skills, staff also get time out to think and reflect on their work, the opportunity to meet colleagues from different fields, and work with research colleagues in their organisations and with researchers at local universities. Having developed an appetite for research, some also go on to further study such as completing a Masters in Research (MRes) or a Bridging Fellowship.

Dr Jane Griffiths is a Senior Lecturer in the Division of Nursing Midwifery and Social Work.



MAKING A DIFFERENCE

Senior Research Fellow Dr Roman Kislov explains how researchers can make a difference in practice.

My academic career has been inextricably linked to CLAHRC GM from the very beginning. CLAHRC GM co-funded my PhD project and then, upon completing my doctoral studies in 2012, I was offered a research post here and have been working for CLAHRC GM ever since.

What particularly fascinates me is ‘knowledge mobilisation’ and how to promote research evidence and innovation in day-to-day healthcare practice. What are the challenges and difficulties of translating academic knowledge into practice? And what are the best ways of co-producing research in collaboration with healthcare practitioners?

I research cross-cutting issues that are relevant to all CLAHRC GM programmes of work, and my role is to make sure that my research captures this vast learning accumulated by CLAHRC GM as a whole. Indeed because my role is very much about helping researchers bridge barriers and distil learning, my research has also led me to look at the very structure of CLAHRC GM itself, assessing whether it is capable of creating new communities of practice and facilitating effective partnerships.

Challenges

One of the key challenges working with the NHS is the difficulty of implementing research. This is usually down to either the complexity and volume of research, a reluctance to change culture and mindsets, or a lack of a trained workforce, infrastructure and co-ordination. Sometimes it is a combination of all three.

Researchers who want to make a difference in practice therefore need to start by looking at what resources are actually available in the health service,

using that information to guide their research plans, rather than issuing recommendations that simply cannot be implemented in practice.

That said, there is a need for constant compromise between researchers and healthcare practitioners. When we work together we will inevitably have to compromise because there are multiple tensions. It means that researchers have to be more creative and change their mindsets too. They have to be asking healthcare professionals ‘tell us what kind of improvements you want to make and we will see how our research could help you achieve your objectives’.

Collaboration

So how do you design effective collaboration? Firstly, structure should never come before function and organisations need loose frameworks so that they can be as flexible as possible. There is no one-size-fits-all approach, so the configuration and staffing of a collaborative project would depend on the nature of the research, the previous experiences of collaborators and the broader context.

Secondly, it is about getting people out of their silos and spreading information. You bridge barriers by making very diverse groups of people share work tasks and creating opportunities for cross-fertilisation.

Finally, it’s about recognising that there will always be tensions and conflicts, but the key point here is to use these as learning opportunities. When the tensions are surfaced, it often gives you a much better understanding of your collaborators. What makes them tick? What are they passionate about? How can we work better together?



It’s about recognising that there will always be tensions and conflicts, but the key point here is to use these as learning opportunities.

Funding Partners

[Salford Royal NHS Foundation Trust](#)
[Manchester University NHS Foundation Trust](#)
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