

Closing the Gap through Changing Relationships: evaluation

An independent evaluation of the programme



Evaluation
June 2014

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Executive summary

The Closing the Gap through Changing Relationships (CtGtCR) programme was launched in 2010. Seven projects (CtG teams) were funded, aimed at changing one or more of three types of relationships:

1. between the individual using a service and those who work in healthcare provision
2. between people using services and the wider healthcare system
3. between communities and the wider healthcare system.

CtG teams also targeted one or more of the Institute of Medicine's six quality dimensions: effectiveness, efficiency, person-centredness, equity of access, safety, and timeliness.

The Office for Public Management (OPM) was commissioned to undertake an evaluation of the CtGtCR programme, with the aim of looking at (a) how and whether implementation of the various interventions led to relationships changing; (b) how change was experienced by the different actors; and (c) the key barriers to, and promoters of, success. An 'improvement story' was also developed for each CtG team (see the supplement to this report).

The evaluation drew on the principles of the 'realistic evaluation' approach, focusing on clarifying the 'context – mechanism – outcome' dynamics underpinning the various interventions. The linkages between interventions, changing relationships and quality improvement are complex and multi-directional.

Changing relationships must be understood as deeply contextualised sets of dynamics. The CtGtCR programme took place within a period of austerity and other significant transformations in the NHS. Yet these same drivers were manifested and experienced in different ways across different localities leading to different opportunities for, and barriers to, change.

Successful interventions aimed at changing relationships must be built on a solid foundation of good project management, strong leadership and effective engagement. These are common across quality improvement interventions and good project management practice.

While essential, these per se will not bring about relationship change. Changing relationships require a number of enabling mechanisms to be layered over these essential building blocks. The evaluation identified four 'enabling mechanisms', namely: (a) changes to patient beliefs, attitudes and behaviours; (b) changes to health professional beliefs, attitudes and behaviours; (c) changes to systems and processes; and (d) changes to organisational culture and environment.

It is important to appreciate the role of, and distinction between, essential building blocks and enabling mechanisms. Even if pre-conditions for successful implementation are established, implementation itself may not always and necessarily be successful. Successful implementation, in itself, may not necessarily change relationships. Likewise, changed relationships may not necessarily lead to improvements in quality. What is supportive of change, and what actually brings about change, are different. Even when change may be triggered in one direction, the trajectory of development may not be linear, as an 'enabling mechanism' can be 'triggered' as well as 'disabled' given the shifting contexts.

To bring about relationship change and to sustain it, key stakeholders must be clear about the relevant change mechanisms and how these may be triggered or disabled in specific contexts. Efforts at changing relationships must not conflate 'activities' with 'change mechanisms'.

Understanding ‘mechanisms-in-context’ is of vital importance to interventions aimed at changing relationships. This evaluation yielded evidence to further our understanding of the mechanisms that bring about relationship change at the level of individual-to-individual interaction (both clinician–patient and clinician–clinician). However, the sustainability of relationship change may be in doubt if changes at the one-to-one level are not embedded within the wider structure. This requires better understanding of the change mechanisms that help relationship change at one level translate into relationship change at another, more systemic, level.

Understanding the different types of ‘mechanisms-in-context’ requires good qualitative data to help stakeholders articulate and surface their own assumptions about how and why things work, and to test these assumptions on an ongoing basis. This performs a formative function, and keeps relationship change ‘alive’. It also contributes towards more relevant and appropriate measurement of outcomes.

Having said this, the wider system within which interventions aimed at changing relationships have been implemented remains very much ‘activity focused’ or ‘activity driven’. While there are pronouncements around reducing the target-driven approach within the NHS, the system is nonetheless founded on an entrenched culture and practice of routinely measuring and reporting against certain items (for example, bed days, length of stay, waiting time).

These cannot tell us the whole story in terms of the quality of different types of relationships, and the dynamics around interactions in different settings. It does not tell us anything meaningful about whether and how being more patient-focused or more compassionate relate to the various quality outcomes such as efficiency, safety and others. As long as measurement of relationships remains separate from the measurement of quality, it will remain challenging to maintain the link between improvement and compassion, as they may be perceived and experienced as unrelated entities with different levels of priorities accorded.

Changing relationships is about fundamental change that requires an explicit and sustained focus. It is not something that can simply be articulated or aspired to and then left to happen on its own. Relationships do not change simply because of good intentions. In order to be purposive and to stay focused, it is vital to:

- make changing relationships an explicit objective, state its centrality, and explain the rationale behind this
- make changing relationships tangible to all key stakeholders in terms of what it looks like in practice. Individuals and groups can then act purposively and reflect on their behaviours on an ongoing basis
- spell out the likely implications of relationship change, and put in place effective plans to capture and disseminate the evidence of benefits as well as to minimise any anticipated or perceived adverse effects.

1 Introduction

This section provides an introduction to the report. It describes the Closing the Gap through Changing Relationships programme and where this fits in the Health Foundation's wider strategy. It gives an overview of the evaluation methodology, design and activities. Finally, it provides a guide to the remainder of the report.

Background to the Closing the Gap through Changing Relationships programme

Closing the Gap is the Health Foundation's annual award scheme dedicated to bridging the gap between best practice and routine delivery of care. By tackling known gaps between best practice and routine delivery of care, Closing the Gap aims to support demonstrable improvements, build the knowledge and skills of the workforce, and test approaches to transforming the quality of healthcare in the UK. The Closing the Gap through Changing Relationships (CtGtCR) programme was launched in 2010 and focuses on the Health Foundation's evolving work, which recognises that to improve healthcare quality we need to change the way healthcare systems work, and to challenge the beliefs and behaviours of those who use and provide health services. While the programme came to an end in early 2014, many of the projects are continuing their work beyond the Health Foundation's funding.

While CtGtCR is a stand-alone programme, it is also part of a wider set of initiatives by the Health Foundation and builds on existing Health Foundation programmes such as *MAGIC* (*making good decisions in collaboration*) and *Co-Creating Health*, as well as external programmes the Health Foundation has been involved in such as the King's Fund's *Point of Care* programme and the Department of Health's *Year of Care* programme.

Existing evidence shows that in order to achieve the best health outcomes and experience, people need to play an active role in their own care and receive support that is responsive to their needs. The capacity for a person to make an active contribution to their care is not a choice they can make alone. Rather it is a factor and a consequence of the dynamic created by the way support is provided.¹ The Health Foundation believes that healthcare services should be organised around the needs of the people using them to enable this to happen. To inspire healthcare services to effectively reorganise around the needs of the people using them requires a shift in philosophy, culture and behaviours across three key relationships (see Appendix 1):

1. Between the individual using a service and those who work in healthcare provision, for example shared understanding of purpose and process, ground processes in the service user perspective.
2. Between people using services and the wider healthcare system, for example proactive integration, coordination and responsiveness by professionals on behalf of service users.
3. Between communities and the wider healthcare system, for example unidentified health need in a local population, restricted access to services.

The Health Foundation recognises that there are already examples of the above happening within the health system (for example by co-producing health, sharing decision making, supporting self-management). Nonetheless, these remain the exception rather than the norm, and there remain significant challenges in implementing them on a large scale.²

CtGtCR awarded funding of up to £400,000 for each of seven projects ('CtG teams') to explore how the relationship between people and health services can be changed in different

contexts and at scale. CtG teams are located in a range of areas (including London and South East, the Midlands and Yorkshire and the Humber), and cover a range of service areas. CtG teams also target one or more of the Institute of Medicine's six quality dimensions: effectiveness, efficiency, person-centredness, equity of access, safety, and timeliness. CtG teams are based on new or existing partnerships of organisations. They are expected to ensure that there are clear plans for sustaining their work and embed good practice beyond the life of their Health Foundation award.

Evaluation of Closing the Gap through Changing Relationships

In March 2011 the Health Foundation commissioned the Office for Public Management (OPM) to undertake an evaluation of the CtGtCR programme. The Health Foundation posed three main questions for the evaluation:

1. How do actors involved in the process of changing the relationship between people and services experience the change in their roles?
2. What are the key barriers to and promoters of successfully changing the nature of relationships between people and services?
3. What is the 'improvement story' of each of the awards?

Structure of the evaluation and associated aims and objectives

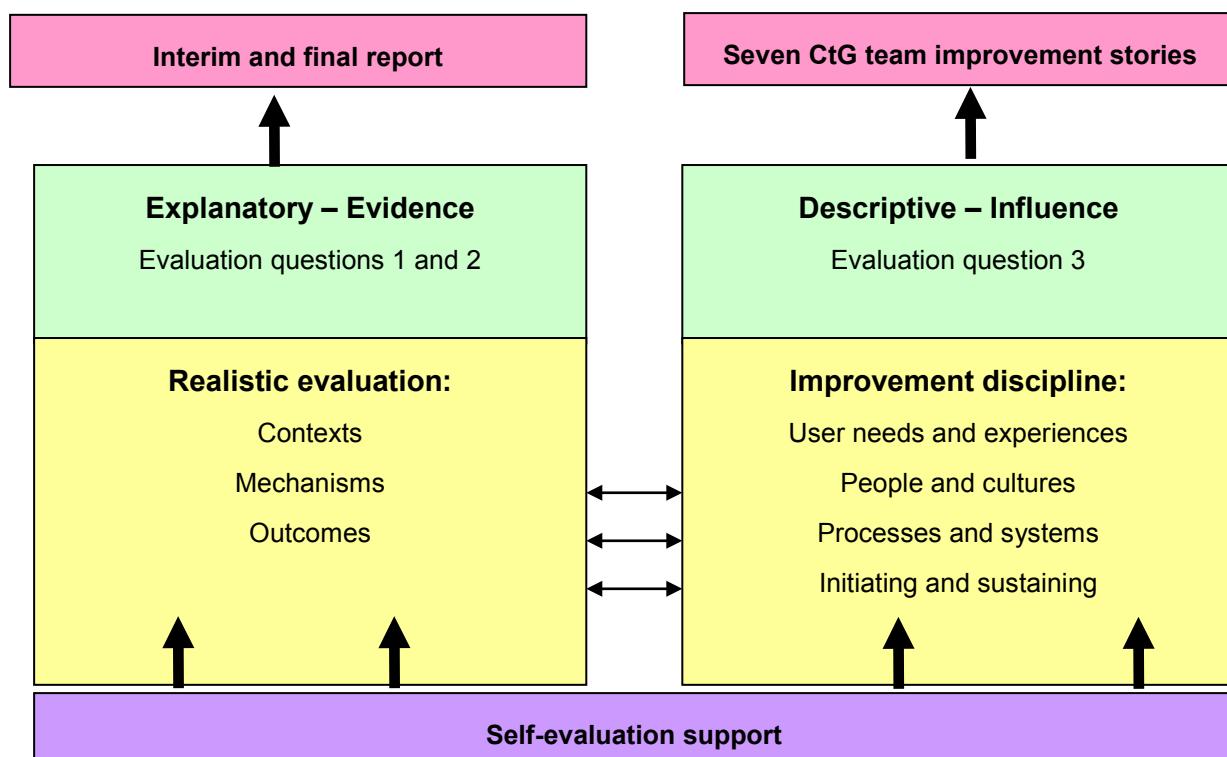
The evaluation comprised two discrete but interrelated components. First, the Health Foundation required evidence and analysis of what supports and impedes efforts to change the relationships between health organisations and people in the seven CtG teams. The evidence base currently lacks in-depth studies, and the Health Foundation wishes to gain a rich understanding of what happens 'on the ground'. This involves generating a better understanding of what it means to change the relationships between health organisations and people, and how to do this in different environments. The focus of the evaluation here is very much on processes and structures. The Health Foundation stated clearly that the focus of the evaluation is on implementation. It is also important to note that the Health Foundation required the evaluators to minimise the burden of evaluation on CtG teams and relevant stakeholders. This had further implications in terms of our ability to access certain stakeholder groups. For example, in a few cases we were unable to have access to patients as colleagues from the relevant CtG teams felt that it would not be appropriate to facilitate access for various reasons (such as the stage of a care and support journey a patient was at; the characteristics of specific subgroups of patients; some data already being collected from patients by the CtG teams themselves as part of their self-evaluation).

Second, while the evaluators' role was to look at implementation, we were required to support CtG teams to measure how the dynamic has been transformed and the impact of their intervention on quality. In other words, the evaluation team provided self-evaluation support to CtG teams who were tasked with the responsibility of measuring impact on (a) changing relationships; and on (b) one or more quality domains. While the Health Foundation desired CtG teams to gather data themselves on the actual impact on changing relationships and on quality improvements, they nonetheless recognised that this is methodologically challenging, and accepted that each team will need to develop appropriate and pragmatic options for what is feasible in their specific contexts. A summary of the types of self-evaluation support provided is presented in Appendix 2.

The evaluation approach

The approach for answering the three main evaluation questions is illustrated in Figure 1.

Figure 1: Evaluation approach for the CtGtCR programme



The evaluation included a six-month scoping phase followed by a two-year evaluation phase, mirroring the timing of the programme. During the scoping phase, the emphasis was on building relationships with each of the CtG teams, and with Berkshire Consultancy which was contracted by the Health Foundation to provide technical and quality improvement support to the CtG teams. In addition, a review of programme and project-level documentation was conducted, as was a rapid evidence review. The scoping phase included contributions from two experts^a who helped shape the framework through which the programme evaluation was subsequently conducted. The scoping phase concluded with the production of a revised evaluation protocol detailing the approach, methods, data collection, analysis and reporting arrangements for the main evaluation and for the ongoing support needs of CtG teams for self-evaluation.

Building on the scoping phase, the main evaluation involved three waves of interviews with CtG teams and relevant stakeholders, with each loosely following a project trajectory of initiating and then sustaining programmes of change, as follows:

- **December 11 – February 2012.** Through the first wave of fieldwork we generated data relevant for understanding the contexts, mechanisms and likely implications for success that deal with setting up a project. This phase focused on the lived experiences of the CtG team members engaged in that process. We also generated information on the key barriers and promoters of successful change at this stage.

^a Angela Coulter and Professor Ian Norman.

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- **July 2012 – August 2012.** The second wave generated data that relate to the early implementation of interventions and emerging impacts as well as the lived experience of the actors involved. During this phase we interviewed CtG team members as well as other healthcare professionals. Corresponding sets of key barriers and promoters of successful change at this stage were identified.
 - **March 2013 – April 2013.** The third wave generated data that related to the overall implementation of interventions to date, and on the plausibility of various impacts achieved. It also encouraged respondents to discuss issues around sustainability. This phase explored the lived experiences of CtG team members, other healthcare professionals and a wider set of stakeholders, including patients in a few cases. Key barriers and promoters of successful change were also identified.

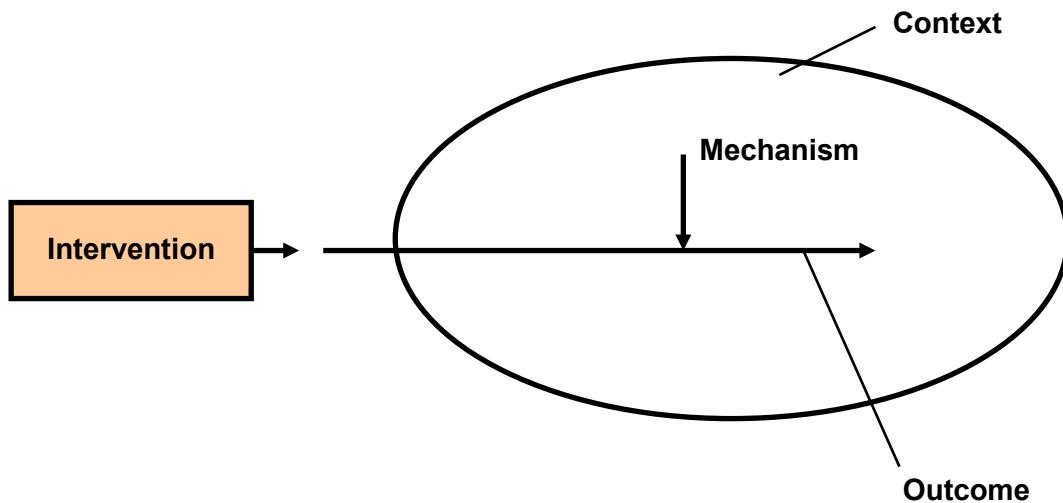
The programme evaluation has been informed by a number of realistic evaluation principles. The term ‘realistic evaluation’ is drawn from Ray Pawson and Nick Tilley’s seminal work, published in 1997.³ An assumption underpinning this approach is that everything in this world is organised in systems, which in turn are embedded in larger systems and connected to other levels. For example, a clinician can be part of a team or department within an NHS organisation. Similarly, ideas can be built into larger systems of belief, which in turn form part of organisational culture. Everything is embedded into other levels and all the systems interact with each other. As a result, any event can have many causes and at the same time may have many consequences. From the realistic evaluation perspective, every outcome of a programme may be the result of multiple causes and every programme may have many different outcomes, which may be positive, negative, intended and unintended.

Social programmes operate as open systems in which all levels are interacting. Programmes change systems and systems change programmes. This means that evaluation is not simple and outcomes are not linear. There are always multiple and, potentially, competing mechanisms operating. Mechanisms also interact with their context, which is why an intervention can generate ‘x’ outcomes in one setting and ‘y’ outcomes in another.

Realistic evaluation does not ask ‘what works, or does it work?’ Instead it asks *‘how [outcomes] are produced, and what is significant about the varying conditions in which the interventions take place’*.⁴ The way this is done through realistic evaluation is to focus the investigation on three interrelated areas:⁵

- Mechanism – what are the change-inducing dynamics that bring about particular outcomes in specific contexts?
- Context – what are the conditions needed for the mechanism to be triggered in order to produce particular outcomes? Context refers to features of participants, organisation structure and culture, workforce, history, culture, beliefs, geography and so on that are required to ‘fire’ the mechanism (or which prevent intended mechanisms from firing).
- Outcome – what are the practical effects produced by the change mechanism being triggered in a particular context?

Figure 2: Relationships between interventions, contexts, mechanisms and outcomes



A realistic evaluation approach assumes that programmes and interventions are ‘theories incarnate’.⁶ That is, all programmes and interventions embody theory (or theories) about how change might occur, although the theory (or theories) may not be explicit^b and/or may not be shared by everyone. Programmes in and of themselves are not the active ingredients that cause change. Instead, programmes offer resources and/or opportunities for change, but that change comes about due to the decision making of participants and resultant behaviours. These can be different among different participants even in response to the same set of resources and/or opportunities, thereby generating different types of outcomes. This recognises that choice, decision making and behaviours never happen in a vacuum. At the individual level, choices and behaviours are affected by the individual’s beliefs, resources, expectations, experiences and attitudes. At the group or societal level, decision making and behaviours are affected by environments, culture, norms and more. Different programme activities can trigger different mechanisms that may all lead to the same outcome. Conversely, the same programme activity may trigger different mechanisms in different contexts, resulting in different outcomes.

Realistic evaluation is particularly helpful when the aim is to learn about a programme. The Health Foundation recognises that there is a paucity of in-depth studies that shine a light on what happens ‘on the ground’ in relation to interventions intended to change relationships between health organisations and people.⁷ Additionally, a study commissioned by the Health Foundation found that there is very little evidence linking changed relationships to improved care quality.⁸ The study called for a greater focus on mechanisms that lead to change.

Reading this report

This final evaluation report presents findings from the main programme evaluation and may be read alongside seven CtG team-specific improvement stories. Detailed information relating to each of the seven CtG teams can be found in their final reports to the Health Foundation.

^b Bemelmans-Videc M-L, Rist RC and Vedung E (2003) argued, for example, that all social policies can be understood in terms of theories around ‘carrots’, ‘sticks’ and ‘sermons’ approaches.

The rest of the report reads as follows:

- Section 2 describes the three levels of relationship that form the focus of the CtGtCR programme. It presents a model for conceptualising relationships in healthcare and discusses a model for conceptualising the link between interventions, changing relationships and quality improvement.
- Section 3 looks at the pathways through which relationship change and/or quality improvements were achieved in the CtGtCR programme.
- Section 4 discusses four ‘enabling mechanisms’ that need to be triggered in order to bring about changing relationships in different contexts. Specific components of each ‘enabling mechanism’ are discussed in relation to experiences from different CtG teams, drawing attention to key barriers and enablers.
- Section 5 presents a brief overview of the essential building blocks that are fundamental to all interventions to change relationships, but are also shared across quality improvement programmes more generally. While these are essential, they are (in themselves) insufficient to bring about relationship change. The four ‘enabling mechanisms’ need to be built upon the foundation of these building blocks, and triggered in context.
- Section 6 summarises the key learning from the evaluation and draws on lessons from elsewhere that can help embed and spread interventions aimed at changing relationships.

2 Closing the Gap through Changing Relationships

This section introduces the four primary dimensions of relationships defined by RAND as a useful construct with which to explore the quality of relationships. It also looks at the RAND Europe framework for conceptualising the causal link between an intervention and the changed quality of care and changed relationship and sets the Health Foundation's learning objectives within this framework. The design of the CtGtCR Programme means there are some challenges and limitations in the degree to which these learning objectives can be met in this evaluation and these are explained. This section also provides a brief summary of the seven projects funded within the CtGtCR programme.

Conceptualising relationships

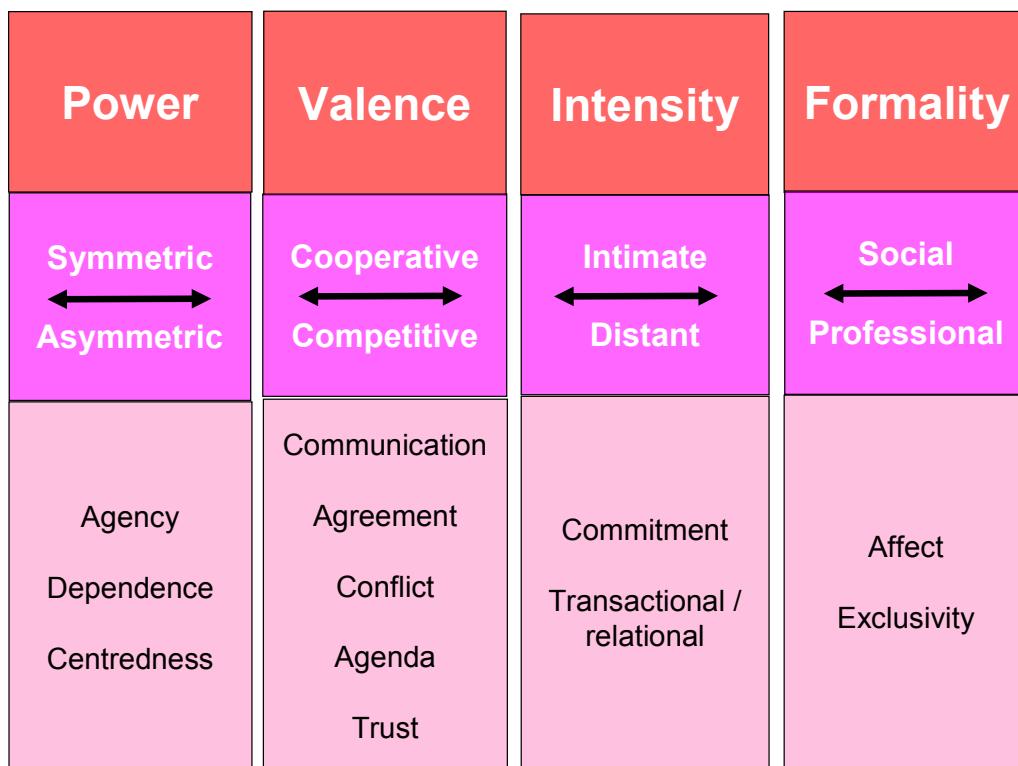
Towards the final stages of this evaluation, the Health Foundation published a literature review conducted by RAND Europe looking at the relationships between service users and providers in the healthcare setting, and the Health Foundation suggested this might provide a helpful way to look at the evaluation findings.⁹ The review drew on a conceptual framework proposed by Wish (1976),¹⁰ who identified four primary relationship dimensions as attributes by which to characterise different types of relationships:

- **Power** includes the notions of agency, dependence and centredness as core concepts.
- **Valence** refers to the nature of a relationship along a continuum from cooperative and friendly to competitive and hostile.
- The **intensity** dimension is most frequently discussed in relation to commitment, which can involve a service user's readiness for a relationship.
- In relation to the dimension of **formality**, the notion of 'affect' in provider–service user interactions is associated with health outcomes.

Each of the four dimensions is posited as being bidirectional in nature, and as a spectrum (Figure 3).

This conceptual model provides a useful framework for looking at different types of relationships, and the factors that may influence their quality. Interventions that seek to transform relationships may therefore be examined in terms of how they bring about changes in one or more of these dimensions. It is, however, important to point out that relationships do not exist and evolve in isolation but are strongly influenced by the contexts within which they take place. These can operate at both structural (eg policies and procedures in the NHS) and individual levels (eg specific patterns of behaviours due to ethnic background or socio-economic status). As the report highlighted: '*any framework aiming to analyse relationships will need to take account of contextual factors in order to understand influences on relationship quality*'.¹¹

Figure 3: Conceptual framework for relationships in healthcare



Closing the Gap teams

The Health Foundation funded seven projects within the CtGtCR programme.

- **Shared Decision Making in Child and Adolescent Mental Health Services (CAMHS)**
 - Supporting children and young people with mental health conditions and their families to become actively involved in decisions about their care and treatment.
- **Pathway** – ‘Care navigators’ (trained former homeless people) helping homeless people to make informed choices and better navigate the complex care offering across primary and secondary care.
- **M(ums) Power** – Empowering pregnant women to take a more active role in determining their own care through changing their relationships with healthcare professionals and helping them access wider support networks.
- **myRecord** – Giving diabetic patients access to their GP record online in order to share information with them and support more informed dialogue and shared decision making with their GP.
- **Peer Support Workers in Adult Mental Health** – Peer support workers are people with lived experiences of mental health problems who have been trained and employed to support adults with mental health issues to focus on their journey to recovery.
- **Shared Haemodialysis Care** – Nurses were trained to act as facilitators rather than caregivers, supporting patients to become more proactive in decision making and to undertake aspects of their own haemodialysis care.

- **Speaking Up** – Improving complaints handling in an NHS Foundation Trust by supporting patients to voice their concerns in new ways and trust staff to translate patient feedback into actions.

Figure 4: Overview of CtG teams

Team	Objective	Target	Scope	Delivery
Shared decision making in Child and Adolescent Mental Health Services (CAMHS)	Collaborative decision making between children/young people and clinicians during consultations	Young people and children with mental health issues, and their families	Four CAMHS sites in Bradford, North East Somerset, East Sussex and Southampton	Structured records supporting collaborative decision making
M(ums) Power	Facilitate access to information, networking and peer-to-peer support	Pregnant women accessing antenatal services	Two hospital settings: University College London Hospital (UCLH) and Newham University Hospital	Website and social networking site, face-to-face group meetings for pregnant women
Pathway	Integrated model of care connecting primary and secondary care provision for homeless people to reduce the number of admissions and repeat admissions to hospital	Homeless people attending A&E and admitted to hospital	Two hospital settings: University College Hospital (UCLH) and the Royal London Hospital	Dedicated team within the hospitals including a ‘care navigator’ with experience of being homeless
myRecord	Promote shared decision making between GPs and patients by providing patient access to GP records	General practice patients	GP practices in Lewisham and Berkshire East, with three test bed sites	Patient online access to GP records

Team	Objective	Target	Scope	Delivery
Peer Support Workers	Service users to relate better to the mental health system and see it as more accessible, approachable and relevant to their needs	Mental health service users	Nottinghamshire Adult Mental Health Services (County) directorate	Peer support worker role with lived experience of mental health issues
Shared Haemodialysis Care	Provide the opportunity for patients to undertake some tasks associated with their haemodialysis	Patients having inpatient haemodialysis care	Yorkshire and Humber renal network covering six renal centres	Educational materials for patients and support from nurses
Speaking Up	Improve complaints handling within Mid Staffordshire NHS Foundation Trust	Patients and relatives who make complaints	One acute trust	Patient champions, peer review panels, digital patient stories and a survey for patients and carers

More details of the projects can be found in Appendix 3 and in the improvement stories supplement.

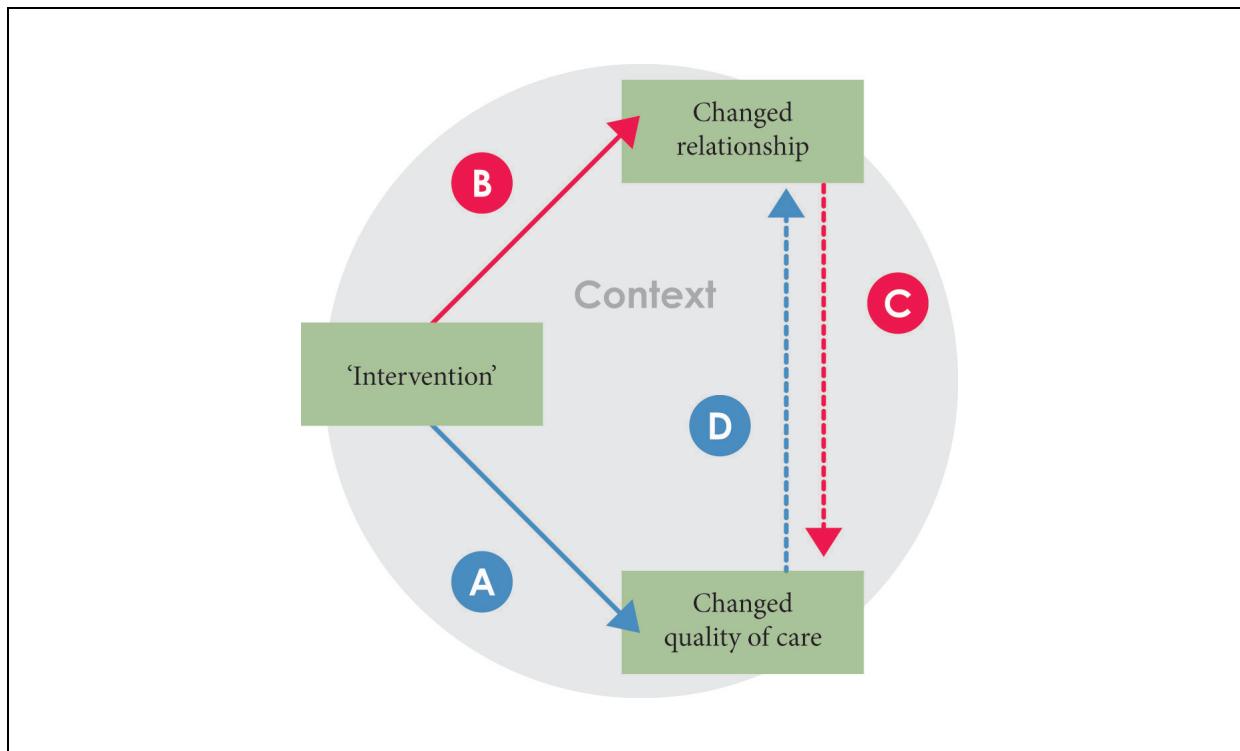
Conceptualising the link between interventions, changing relationships and quality improvement

The relationship between interventions, changing relationships and quality improvement is complex. There is little evidence on how we can successfully change relationships in healthcare settings. There is also a lack of clarity in relation to the link between changing relationships and quality improvement. The evidence base is patchy and sometimes contradictory. There is particularly poor understanding of the mechanisms underlying interventions and how these interventions are expected to change outcomes.

RAND Europe proposed the following conceptual model (Figure 5) for helping to understand the link between interventions, changing relationships and quality improvement. The model identifies four principal conceptual linkages. An intervention may be intended explicitly to bring about a change in quality of care (ie blue solid arrow marked 'A') or to bring about a change in relationship (ie red solid arrow marked 'B'). The key questions, here, are therefore the extent to which the intervention is effective in either changing quality of care or changing relationships, and what the key barriers and facilitators may be. Beyond this, however, the model further acknowledges that changing the quality of care may result in changing relationships (ie dotted blue arrow marked 'D'), and changed relationships may result in changing quality of care (ie dotted red arrow marked 'C'). Neither C nor D may be assumed to take place simply because a pre-condition exists that may facilitate these changes. Hence, just because a relationship has been changed does not necessarily lead to changes in

quality of care, and vice versa. Again, a range of facilitators and barriers may either encourage or inhibit such transformations in different contexts.

Figure 5: RAND Europe Framework



Considerations of, and implications for, the evaluation

The Health Foundation is interested in learning about:¹²

- what is (in)effective in changing relationships between people and health services; and
- whether and how changed relationships result in improvements in quality.

It is important to reiterate the fact that this evaluation is concerned, primarily, with the first issue. Nonetheless, the evaluation does explore the plausibility that changed relationships lead to improvements in quality.^c

The expressed interest, stated above, reveals implicit hypotheses about the likely links between interventions, changing relationships and quality improvements. There may have been an implicit assumption (at the outset of the programme) that CtG teams will go through pathway B, followed by pathway C (as expressed in Figure 5). In other words, CtG teams will put in place interventions that change relationships. These changed relationships will then bring about improvements in quality.

Additionally, the programme design meant that the task of exploring these various pathways needed to be completed in two years. The experience of setting up interventions demonstrates, however, that most of the CtG teams took a considerable amount of time to get their projects ready for implementation. In fact, all CtG teams indicated that project set-up

^c There are acknowledged challenges as a result of the programme design which meant that the evaluation team does not have direct responsibility for generating outcome data on quality.

took longer than originally anticipated. In the case of the CAMHS CtG team, for example, there were delays due to practical considerations such as recruiting sites to be part of the project and the logistics of bringing together a geographically disparate group of professionals for a launch event. For M(ums) Power and myRecords CtG teams, problems with technology took longer than expected to be resolved. While the specific reasons for the time spent setting up varied across the different CtG teams, it is fair to say that the complexity and scale of each project, once it came to turning plans into reality, proved to be a barrier to progressing in line with original plans. As one team member from the myRecords CtG team expressed: '*it has been a lot more complicated than I ever thought*'.

In addition, different types of outcomes manifested themselves on different timescales, regardless of how long it may have taken for projects to be set up. While all CtG teams introduced or transformed activities, processes, protocols, etc., many of the full implications of these changes on changing relationships (particularly in the sustainability of any relationship change) and on quality improvements are not likely to be felt in their entirety within the duration of the evaluation. This report is therefore a snapshot, based on what the CtG teams have managed to achieve at a particular point in time and not on what they might achieve in the long term.

These observations reflect the reality of set-up and implementation of highly ambitious interventions at a time of radical change within the NHS. Indeed, the Health Foundation adopted a development approach to the CtGtCR programme. This recognised that implementation was an iterative process of reflection and redesign, rather than simply sticking to an unchanging plan defined from the outset. This was particularly important as the context that CtG teams were operating in changed significantly over the course of the programme duration. This constant process of reflection and redesign (where necessary) yielded extremely rich learning that has been shared within the programme and with wider sets of audiences.

Despite the diversity of interventions, short timescales and focus on project design and set-up, the evaluation has identified a set of factors/conditions that appear to play a role in changing relationships. These should be considered as discussion points that represent emerging rather than definitive learning and provide some interesting insights into the specific challenges CtG teams faced.

3 Programme achievements

This section builds on the RAND Europe framework and elaborates the pathways and rationale that connect interventions with quality and/or relationship changes as experienced by the seven CtG teams.

In summary, it is vital to understand **changing relationships as deeply contextualised sets of dynamics**; rooted in a specific time, place, organisational and cultural milieu. The CtGtCR programme took place within a period of unprecedented budget cuts and other significant transformations in the NHS. Within this overarching context, however, individual CtG teams experienced different opportunities and barriers. The **same drivers do not always have the same impact or lead to the same experiences across different localities**.

Partly because of the variability of local contexts and the non-deterministic nature of their influence, **efforts at changing relationships must not conflate ‘activities’ with ‘change mechanisms’**. An activity may change relationships successfully in one context, but may not have the same effect in another. **What needs to be replicated is the successful change mechanism, rather than the manifest activity per se**.

With this in mind, this section crystallises **four ‘enabling mechanisms’**, namely: (a) changes to patient beliefs, attitudes and behaviours; (b) changes to health professional beliefs, attitudes and behaviours; (c) changes to systems and processes; and (d) changes to organisational culture and environment. Within each, the **specific triggers can look very different** in different contexts.

While being very different interventions, CtG teams that have been successful in bringing about some form of relationship change have **all had to develop a clear understanding of what it takes to ‘activate’ one or more of the ‘enabling mechanisms’ in their specific contexts**. They have had to distil the underlying ‘logic’ of why doing things a certain way in a specific context is likely to bring about desired effects. This has enabled them to be far clearer about identifying, and subsequently measuring, the types of outcomes that are achievable.

It is important to note that the evidence for this, and the following, section derives from data generated largely from the third wave of the evaluation. This was at a stage of CtG teams’ development where evidence around relationship change remained largely qualitative. While there are clear indications that some forms of relationships have changed and that some types of quality improvements were being realised, these were still emergent and nascent. As such, the findings reported are suggestive rather than conclusive, particularly as we acknowledge that:

- even if pre-conditions for successful implementation are established, implementation itself may not always and necessarily be successful
- successful implementation may not necessarily change relationships
- changed relationships may not necessarily lead to improvements in quality
- trajectories are not always linear, and that an ‘enabling mechanism’ can be ‘triggered’ as well as ‘disabled’ given the shifting contexts.

What is clear from the evidence is that **changing relationships is a fundamental long-term journey that requires an explicit and sustained focus**. It is not something that can simply be articulated or aspired to and then left to happen on its own. To change

relationships, all key stakeholders need to know that this is the **explicit and primary aim** of an intervention, and that delivery, measurement and learning all need to maintain a clear focus on relationships. It cannot simply be assumed that relationships will change just because good intentions exist. Changing relationships is **not something incidental**. For relationships to change, stakeholders must be **purposive about bringing about fundamental change**.

These were lessons learned by the CtG teams over the duration of the CtGtCR Programme. It is fair to say that at the outset, local stakeholders designed interventions that inevitably aligned to local priorities, interests and existing projects, rather than simply responding to the imperative to ‘change relationships’ first and foremost. With the scale and speed of transformations in the wider NHS, with a sharply increasing emphasis on efficiency savings with attendant implications for staff turnover and morale, there have been additional challenges for CtG teams in terms of staying focused on changing relationships.

Concepts

The realistic evaluation approach enabled us to build on the RAND Europe framework and to flesh out some of the key components and enabling mechanisms for change. The CtGtCR programme as enacted by the seven CtG teams can be conceptualised as follows (illustrated in Figure 6).

(i) Context

Each CtG team introduced new ideas and/or new activities into a pre-existing context, with its social norms, values and interrelationships. This, in turn, is situated within a wider local, regional and national context. The pre-existing and transformed structures, relationships and norms can ‘enable’ or ‘disable’ mechanisms of change, therefore influencing the extent to which CtG teams may be successful in changing relationships and/or improving quality.

(ii) Mechanisms

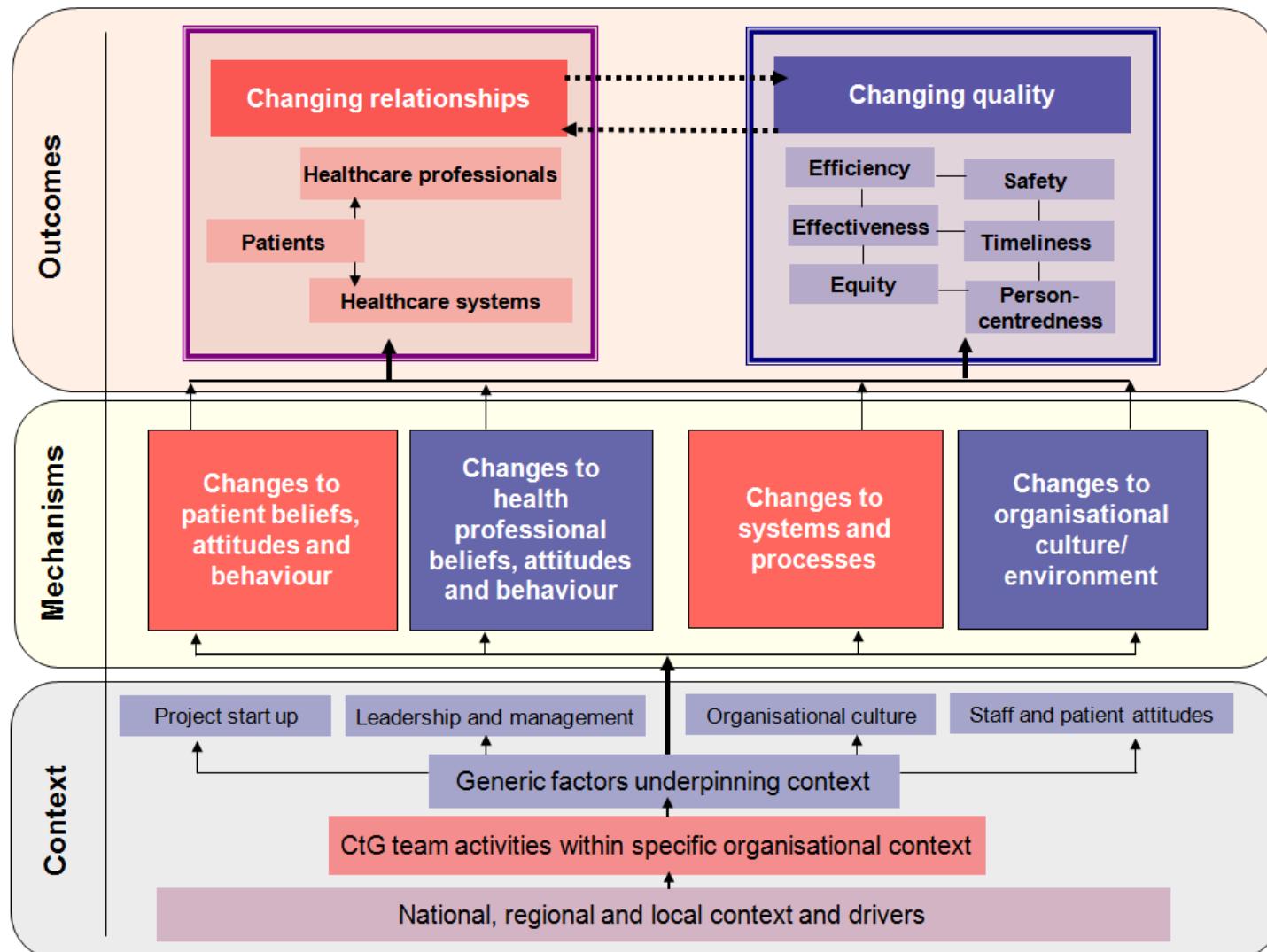
While the exact activities undertaken by each CtG team looked very different in practice, their attempts to change relationships can be conceptualised as being underpinned by four groups of ‘enabling mechanisms’, as follows.

- **Changing patient beliefs, attitudes, behaviours.** Examples include implementing shared decision making; training patients in self-management; developing new materials and resources so patients are better informed about their condition and treatment options.
- **Changing health professional beliefs, attitudes, behaviours.** Examples include: developing training resources and establishing learning networks; new supervision and support models; and co-delivery with patient experts and other healthcare professionals.
- **Changing systems and processes.** Examples include introducing new technology or using existing technology differently; using social media and other technology to communicate more effectively with patients; and more fluid job descriptions for staff to facilitate more patient-centred and more timely support to patients.
- **Changing organisational culture/environment.** Examples include valuing user-led experience through the introduction of new professional roles; creating ‘champions’ to share learning and promote change across the organisation; and co-designing services with patients.

(iii) Outcomes

All CtG teams sought to change relationships between patients and health professionals and in some cases, between patients and the wider healthcare system. CtG teams, through their self-evaluations, collected some evidence about the extent to which they have achieved this. Changed relationships are not, in most cases, the end goal. Beyond assessing whether relationships have changed and whether clinician and patient are 'satisfied' with the changed relationships, we explored what changed relationships mean in terms of end point outcomes for patients (such as increased feeling of empowerment, greater confidence in managing their condition), healthcare professionals (such as increased job satisfaction, altered professional identity, new ways of thinking and behaving), the healthcare system (such as higher levels of patient trust) and how these map onto the six domains of quality. In some cases these are experienced differently by the various stakeholders. It is important to note, however, that not all CtG teams sought only to bring about quality improvements through changing relationships. There is evidence that interventions may be focused, initially, on demonstrating changes in quality and using these to support and encourage changing relationships.

Figure 6: Conceptualising how CtG teams sought to change relationships and/or quality



Pathways through which changing relationships and/or quality improvements may be achieved

Our approach, influenced by realistic evaluation principles, enabled us to explore the relevance of this model for understanding CtGtCR. We are able to identify specific examples of the following:

- **How implementation contributed to specific forms of changed relationships (ie pathway B in Figure 5)**

Example

As part of their efforts to change relationships, staff from the CAMHS CtG team produced and shared a range of accessible information with clinicians working in four CAMHS services. They provided a range of training, materials and support to frontline practitioners and their colleagues to make changes to the way they engaged young people in clinical interactions. They also engaged these colleagues in meaningful discussion to explore and learn from their experiences and feedback.

Changing relationships, in this instance, did not merely rely on clinicians changing their own behaviours and processes. For service users, a positive experience was often linked to how receptive and enthusiastic they were with regard to changing relationships. It is important for a service user to be able to choose if and how they participate. Service users, in the case of the CAMHS project, needed to be in the right frame of mind to be able to participate in shared decision making. For example, young people often arrive in the CAMHS in a state of crisis that must be managed or resolved before they are able to consider participating in shared decision making. It is also clear that some service users need developmental support to be able to engage with shared decision making. It may not be something they are familiar with, or they may not understand the ‘rules of engagement’.

Overall, clinicians and service users recognised that not everyone will want to participate in shared decision making and that changing relationships needs appropriate and sustained support and is a long-term change.

A crucial piece of learning that emerged from the evaluation is that CtG teams needed to **reflect on and clarify the actual change mechanisms that underpin changing relationships, rather than simply focus on activities**. The CAMHS CtG team, for example, initially focused on developing a range of tools with which to encourage clinicians to implement shared decision making. They realised, at some point, that the use of tools per se does not guarantee that shared decision making is in fact taking place. While tools can act as a vehicle for implementing shared decision making, it is through encouraging clinicians to experiment with shared decision making and to reflect on their practice that their attitudes and behaviours are likely to change. This realisation led the CAMHS CtG team to focus much more on the mechanisms underpinning changing relationships, rather than on project activities. Rather than to simply ask clinicians to talk through all the different activities they have been involved in, the CAMHS team encouraged clinicians to reflect on their relationships with a child/young person and what has made a difference.

Understanding the distinction between ‘activities’ and ‘change mechanisms’ arguably lies at the heart of any intervention to change relationships and/or improve quality. For success to be achieved, it is important for the change mechanisms to be identified. For success to grow, it is this change mechanism that should be replicated (with a clear understanding of contextual differences), rather than activities per se. As the ‘realistic evaluation’ approach

highlights, the same activity can trigger different change mechanisms in different contexts. Similarly, different activities may actually be underpinned by the same change mechanism.

- **How, subsequently, specific changed relationships can plausibly lead to improved quality in specific domains (ie pathway C, following on from pathway B in Figure 5)**

Example

The Shared Haemodialysis Care CtG team aimed to transform the dynamic between haemodialysis patients and the nursing staff who provide care in all 26 renal dialysis units in Yorkshire and the Humber by changing their respective roles: from passive recipients of care to active partners; and from caregivers to facilitators. Through training and proactive engagement, the CtG team supported nursing staff to form active partnerships with patients. They also supported service users to learn how to undertake aspects of dialysis, so that service users are able to perform certain tasks confidently and safely. Service users reported that they knew more about their conditions and were therefore better placed to look after themselves. While the Shared Haemodialysis Care team, like all other CtG teams, acknowledged the challenges of demonstrating, conclusively, improved quality of care within the timescale of the CtGtCR programme, it is plausible that empowered and activated patients are likely to have better healthcare outcomes.

It is important to note that **where relationships may have changed, it is simplistic to assume that this necessarily results in quality improvements**. This can be exemplified by drawing on some of the experiences of the Speaking Up CtG team that aims to improve complaint handling within Mid Staffordshire Hospitals NHS Foundation Trust. The Trust has a history of mishandling complaints. This has fostered a lack of trust in the complaints handling process among both clinicians and complainants. The Speaking Up CtG team spent considerable time and effort to slowly rebuild confidence in the complaints handling process. Through improving processes and structures to enable complainants to have their voices heard through the complaints process, while supporting the Trust to learn from these complaints, the team aimed to transform the nature of the dynamic between patients and clinicians to one of equality and transparency.

While aspects of complaints handling have improved, leading to improved patient experiences of these processes, the Speaking Up CtG team did not think the Trust had fundamentally changed the way it acted towards patients. Lessons from complaints did not seem to have translated into improvements in the quality of care. The team reported fragmented relationships within and beyond the Trust that inhibited progress:

'It still feels a little bit them and us. And now that is fragmented into them and us, us and them and then another fraction of them and another fraction of them, if you know what I mean, because there is no solidarity ... if everyone at the Trust didn't like what we were doing you could almost kind of manage that, but actually I think even that is fragmented.'

Therefore a relationship change in one place may not necessarily ripple outwards to effect wider sets of changes to relationships and to quality.

- How implementation leads to improvements in quality in specific domains (ie pathway A in Figure 5)

Example

The M(ums) Power CtG team has implemented a model of women-centred antenatal healthcare. It seeks to transform women's health outcomes by improving experience of antenatal care by putting women at the centre of their own care through changing their relationships with health practitioners so that women feel empowered to make choices and shape the care they receive. In addition, it changed ways of working to optimise the number and timing of antenatal visits and improve pregnancy outcomes. The M(ums) Power CtG team recognised that antenatal support services face resource constraints while needing to improve the quality of care. As part of their intervention, the team worked to increase efficiencies by securing more bookings at 12 weeks; reducing 'face time' with clinicians where appropriate; and maximising the benefits of early intervention. Efficiencies can be gained by holding a group session at first booking, rather than having individual meetings with midwives.

- How, subsequently, the specific improvements in quality may contribute towards changing relationships (ie pathway D, following on from pathway A in Figure 5).

Example

The Pathway CtG team is a model of integrated healthcare for single homeless people and rough sleepers. It works to improve healthcare experience and outcomes for homeless people by putting the patient at the centre of their own care pathway and changing the relationship between the service user and health practitioners based on compassion and professional quality. The team recognised that the current climate of financial constraints could be a powerful driver for senior leaders and service managers to engage with the project. The team acknowledged the importance of demonstrating the project's potential to reduce costs to the hospital, particularly through bringing about more efficient use of hospital bed days for homeless people. One member of the Pathway CtG team indicated: '*In A&E, they are much better now. They welcome us with open arms now.*' This was felt to be due to the fact that '*because of the four-hour window, they can't delve into the details about the patient so they will contact the Pathway team. For one patient, it can take a whole day to get them sorted.*' The Pathway CtG team felt that by supporting the hospital to achieve quality improvements through making care more timely and efficient (reducing waiting times), they were able to engage other staff to see the importance and benefits of changing relationships.

It is important, from the experiences of M(ums) Power and Pathway CtG teams, to point out that seeking to bring about (or expedite) changing relationships through demonstrating quality improvements (usually in relation to efficiency) can be fraught with tensions. With the external context within the wider NHS being characterised by significant transformations and resource squeeze, **it can be easy to lose sight of the focus on changing relationships**. Indeed, both teams expressed the view that maintaining a good balance can be challenging.

As efficiency improvements can often be a more tangible form of measurement in comparison with changing relationships, there may be a further risk that relationships could be assumed to have changed (rather than be demonstrated through measurement) simply because a quality outcome has been achieved. Members from the M(ums) Power CtG team indicated that they found it difficult to balance service effectiveness data and person-centredness data because of the tendency for evidence on efficiency gains to dominate other

forms of evidence. Indeed, the M(ums) Power CtG team had to develop a clear narrative that their encouragement of increasing group bookings and reducing ‘face time’ is not simply about achieving greater efficiencies. Instead, it must be about improving the quality of face time and releasing time that can be better spent on other activities to improve the care of women who may have more complex needs.

4 Factors that play a role in changing relationships

This section shines a light on what each of the four ‘enabling mechanisms’ looked like in context across the various CtG teams. Each CtG team is very different, working to change different types of relationships across different groups of people in different settings. Thus the evaluation of the CtGtCR programme has had to adopt a very careful approach in looking across the contexts and mechanisms active in the various teams that allows us to distil a level of generalisability (without ending up with statements that are overly generic) while at the same time not losing sight of the highly specific interventions and experiences of each team (without ending up with being too detailed and particular).

The realistic evaluation approach involves the development of so-called ‘middle-range theories’ by looking at whether and how common mechanisms may operate across different contexts to generate similar changes. While generalisable to a degree (hence ‘middle-range’), because causal mechanisms are always embedded within particular contexts and social processes, there is a need to understand the complex relationship between these mechanisms and the effect that context has on their operationalisation and outcome.

Through this process of distilling ‘middle-range theories’, the evaluation of the CtGtCR programme has identified a number of additional considerations within the four ‘enabling mechanisms’ that may be important for interventions that have a focus on changing relationships. These are described below and build on the conceptual model presented previously in Figure 6.

This section concludes with an overview of the key messages that emerge from the rich and detailed findings.

Changes to patients’ beliefs, attitudes and behaviours

Targeting

Patients and service users are reluctant to change their relationships with healthcare professionals unless they perceive there is a clear rationale and benefit to them personally. Therefore, it is essential to understand their requirements, motivations and concerns in order to ensure an effective approach to changing relationships. It is fair to say that all the CtG teams have had to **develop greater specificity in terms of who to target with an intervention**. While most started with a declared aim of working with ‘professionals’ and/or ‘patients/service users’ generically, all subsequently refined their approaches to target specific subgroups as a result of clarifying how their interventions may be more or less appropriate for different groups.

Experiences of barriers and enablers

Patients/service users and health professionals are not uniform groups and CtG teams soon recognised that they needed to **take into account user demographics and characteristics in their approach to changing relationships**. For example, staff in the myRecord CtG team found that not all service users have access to the internet or the knowledge to use it. Staff and service users may need training to use technology and this needs to be factored into project plans.

More importantly, the team initially hoped to secure records access sign up and use by as many patients as possible within GP practices in Lewisham and Berkshire. However, through carrying out reviews on initial usage and assessments of where records access can be of most use in changing the relationship between clinicians and patients, the team decided to target the initiative towards certain patient groups. The team refocused their efforts on recruiting groups with high levels of engagement with their GP, for example, diabetics. This was based on evidence suggesting that this has strong potential to influence a change in relationship. The team subsequently worked to develop condition-specific support for using records access effectively, for example, by working with Diabetes UK. This is an example of how the '**intensity**' domain of Wish's (1976) conceptual framework could be played out. This dimension can involve the willingness to tailor approaches to different needs and priorities. Recognising different levels of 'intensity' of relationships can mean investing time and resources more appropriately to bring about desired changes.¹³

This segmentation and better targeting of different subgroups was also played out in the M(ums) Power CtG project. The team realised that the women accessing services in Newham and in UCLH had very different socio-demographic characteristics. The characteristics of women in east London (Newham) made them more difficult for the team to engage. Through local leads in each site who are people with good understanding of the local context and are engaged with the right key people, the team sought to develop a better understanding of the needs of local women and to clarify whether different approaches were necessary to engage with women in Newham.

In addition, as part of their intervention, the M(ums) Power CtG team tried to make group meetings for pregnant women a relaxing and fun experience. However, feedback showed that some groups would have preferred more formality. This maps onto the '**formality**' domain of Wish's framework. While the wider literature seems to suggest that greater 'affect' between service user and service provider is a 'good thing', with positive associations with health outcomes,¹⁴ the experience of M(ums) Power exemplifies the fact that we **cannot simply assume that the shift from 'professional' to 'social' is necessary experienced as being desirable across all groups**. Indeed, increasing 'affect' may be experienced as being uncomfortable or unsettling for some groups that may prefer a more formal relationship between clinician and patient.

Motivation to engage

Evidence from the evaluation suggests that patients' and service users' motivation to engage are influenced by (a) a **clear understanding of what changing relationships looks like** (ie 'changing relationships' made tangible); and (b) **perception of the motivation behind and potential consequences of changing relationships**.

Understanding what changing relationships look like: experiences of barriers and enablers

CtG teams had different approaches to help patients and service users develop clearer understanding of what changing relationships look like. At risk of over-simplification, these can be categorised as approaches that involved **creating specialist roles, particularly those involving service users as service deliverers**; as well as approaches that involved **modelling certain types of behaviours** regardless of whether specialist roles are created. The former is discussed in the sub-section 'Changes to organisational culture and environment' later on in this report. The discussion in this section focuses on the latter.

Modelling the right behaviours can be done by both professionals and by service users, with the aim of helping services users to understand what changing relationships look like. The Pathway CtG team felt that they, initially, had to act as an interface between homeless patients and other clinicians, to build up a 'stock' of positive interactions between them that, hopefully, reduces fear and mistrust and leads to changes in future behaviour.

Interviewees from the CtG team identified that the relationships most in their control to improve are those between the Pathway team and homeless people. They operationalised this through seeking out homeless people across the hospital, then making direct contact and providing 'simple acts of kindness' such as washing, food and just listening to someone. Through modelling compassionate care for homeless people, the team can overcome some of the resistance and/or anxiety of homeless patients in engaging with their healthcare that originated from previous negative experiences (or the expectation of negative experience) of healthcare professionals. The CtG team has compelling qualitative evidence from homeless patients that these compassionate acts have had considerable impact on them in making them feel cared for, which **has the potential to lead to positive health outcomes**: '*I've never stayed in hospital as long as this [two weeks] but I know you are really going to help me, I trust you, that's why I'm staying*' (homeless patient).¹⁵

In the above ways, the Pathway CtG team can be seen to have intervened across all four domains in Wish's (1976) framework: **power; valence; intensity; formality**. They have shifted the power differential between clinician and patient and fostered a more cooperative approach towards care. The relationships are marked by commitment and a degree of intimacy, as well as by affect.

Other CtG teams, through supporting a small number of patients/service users to begin with, have facilitated these patients/service users to model desired behaviours to other service users. For example, the Shared Haemodialysis Care CtG team spent time working with a number of service users to support them to be able to perform certain tasks themselves safely and effectively:

'... because they had a fear of whether they could do it properly themselves.' (Shared Haemodialysis Care, staff member)

Here, the shift in relationships is underpinned by the provision of a portfolio of techniques and tools that help patients enact specific behaviours effectively, and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership.¹⁶

Having developed the skills and built their confidence, these **service users were able to model the right behaviours to other service users**, which encouraged others to give it a go. In this way, the Shared Haemodialysis Care CtG team can be seen to have intervened in the '**power**', '**valence**' and '**formality**' domains of Wish's (1976) conceptual framework; where power is distributed across wider groups of service users who have developed a greater sense of 'agency', thereby reducing their 'dependence' on healthcare professionals. These acts have also encouraged greater cooperation in fostering self-care, with enhancing the 'social' aspect of relationships to extend beyond that between a clinician and the service user.

Perception of the motivation behind and potential consequences of changing relationships: experiences of barriers and enablers

The way in which patients and service users **perceive the motivation behind and potential consequences of initiatives** aimed at changing relationships can impact on their willingness to participate. The Shared Haemodialysis Care CtG team recognised that service

users who had become resigned to being dependent on nurses for their care were harder to engage with than those who had not:

'They thought it was about making them do things, that they would be pushed to take care of themselves, they were fearful that it would push them to home haemodialysis and some of them didn't want to do that.' (Shared Haemodialysis Care, staff member)

This resistance can often be interpreted in terms of a patient's or service user's weighing up of relative risks and benefits to themselves. While this is certainly true in some cases, it does not tell the full story. In the case of the Shared Haemodialysis Care CtG team, there is evidence that patients may have resisted shared care because of a fear of staff losing their jobs:

'One thing I keep hearing over and over again is that they're worried that the nurses will lose their jobs so they won't do it. They've got that loyalty with the nurses. Patients think I'm a mug for doing it, and to be honest I agree with them in a way because they get on quicker... if they lay back and wait for the nurse.' (Shared Haemodialysis Care, patient)

There was a perception that if patients took on greater self-care, this would mean fewer nurses may be needed on dialysis units, which could ultimately **put nurses' jobs at risk**. For the small number of patients who saw it as a staff-cutting agenda, shared care can be viewed negatively or with suspicion. Any intervention aimed at changing relationships therefore needs to **surface and address how service users and patients perceive relative risks and benefits not only to themselves but also to others**.

Proving service users with clear rationale for initiatives aimed at changing relationships and having a detailed explanation of what this would entail is a key enabler of success. However, this enabler may not always be 'triggered' if patients and service users do not have the motivation or confidence to engage in relationship change. There is recognition that **not all patients and service users may be 'change-ready'**, and that readiness may need to be developed before patients and service users can move forward:

'Some had a job and then the motivation of self-care seemed like a good idea. People who had some kind of commitment in their life that they wanted to maintain were more pro generally... people with something to gain showed more interest.' (Shared Haemodialysis Care, staff member)

Changes to professionals' beliefs, attitudes and behaviours

Motivation to engage

Similar to the discussion in relation to patients and service users, professionals' motivation to engage is also influenced by (a) a **clear understanding of what changing relationships looks like** (ie 'changing relationships' made tangible); and (b) **perception of the motivation behind and potential consequences of changing relationships**.

Understanding what changing relationships look like: experiences of barriers and enablers

CtG teams adopted different approaches to help healthcare professionals understand what changing relationships look like. The approach involving the **creation of specialist roles** is discussed in the later section on 'Changes to organisational culture and environment'. Over and above this, a number of CtG teams put in place initiatives that involved **modelling the**

right behaviours to other healthcare professionals. As mentioned previously, the Pathway CtG team placed significant emphasis on modelling compassionate care towards homeless patients. In addition to signifying appropriate behaviours towards service users in order to encourage engagement, these acts of compassionate care also aim to model desired behaviours to other healthcare professionals that are achievable and lead to outcomes that may benefit them, for example by contributing towards meeting specific targets.

While aiming to change the way other people in the hospital behave and respond to the homeless, the team nonetheless acknowledged the significant wider challenges. As one team member remarked, '*one team in a hospital will not overturn 200 years of social policy*'. Changing relationships, for the Pathway CtG team, means overcoming a culture of discriminatory policy and systems, as well as challenging and changing the negative attitudes of some clinical staff, who 'write-off' homeless people as lost causes for help and behave disrespectfully. In this respect, the Pathway CtG team can be seen to have been attempting to address the '**power domain**' of Wish's (1976) framework. The team acknowledged that impact in this area has been patchy, and varies across the different staff groups and departments.

In comparison, the experience of the Peer Support Worker CtG team demonstrates how the **modelling of behaviours to other healthcare professionals can have an impact beyond the clinician–patient interface.** While modelling a recovery focused approach to working with people with mental health issues, the project was recognised as helping the Trust in becoming more recovery focused across a wider range of concerns beyond the specific confines of service delivery. Most crucially, the Trust has taken on a more recovery focused approach to ensuring that their own staff, in particular members of staff with mental health conditions, feel supported in their roles and are able to use their own experiences to help other service users. Seen through the lens of Wish's (1976) conceptual framework, this may be interpreted as **shifting towards a more 'social' approach within the 'formality' domain within the workforce (as opposed to between the workforce and service users).** This shift has been characterised by an increase in 'affect' and trust, leading to a closer bond between the employer and employee.

Perception of the motivation behind and potential consequences of changing relationships: experiences of barriers and enablers

The way in which healthcare professionals perceive the motivation behind and potential consequences of initiatives aimed at changing relationships can impact on their willingness to participate. As in the case of patient and service user motivation, **healthcare professionals similarly weigh up the relative risks to and benefits for themselves and for others.** In the case of the Pathway CtG team, the project objectives were clearly aligned with A&E targets and in particular the four-hour waiting time target. Therefore, staff in A&E supported the project as it provided a means of dealing with homeless people as quickly and effectively as possible:

'Because of the four-hour window they can't delve into the details about the patient so they will contact the London Pathway team. For one patient it can take a whole day to get them sorted.' (Pathway CtG team, team member)

On the other hand, many of the GPs who were initially involved in the myRecord CtG project quickly developed negative perceptions about how records access would impact on patients and on their own workload. Consequently, they were unwilling to participate. In one practice, an incident in which a patient was inadvertently allowed to view a positive test result before this had been discussed with their GP caused an immediate halt to the project. In another

practice, the project took place at the same time as the introduction of a new IT system that GPs felt was already overburdening them.

The perception of both **tangible and intangible ‘costs’** is a key finding across the various CtG teams in terms of the willingness of healthcare professionals to engage. This can often be experienced in terms of **perceived risks to jobs**, as well as in terms of **perceived burden**. For example, while participants in the evaluation felt that senior management were enthusiastic about peer support workers, they were less confident initially that operational staff were actively welcoming peer support workers into their teams. This was felt to have stemmed from fear on the part of operational staff that the introduction of peer support workers was likely to put their jobs at risk, particularly in the context of wider cuts and job losses in the health service. They were felt to perceive peer support workers as being likely to be privileged as part of any recruitment processes because of their lived experience of mental health problems and the training that they have received. This fear could, paradoxically, have been increased as a result of the Trust Board’s strong support for the intervention. There was also evidence that, prior to the introduction of peer support workers, some middle managers were resistant to the introduction of these new roles because they were felt to divert financial resource from their own budgets. They anticipated a negative impact on operational capacity within teams, particularly for performing roles that might otherwise be played by healthcare assistants, like giving service users their medication and making beds.

In relation to perceived ‘burden’, it is clear that **where interventions to change relationships were not perceived to fit readily within existing routines and practice, and where there is a lack of readiness for change** healthcare professionals can resist these interventions. Some midwives in the M(ums) Power CtG project, for example, had mixed views with regard to the need to change relationships with the pregnant women they cared for. Some felt there was little synergy between the rhetoric of the project and the practicalities of their day-to-day work roles and this led to reluctance to engage with the interventions. Similarly, the early experience of the Peer Support Worker CtG team indicated that:

‘It has been a challenge to change behaviour and change working practices because a lot of people were very stuck in their ways, they didn’t really want to move, they didn’t see the benefits of it and they don’t buy it.’ (Peer Support Worker CtG team, team member)

Efforts to change relationships therefore have to contend with entrenched existing cultures and ways of working.

Changes to systems and processes

The role of technology

Technology has been defined as ‘any device, product, service or application with an IT element’.¹⁷ A number of different healthcare needs can be supported or enabled by technology. These include: information and advice; administration and transactions; consultations and clinical care; diagnosis; monitoring; and relationships. In terms of relationship change, the NHS Confederation argued that digital interfaces can narrow the gap between clinicians and patients, facilitating shared decision making and other improvements in consultation quality.¹⁸ Technology has been seen to hold the potential for relationships between patient and clinician to be equalised by providing standard information

to patients about things such as the trade-offs involved in different treatment options and providing clinicians with insights into the patient's values and priorities.

Two of the CtG teams sought to use technology to change relationships. The myRecord CtG team provided an online patient interface to access GP records, while the M(ums) Power CtG team hosted an online portal that provided information about maternity services ('My Pregnancy Journey') and a social media tool ('Mums Talk') for women to share their experiences and support each other.

Experiences of barriers and enablers

Both teams experienced difficulties with their technological innovations. For myRecord, there were problems providing a simple route for patients to access their records online. The few patients who did access their records as part of the myRecord project were positive about the experience and potential value. However, the online interface was complex and difficult to use, and acted as a deterrent:

'It's convenient, but having said that, I don't do that too often ... There are functionality issues and I have had to have numbers reset on several occasions. Not because I've forgotten the password, because of the system. The whole thing seems to be an amateur attempt to use IT.' (myRecord CtG project, patient)

Women who accessed the online portal used in M(ums) Power reported mixed experiences, some of which were due to functionality problems. A key aim of the system was to facilitate peer support and women were positive about this aspect. However, they also said technology could not replace face-to-face contact and needs to be used as part of a mixed approach.

Implementing successful technology to facilitate relationship change requires careful planning, good design and extensive testing prior to release. Service users and staff can become quickly disenchanted with technology that is difficult to use, inflexible, slow or prone to crashing. This was apparent in the myRecord project, where access to GP records was intended to be the prime mechanism for changing relationships. In M(ums) Power, technology played a dual role with face-to-face group sessions, which rendered its inadequacies less of a barrier to changing relationships.

Effective implementation of technology to facilitate relationship change in the health context is not simply about the technology itself, but also about the wider context within which it is supposed to be accommodated. A number of considerations are paramount:

- **Who the technology is meant to serve**

The implementation of technology and the persuasion of clinicians and patients of its benefit rely on a **clear understanding of the 'customer base' for the technology and their preferences**. Not all service users have access to the Internet or are competent to use IT. Likewise, staff may not be confident using different types of technology. In the myRecord CtG project, staff were expected to train patients to access their online records but they themselves also experienced difficulties using the software, placing further barriers in the way of progress.

Technology may have an impact on the relationship between patients and clinicians in ways that may sometimes be **perceived by clinicians as counterproductive**. For example, there is wider evidence to show that some doctors viewed the availability of online information to patients as a threat to the delicate balance of the patient-clinician relationship.¹⁹ This was certainly experienced by the myRecord CtG team. Clinicians and practice staff were wary about the system and its implications, leading to resistance to adopting records access due

to lack of knowledge (eg GPs and practice staff concerned that records access increases their workload) and/or confidence (eg GPs concerned about what patients may see in their records).

A number of factors have been put forward in the wider literature in relation to **strategies that are likely to increase health professionals' adoption of new technologies**, namely: a proven clinical benefit for patients; a convincing proof of concept and business case; low risk in monetary terms; and time to invest in adopting the technology.

- **What are the goals of using technology?**

It is important that interventions using technology as a basis of or facilitator for changing relationships clarify the role that technology plays. What types of relationships might the technology be expected to shift; how and why? Is the goal of changing relationships entirely dependent on technology, or is technology one of several tools that can help?

Up to early 2012, for example, the M(ums) Power CtG team had based their intervention largely on a bespoke technological solution, which they expected would empower women through giving them interactive access to their care records and to information tailored to their specific needs. When their technology provider unexpectedly withdrew from the market, the project team were left without this solution and had to reconsider their innovations/interventions. The team had not anticipated this, and the loss of a significant technology innovation was experienced as a significant setback, leading to an initial loss of momentum and a temporary increase in scrutiny from the Health Foundation. On reflection, however, the team felt that this event might have been a blessing in disguise as it motivated them to take stock of their objectives and to **refocus on the culture change necessary to change relationships, rather than placing IT at the heart of changing relationships**. This helped them clarify the role that technology played in changing relationships, and to see that it was a means to an end, alongside other interventions that can help change relationships.

To inform this refocusing, they consulted women directly to share their experiences around antenatal care and priorities for change. The consultation, through co-production workshops, identified that the project objectives did indeed reflect women's real concerns and led to the suggestion of several new mechanisms/innovations to transform women's experiences of care. This led to the intervention combining face-to-face and online elements.

Underpinning the use of technology, in the two CtG teams, is a desire to **shift the power imbalance in the relationship between clinicians and patients**. This maps directly on to the 'power' domain in the conceptual model proposed by Wish (1976).²⁰ In attempting to do so, both teams had to contend with the issue of how potential conflict between clinicians and patients should be resolved. Successfully shifting relationships in this domain, for both teams, required **emphasising the 'win-win' element that may be facilitated by technology**. For example, the myRecord CtG team produced a number of information leaflets and tools to support GPs, practice staff and patients. These were aimed at understanding and correcting clinicians' and patients' misconceptions about the effects of technology and reducing their reticence to adopting it. It further supports clinicians and patients to use the technology appropriately and correctly, and to understand the limitations of technology.

The way that technology is integrated into the patient-clinician relationship is crucial. If technology is seen as a substitute for personal contact, it can impact negatively on levels of trust and lead the patient to feel that they have little influence over decisions.²¹ The M(ums) Power example demonstrates this clearly. While service users had positive experiences of some aspects of technology, they did not feel that it should substitute completely the need for

face-to-face interactions. Healthcare delivered remotely through technology can also exacerbate social isolation or exclusion, either because people have no access to the technology or simply because a personal relationship with a healthcare professional is valued highly. Well-designed systems that support and work alongside face-to-face relationships can be effective, providing people with a **reason** to go online.

- **How will the technology actually work in a specific context?**

It is important to understand and take into consideration the contextual factors that contribute to the effectiveness of technology. Learning from myRecord and M(ums) Power CtG teams highlighted the need for **technology to be part of a wider system change intended to change relationships**. It also emphasised the need for careful consideration of how technology fits into that system. The problems experienced by the myRecord CtG team, for example, led them to recommend carefully considering, and piloting, software products prior to promoting their use: '*Look at the product in detail before you promote it*' (team member). Building on this, the team also advised against over-promising or building expectations regarding any technological solution before being fully confident in its capabilities and how it would work in specific contexts. Initially, the team failed to ensure that this was the case and experienced frustrations in responding to patient complaints regarding the system.

On the technical side, the **compatibility of new technology with existing systems** can be crucial to its effectiveness. For example, the M(ums) Power CtG team experienced challenges at the Newham site due to operational difficulties with the inflexible booking system there. This made it impossible to control which women were targeted, so the sessions could not be tailored accordingly, thereby undermining the effectiveness of the intervention.

Over and above technical compatibility with wider systems, the effectiveness of any technological innovation is dependent on its use. This has to account for **social factors**, including the need for **strong leadership and direction** to make the adoption of technology happen 'on the ground'. For example, the experience of the myRecord CtG team indicates that the leadership and championing from GPs had an impact on whether record access is taken up and promoted consistently.

Fundamentally, both CtG teams realised the need to **explain and support changes in ways of working**, rather than simply to implement new technology as a parallel to existing ways of working. There must be a willingness to accommodate changes in service delivery necessitated by the new technology.

The balance between tacit and explicit knowledge

One of the fundamental challenges confronting interventions to change relationships lies in the fact that **relationships are always 'held' by people**. It is people who enact behaviours that have the potential to change relationships. This enactment depends on particular skills, inclinations, beliefs and so on. As such, one can argue that **interventions to change relationships will always encounter 'stickiness'**: the tendency of knowledge to stay where it is generated.²² **Successful implementation of interventions aimed at changing relationships is dependant upon tacit knowledge held in an individual's head but it is reinforced when this knowledge is embodied in procedures or tools**, such as care protocols or structured care records.

Explicit knowledge is codified or easily codifiable. It can be abstracted from a specific situation or individual and stored. Examples include databases, reports, checklists and manuals. Explicit knowledge requires specific unpacking and adaptation in order for it to be useful and usable in particular situations.²³ In the process, explicit knowledge is appropriated,

interpreted and often recast. Hence the use of explicit knowledge is not simply a case of ‘cutting and pasting’.²⁴

Tacit knowledge, on the other hand, is described as non-verbalised and often non-verbalisable, intuitive, personal and situated.²⁵ As tacit knowledge is gained through experience in specific contexts, it is intrinsically bound to a specific person and situation. Transferring tacit knowledge involves face-to-face interactions that meaningfully generate shared experience. The word ‘transfer’, however, is misleading, as in the process of generating understanding tacit knowledge is recast and new knowledge is generated (often co-created).

Movement along the tacit–explicit continuum involves two types of processes. Through the process of **articulation**, tacit knowledge can be made more explicit (although never completely). Conversely, **internalisation** is required for absorbing explicit knowledge and making it more readily available for use and action by the individual. The process of internalisation is often idiosyncratic, with individuals relying on a variety of sense-making mechanisms to embody the explicit knowledge. This tacit–explicit continuum is mapped onto the extent to which knowledge and skills relating to changing relationships are shared within and beyond an organisation. **The transformation of individual to organisational knowledge, and the successful appropriation of organisational knowledge for use by individuals in specific situations are central to whether interventions to change relationships are effective beyond the one-to-one situation of interaction.** The emphasis here is on how such processes are to be incorporated into the wider organisational structure and culture in order to bring about benefits beyond the individual clinician–patient interface.

Experiences of enablers and barriers

While CtG teams are generally small and involve highly committed staff, it is possible for healthcare professionals to operate using tacit knowledge. However, this means that there are limits to the extent to which relationships are changed more widely beyond those held directly by CtG team members who may be interacting directly with patients and service users, and/or with other healthcare professionals.

As described previously, the enactment and transfer of tacit knowledge is time intensive, involving face-to-face exchanges to help others generate their own understanding of how to bring about relationship change in specific situations. However, as interventions increase in scale, this knowledge must be formalised and communicated to a much wider group. Failure to do this means that efforts to change relationships may be undertaken inconsistently or inadequately by different staff or organisations.

In the CAMHS CtG project, staff were initially given the freedom to decide their own interpretation of shared decision making, but soon realised they wanted more guidance on how to implement it:

‘It was good to have the opportunity to think more broadly but it also left us floundering as so many options – we could have had more support at this stage.’
(CAMHS CtG team, staff member)

The CAMHS CtG team developed new forms for recording the outcomes of a consultation, which focused on the service users’ goals for therapy:

‘There was an equal investment in the therapy with goals held not just by the clinician – this has changed the relationship directly. I’m not sure something like an outcome

tool actually changes an outcome but it does change a relationship and relationships drive quality improvements.' (CAMHS CtG team, project staff member)

Across the various CtG teams, there have been numerous efforts to try to ‘codify’ knowledge about changing relationships by generating different types of implementation tools. The Peer Support Worker CtG team generated visual tools to help illustrate progress against goals and outcomes, while the myRecord CtG team created a number of implementation tools for GPs and practice staff to help ‘make it real’ for them. The Shared Haemodialysis Care CtG team found that implementing shared care with patients became much easier when there were templates and tools to support this:

'She set it up in phases so we had strict timelines, she split it into work streams, she broke it down and that's what worked. It made it smarter whereas before there wasn't any of that. It was specific and it was timely, it was all those smart objectives.'

(Shared Haemodialysis Care CtG team, staff member)

The move from tacit to explicit knowledge relied on a number of factors. First, there needs to be **clarity about what is important to be ‘codified’ and how this should be done**. There is no point codifying everything as this will merely result in excessive guidance, tools or other outputs that may end up not being used. In the case of the CAMHS CtG team, their clarity about the key intended outcomes for the project helped them identify where and how they could translate tacit knowledge into formal procedures. In their case, a key outcome was identified as service users defining and achieving their own goals for therapy, and tools were developed to help wider sets of healthcare professionals capture this consistently:

'We have the mechanisms to pay more attention to the relationship and the tools are helpful to do that.' (CAMHS CtG team, staff member)

Second, producing explicit knowledge in itself is not sufficient in ensuring that behaviours do indeed change. **Training** is a key enabler for giving staff the skills and confidence to know how to use tools appropriately and consistently in their routine practice:

'The course has also been the biggest change, they said "it's not what I expected". It's about them saying actually we can do this, and we're giving them the skills and tools they need – how to teach adults in short periods of time, how to make better use of their time, motivational interviewing, learning styles.' (Shared Haemodialysis Care CtG team, staff member)

Third, many CtG teams cited the **importance of having someone with well-established skills and expertise in the relevant sector/issue who could support the effective capture and communication of tacit knowledge**. In the case of the Shared Haemodialysis Care CtG team, for example, the project manager was identified as playing a critical role in helping to capture and transfer important knowledge to support relationship change:

'She has a degree of knowledge of renal disease, she has good project management skills, she's good with people, presents herself well.' (Shared Haemodialysis Care CtG team, team member)

Striking a good balance between tacit and explicit knowledge is challenging, and may be frustrated by other structural challenges. In addition to these, all CtG teams had to contend with variable **scale and pace of change** within and beyond their respective organisations and partnerships. While all recognised the importance of formalising processes, tools and training to support wider scale relationship change, all have experienced significant **staff turnover** both within their teams and in other parts of their organisations. This has made it **difficult for knowledge to be retained and sustained organisationally**. These challenges limit the extent to which CtG teams have been able to scale up quickly and effectively.

Achievements over the duration of the CtGtCR programme may fail to become fully embedded, thereby threatening the legacy of interventions.

Ability to evidence

Changed relationships may manifest in subtle ways that are **not easy to measure**. While all CtG teams set out to change relationships in some way, teams were unable to predict at the outset which aspects of what relationships may change, and in what ways. This posed significant challenges for how the teams went about measuring changing relationships. While there are a number of validated instruments for measuring the characteristics and quality of relationships, each only measures specific dimensions of relationships within specific forms of interactions. There is no single instrument that measures all possible domains of relationships across different types of settings and interactions. For example, the Patient Activation Measure (PAM)²⁶ measures the degree of responsibility, confidence and control exercised and experienced by patients in terms of managing their own health/condition. The Consultation and Relational Empathy (CARE) measure,²⁷ on the other hand, is a person-centred process measure that measures the amount of empathy that a patient feels they have received during a consultation.

Experiences of barriers and enablers

There are examples of CtG teams that used particular instruments initially, but abandoned these at some point during implementation as the specific tool was not found to be appropriate for the types of changes to relationships that actually emerged (as opposed to initially predicted). The myRecord CtG team, for example, initially used the Patient Enablement Instrument (PEI).²⁸ The PEI measures the extent to which a patient is capable of understanding and coping with their health issues after a medical consultation. As the project developed, the CtG team realised that the PEI in itself was not sufficient. In the words of a myRecord CtG team member: '*our initial measures were awful*'.

As they developed clarity around the key aspects of relationships that are likely to be relevant for their intervention, the team subsequently identified a number of dimensions they would like to measure that were not captured by the PEI: power; proactivity; knowledge; respect; choice; cooperation; and trust. The team subsequently worked with the evaluation team to develop a single patient questionnaire that combined elements of the PEI, elements of the Self-Reported Use Questionnaire (SRUQ), and bespoke questions.

CtG teams, in general, relied largely on a wealth of qualitative feedback from service users and healthcare professionals who reported changes in the way they interacted in different contexts. The interesting issue here, however, is not simply about measuring changing relationships. Instead it is about **whether and how measuring changing relationships enabled or facilitated relationship change**. There are examples indicating that the ability to demonstrate that relationships have changed can have an impact on sustaining or spreading changing relationships. CtG teams collected data from staff using questionnaires, interviews, focus groups, workshops and digital stories, which provided a qualitative understanding of their experiences and perceptions about changing relationships. Likewise, they collected a great deal of qualitative feedback from service users using a range of data collection methods and covering patient experience, satisfaction and perceptions about relationships:

'Having the evidence at your fingertips was important – being able to show to other staff that young people did like something. This was really powerful in convincing people.' (CAMHS CtG team, project team member)

Evidence on relationship change was not the only type of evidence that played a role in enabling or facilitating relationship change. Indeed, all CtG teams felt that **measuring a number of quality outcomes can play a significant role in supporting or aiding changing relationships**. In other words, having evidence that '*it worked*' in terms of contributing to quality improvement was perceived as being influential in convincing and persuading others '*it was worthwhile*'.

While this was true for all CtG teams, it was especially so for the Pathway CtG team as this team's strategy for changing relationships was to prioritise efforts that can lead them to demonstrate that the intervention has contributed to quality outcomes (in this case, efficiency). Through this, the Pathway CtG team then felt that they were more able to transform relationships more widely throughout the organisation as people become convinced of the value of the intervention. It was unsurprising that the team placed significant emphasis on indicators and measures that could help them make the economic case (eg data on bed days and (re)admissions). The team also drew on self-evaluation support to produce an economic impact output as they recognised the importance of being able to demonstrate the cost consequences of their model. They were aware that spreading the service model, and getting other professionals to change their behaviours, relies not only on the ability to demonstrate improvements in the health of homeless people, but must also convince commissioners and other funders that the model is cost-effective.

All CtG teams encountered challenges in measuring outcomes due to a number of reasons:

- they have not been able to gather sufficient quantitative evidence of outcomes at this relatively early stage of implementation
- changing relationships is a long-term goal, and there is a need to balance the imperative to collect outcomes data with the need to take time to understand more fully the likely impact of their interventions before they could devise appropriate measures
- there were different views within each CtG team about what data to collect, and how, which led to delays in agreeing data collection approaches
- some teams did not have a clear understanding of the scale of resources required for robust self-evaluation and for establishing their metrics and measures
- many of the interventions are small (but intensive) in scale, involving relatively few patients and service users. CtG teams experienced difficulties telling a compelling story around impact given the small sample sizes and the existence of numerous confounding variables.

In moving forward, all CtG teams recognised the importance of resourcing outcome measurement and embedding data collection in routine processes as part of long-term sustainability.

Changes to organisational culture and environment

New roles

Two of the CtG teams created completely new roles within their care systems. The Pathway CtG team trained and employed previously homeless people to work as 'care navigators', while the Peer Support Workers CtG team trained and employed people with lived experiences of mental health problems. These approaches are underpinned by: '*relationships and interactions between people ... who are equal in ability, standing, rank or value*'.²⁹ There is a growing body of evidence indicating that such approaches are beneficial,

particularly in relation to certain disadvantaged groups, and have contributed to transformations in the delivery of health and social care.³⁰

The wider literature suggests that these approaches can help transform relationships through reciprocity, thereby transforming the '**power**' **dynamic** underpinning conventional clinician–patient relationships. For such approaches to work, the evidence base recommends a number of considerations:

- clarity about the role and clear boundaries between the role and other kinds of support being provided
- ensuring quality through training; monitoring for consistency and observation of appropriate boundaries; providing supervision;
- ensuring adequate resourcing: eg through employing a paid coordinator; covering out-of-pocket expenses
- offering choice to patients and service users, recognising that they may have different preferences.³¹

Experiences of barriers and enablers

The experiences of CtG teams in introducing new roles can be grouped under two headings **(a) issues that are generic to the introduction of any new role; and (b) issues around new roles that problematise the conventional service provider–service user divide.**

In terms of the first issue, there can be initial resistance from other members of staff. For example, the Peer Support Workers CtG team felt that other staff were, initially, not always receptive to the introduction of peer support worker roles. As discussed previously, the weighing up of relative risks and benefits by other staff can mean that the introduction of new roles could be seen as a potential threat to jobs or as an additional demand on tight and shrinking budgets held by specific departments. For example, some staff thought that the introduction of peer support workers might threaten the role of healthcare assistants.

Over time, however, through modelling appropriate behaviours and demonstrating positive change, both peer support workers and previously homeless 'care navigators' **became increasingly valued by other staff as the ways of working and the benefits arising from these staff were demonstrated through actual experience.** For example, once the peer support workers were in post and started working alongside other professionals, the enactment and benefits of the role 'became real' for others. They could see first-hand, through collaborative working, what a 'recovery focused' approach to mental health looked like in practice. As a result of working alongside peer support workers, other staff were perceived to have become inspired to be more recovery focused in their approach, and to see service users more holistically instead of merely focusing on their presentation of diagnosis and distress:

'Yes a lot did [change their attitudes] because they saw peer support in action. I would go onto a ward and be able to engage with patients in way that perhaps staff hadn't been able to. When staff saw that and saw that it works, that changed their views.' (Peer Support Worker CtG team, staff member)

Similarly, hospital staff related to the Pathway CtG project reported a better understanding of the multiple health problems homeless patients face that '*helped stop automatic actions which might not be appropriate for the patient*'. These experiences indicate **shifts across all four dimensions of relationships** described in Figure 3.

While acknowledging the positive impact that this can have on healthcare professionals, it is important to be clear that **accommodating new roles also mean changing ways of working**. This is likely to have **implications for existing roles and how they operate**. In the Shared Haemodialysis Care CtG project, for example, promoting greater self-care meant that nurses took on a new role as part of their care delivery (eg as facilitators). However, some nurses raised concerns about their legal liability:

'Another thing was about giving control to patients and accountability, where would they stand if something went wrong, if the patients do something wrong. Is their registration on the line?' (Shared Haemodialysis Care CtG team, staff member)

Interventions that successfully introduce new roles therefore also need to examine the implications for other roles, and to provide relevant training and support where necessary.

At the same time, these '**experts by experience**' across the Peer Support Worker and the Pathway CtG teams were able to engage meaningfully with respective sets of service users and patients, and to change their attitudes and behaviours towards healthcare professionals and services. The care navigators, for example, have personal experiences of homelessness. As core team members, they have been critical to **achieving meaningful contact and a rapport** with homeless people. The Pathway CtG team felt the care navigators are sometimes the only people who could have engaged successfully with some homeless people and in working alongside staff, they have effectively challenged some of their negative stereotypes of homeless people. They also use their personal experience and expertise to **guide the recruitment of others** into the team. Care navigators have been able to befriend, support, challenge and mentor homeless patients in the hospital, **helping them navigate the hospital environment**.

In relation to the Peer Support Worker CtG project, the peer support workers were a **role model to service users giving them the confidence to engage with their own care**:

'People do start to recognise that they can recover, and also that they are responsible for keeping themselves well, that they can control their own wellbeing, have more of a say on how they live their lives.' (Peer Support Workers CtG team, staff member)

Both CtG teams felt that it was **important for the new role holders to be able to work with other professionals as part of an integrated team, at the same time maintaining their own distinct identities and values while adapting these to the contexts in which they worked**.

A key issue that influences the extent to which the creation of new roles may help transform relationships rests on whether the responsibility for changing and sustaining relationships rests largely, or solely, with the new role holders. In other words, **is changing relationships reliant on the new roles, or facilitated by the new roles?** A member of the Peer Support Worker CtG team articulated this eloquently: *[we do not] see peer support workers as being a bridge between the service and service user, because this implies that the two need to be "bridged"*. Instead, peer support workers are intended to act as a catalyst to 'join up' the two, so that relationships can be sustained throughout the wider service. In other words, the effectiveness of peer support workers is perceived as resting on the fact that **they are not just the interface, without which the relationship may fall apart**. This is a vital piece of learning in relation to how and whether new roles support relationship change, and whether changes in relationships are subsequently sustained.

While both the Peer Support Workers and the Pathway CtG teams introduced new roles, there are specific characteristics of these new roles that influence their ability to change relationships, over and above the issues discussed above that arise from the introduction of

new roles in general. In both cases, the **new roles problematised the conventional service provider–service user divide. This caused additional challenges.**

The creation of new roles that turned on the conventional service provider–service user divide on its head necessitated new staff contracts and posed specific **HR challenges** in relation to recruitment, all of which took considerable time to put in place. For example, delays were experienced in recruiting care navigators because standard hospital processes for background/criminal records checks and health checks are not supportive of their different histories and experience. Senior level intervention has been necessary to ensure the recruitment system can accommodate former homeless people appropriately. One Pathway CtG team member reflected that if the project is replicated elsewhere, a requirement must be good preparation ahead of time for recruiting care navigators, specifically for human resources procedures around background and health checks. Indeed, if **these approaches are to be made more commonplace, there is a need to revisit NHS recruitment and HR policies and procedures more widely so that negotiations are not handled on an ad hoc basis.**

In addition to the structural barriers encountered, bringing ex-service users/patients into the role of service deliverer can pose further challenges. First, these candidates **need to be ready to support others.** In the case of the Peer Support Worker CtG team, for example, it was essential that peer support workers were at a stage of their own recovery process that enabled them to support others. The CtG team had to build in systematic and robust processes for recruiting, training, selecting, supporting and employing peer support workers to ensure that they are able and ready to perform their role well. This included targeted support for those candidates who were not yet ready for employment, but who could make valuable contributions to the project. The team felt that failure to assess the readiness of peer support workers could carry significant risks not only to the peer support workers themselves, but also to other services users and members of staff.

Second, projects that involve bringing in ex-service users as service deliverers also need to consider whether there are any **risks or challenges associated with having them work alongside other healthcare professionals who may have, in the past, been providing care to these individuals.** This was experienced by the Peer Support Worker CtG team where a peer support worker had previously been treated at the hospital:

'We have had a few exceptions, a few critical incidents we have written up where staff have taken exception to a particular peer support worker they might have treated before, coming into work with them when they've felt really frightened because they've known that person before.' (Peer Support Worker CtG team, staff member)

Organisational priorities and wider drivers

CtG teams have been operating within a wider context of austerity and transformations within the NHS and more widely. There has been a greater emphasis on efficiency and value for money. Many also encountered local issues or challenges that impacted on project progress. External and internal drivers and contexts can both trigger and disable change mechanisms around changing relationships.

Experiences of enablers and barriers

Where CtG teams have been able to **align project objectives with wider organisational goals and priorities**, this has had the effect of enabling progress with implementation and in securing longer-term sustainability. For example, by being able to piggyback onto other shared decision making initiatives taking place within their Trust, the CAMHS CtG team felt

that they were able to make good progress with their intervention. For the Peer Support Worker and Pathway CtG teams, there were clear quality improvement objectives that aligned with local and organisational priorities to increase efficiency by helping service users become more independent and reduce their use of services.

These **local/organisational priorities may have been pre-determined or may have been co-generated as a result of the interventions**. In the case of the Peer Support Worker CtG team, they worked hard to secure high-level buy-in to the intervention by executive and senior level colleagues, who have been kept informed over the project lifetime. The continuing engagement and support from senior colleagues was attributed to the project's success in showing that peer support working is effective and contributes to service users' satisfaction and self-belief. In part as a result of these efforts, peer support has been designated as one of the five work streams in the Trust's recovery strategy and a recommendation made to embed peer support workers into the Trust's existing structures and delivery teams. They have become aligned with recovery champions in each of the clinical teams and integrated with current directorate forums so that positive learning from the project can influence current working practice. The team put together a 'Peer Support Worker Strategy' to increase the number of peers in every team and a 'Recovery Strategy' to support replication of their approach. They also proactively sought to create relationships and networks with influential stakeholders, thereby adopting a 'snowball' effect promoting the work within the Trust and beyond:

[We are] constantly making alliances, nationally, internationally, locally, regionally, looking for opportunities to gain support, spread the message, inspire people with what's happening. We do demonstration days where people come to hear about what we are doing and then go off and do the same thing with their Trust, so really trying to snowball the impact.' (Peer Support Worker CtG team, staff member)

In comparison, the Pathway CtG team identified existing organisational priorities and organised efforts to present convincing evidence to show how the intervention contributed to these organisational priorities. Evidence, particularly in relation to reductions in repeat admissions and bed days for homeless people, has been particularly influential in convincing senior leaders that the intervention was **cost-effective while contributing to the organisation's strategic goals**. This helped to secure the commitment of senior leaders. The Pathway CtG team was able to ride this wave of enthusiasm by creating wider positive perceptions of the intervention. For example, they developed new guidelines (eg for substance abuse) that helped other staff meet local targets and therefore improved compliance. This helped secure wider pools of staff to engage with the intervention.

Where project goals are not aligned to organisational priorities, this can have a negative impact on engagement with healthcare professionals. For the myRecord CtG team, limited support and leadership from senior GPs meant that project staff became disengaged and passively allowed the project to happen but did not take control. A more extreme manifestation of this disengagement can be found in the experiences of the Speaking Up CtG team. Senior leaders in Mid Staffordshire NHS Foundation Trust were preoccupied with addressing the findings of the public inquiry as an upmost priority and the Speaking Up CtG project received little attention from them, despite obvious relevance:

'We underestimated how stretched our staff were, the organisation context impeded progress. If you'd put this project into a Trust not under the media spotlight or so badly broken, you could have made such amazing progress. It's not just [that we have] stretched teams here, it's so restrictive when you have teams turning up for unannounced inspections once a week – SHA, CQC, DH – but there's only so many'

hours in the day. We'd report progress, but there was a sense that we could have done more.' (Speaking Up CtG team, staff member)

It is important to note that **simply because a project objective is aligned with an organisational or wider priority does not mean that it will be plain sailing**. The Speaking Up CtG team's experience exemplified this. There can be confounding factors that distract. This can have a negative impact on the ability to keep focused on the task of changing relationships. The morale of staff in the Speaking Up CtG team was eroded by the public inquiry and they reported feeling vulnerable to criticism and scrutiny. As a consequence, staff turnover was high. Both these factors put huge pressure on the project:

'If you have a hospital in a crisis, in the spotlight, and you want to run a project like this where you are scrutinising their performance, it might not be a great idea.'
(Speaking Up CtG team, staff member)

In another case, while the myRecord CtG team's intervention aligned with national policy which states that by 2015 all general practices must offer patient access to GP electronic records, this did not mean that practices were willing or able to engage with the CtG team. While enabling records access is a national policy, the CtG team was trying to implement their intervention at a time when new policies around commissioning meant that GPs' attention shifted to more pressing issues. In general, GPs and practice staff reported feeling overwhelmed with wider changes in primary care.

Wider sets of relationships within and beyond an organisation

Changing relationships involves **challenging a culture in which service users and patients traditionally defer to healthcare professionals**. CtG teams were working against the tide to change these relationships that have been established over many decades and are **ingrained in the ethos and delivery of healthcare**. In the context of changing relationships, it is important to appreciate the fact that **service users and patients have relationships with a large number of healthcare professionals during a single episode of care, and many more over their lifetime of experiencing care**. Changing the relationship between a service user and a few of the healthcare professionals they encounter is unlikely to lead to sustained change. Therefore, **changing relationships needs to take place at a wider system level**. CtG teams recognise that they themselves cannot 'be there' all the time, every day, in every setting and in every interaction. They need to rely on other professionals and staff to be able to behave in desired ways even when team members are not around.

Experiences of enablers and barriers

Unsurprisingly, all the CtG teams have focused upon relationship change between the individual using a service and those who work in healthcare provision, and fewer have included interventions targeting the relationship between people using services and the wider healthcare system. None have had an explicit and direct focus on changing relationships between communities and the wider healthcare system. In **moving from one level of relationship to the next, the locus of control reduces significantly in terms of whether an intervention is able to bring about change directly or whether it needs to be more reliant on others to effect change through more indirect means**.

Within a narrow area of service delivery, and within a specific and discrete type of interaction, CtG teams have been able to demonstrate changes in relationships:

'I was giving feedback on an anxiety and depression tool and the young person said it was the first time anyone had ever fed back to her following a questionnaire. This

changed our relationship as it built trust and she knew that I would share information with her in the future.' (CAMHS CtG team, staff member)

However, CtG teams acknowledged the limited number of individuals directly involved in the interventions, and this had a limited effect on establishing new ways of working as the norm:

'We need to reach a certain threshold of people doing it then it becomes common practice.' (CAMHS CtG team, staff member)

CtG teams recognised that interventions with a limited remit will not change the wider culture of the NHS, and that culture change requires an approach that **goes beyond being 'done to' to becoming 'done with'**:

'Peer support workers have been influential in changing culture, they are described as culture carriers that model a way of behaving and interacting with people, but actually on their own they couldn't change the culture. It actually needs a complex and multifaceted approach with buy-in from lots of people from different levels.' (Peer Support Worker CtG team, staff member)

This is, of course, easier said than done. Some of the CtG teams worked across **multiple sites and organisations, including those external to the NHS, which posed particular challenges for changing relationships**. The intervention implemented by the Speaking Up CtG team, for example, involved many partners who deal with patient complaints working within the Trust and externally in the local Patients Association. The CtG team recognised that in order to change patient experience, they would need to change the relationship between the patient and all the partners they encountered on their journey. While staff from the Patients Association were able to focus all their attention on the Speaking Up CtG project, staff in the other partner organisations had other priorities, responsibilities and established ways of working. As a consequence, agreed actions may be difficult to implement consistently across the partnership:

'I think it's always a challenge when you have a partnership project ... The Patients Association staff worked solely on this, but the staff working group had other responsibilities, so it's hard to keep them as on board and up to speed as you are. It's not necessarily a core priority for them.' (Speaking Up CtG team, staff member)

A few CtG teams identified a number of considerations that underpin relationship change involving wider groups of people:

- the need for appropriate face-to-face interaction across wider groups of staff. This, however, recognises that **face-to-face interactions are time intensive and therefore can be a limiting factor** in terms of how meaningfully relationship changes may be effected across a wider group of individuals. This does not preclude the use of non face-to-face means of interaction, but there is acknowledgement that these on their own will not be sufficient
- the need for all those involved to have **sufficient time to assimilate learning and change their practice.**

Overview of key messages

The preceding discussion has explored very rich and complex sets of findings. It made clear that each of the four 'enabling mechanisms' can look very different in situ. They can also be 'triggered' and 'disabled' by different things. Despite the complexity, there are a number of key messages about the process and findings that warrant further distillation.

- In terms of the specific findings reported here, a key message underpinning any effort at changing relationships pertains to the need to be clear about the active ‘change mechanisms’ involved, and how these may be triggered and sustained. It is vital that stakeholders do not confuse ‘activities’ with ‘change mechanisms’. For example, producing tools for practitioners may help support relationship change in one context when used as part of an effort to engage in meaningful conversations about interactional dynamics, but may be treated as a ‘tick-box’ exercise to demonstrate compliance when used in another setting characterised by a different mindset. Changing relationships is not simply about ‘doing good things’, but is about doing the right types of things in ways that bring about desired changes.
- To change relationships and to replicate effective interventions elsewhere, it is important that stakeholders have a good understanding not only of the active change mechanisms, but also about how these interact with specific contextual factors. In designing and implementing interventions to change relationships, there is a clear need to understand where a particular system (eg the NHS) or subsystem (eg specific hospital, specific subgroup of patients and their readiness to engage) is at, and whether efforts may have to be focused on building up certain prerequisites first in order to have contexts that are more amenable for the intervention itself to be implemented. Interventions may be introduced into settings that are at different ‘starting points’, and this is reflected in the experiences of all the CtG teams in terms of the different amount of effort they have had to invest in setting up. Likewise, any attempt at doing something ‘new’ or ‘different’ needs to have thought through how the ‘new’ or ‘different’ activities or behaviours interact with existing and often deeply entrenched systems and cultures.
- The appreciation of ‘mechanisms-in-context’ is of vital importance as interventions aimed at changing relationships are fundamentally about challenging the existing system, rather than simply replicating the system or making inconsequential and peripheral changes that do not fundamentally transform dynamics in a sustainable way. As such, while most of the observable impact has been at the level of individual-to-individual interaction (both clinician–patient and clinician–clinician), all interventions aimed at changing relationships need to find ways of embedding change at this level within the wider structure. Otherwise good practice and early achievements can fizzle out over time as relationships held and maintained solely between sets of individuals are prone to erosion (eg due to staff turnover). This means that stakeholders also need to be clear about the mechanisms that help trigger and sustain relationship changes beyond one level.
- In trying to understand the mechanisms that bring about relationship change, and the mechanisms that link relationship changes at different levels, the evaluation has identified the importance of qualitative data to help stakeholders articulate and surface their own assumptions about how and why things work. These should then be tested and refined on an ongoing basis. Without having a clear ‘theory of change’, for example, stakeholders will struggle to understand how and whether what they have been doing may be related in some ways to the system-level outcomes that they have been measuring. There will be continued doubts as to whether they are measuring the ‘right’ things in terms of the quality outcomes. It may be advisable for relationship change interventions to have a staged approach to measurement, whereby the initial stage involves theory articulation and testing using qualitative data, in order to inform thinking around relevant outcome measures (both in terms of the outcomes pertaining to relationship change, and outcomes pertaining to quality domains), and how these may be interpreted.
- While it is undoubtedly important to understand the ‘change mechanisms’, what has emerged strongly from the evidence is the accompanying need for changing relationships to be ‘made real’. It is not sufficient simply to state the desire to change relationships or to

identify it as an objective to be measured against. Instead, three specific things are required in terms of making it tangible.

- First, the objective of changing relationships has to be stated clearly with the underlying rationale explained. Others may not necessarily understand that an intervention is trying to achieve relationship change (as opposed to, say, quality improvement). In addition, lack of clarity around the motivation for embarking on such an intervention may prevent key groups from engaging.
- Second, what changing relationships look like in practice has to be made as tangible as possible to all key stakeholders. This moves it away from being an abstract and vague concept and aspiration to something that makes sense to people in terms of what they do and the world they inhabit. Changing relationships has to be purposive, rather than incidental. This requires key stakeholders to behave and reflect individually and collectively in ways that make relationship change come to life and stay alive.
- Third, the likely implications of relationship change have to be spelt out as clearly as possible. Key groups may be reticent to participate if they are unclear about the likely costs and benefits to themselves and to others. This is particularly important as changing relationships is about fundamental changes, the implications of which need to be thought through.
- The process of generating ‘middle-range theories’ that allowed us to conceptualise the ‘enabling mechanisms’ has involved explicit translation and interpretation through the ‘borrowing’ of frameworks and perspectives originating from different sectors and drawing on different associated evidence bases. For example, perspectives and concepts from the disciplines of knowledge management, (technological) innovation and more have been used to help us make sense of the findings and their relevance in relation to changing relationships and/or quality in healthcare settings. This has meant looking at the issues through different lenses and, in the process of doing so, making connections with discourses and evidence bases beyond quality improvement, changing relationships, and even the healthcare sector. There are real opportunities for cross-fertilisation and ‘closing the gaps’ across different intellectual disciplines and traditions, as well as across different policy sectors.

5 Essential building blocks

This section explores some of the essential building blocks underpinning any intervention aimed at changing relationships: including project initiation; leadership and project management; organisational culture; staff engagement; and patient and service user attitudes. These are commonly known attributes for the success of any complex change process (ie not simply limited to those focused on changing relationships), but are presented as specific examples from the CtG projects to provide an illustration of how they were addressed in the CtGtCR programme.

CtG projects were given two years to implement projects intended to change relationships. A relatively large proportion of this period was spent on the project (re)design and initiation and engaging with delivery staff and partners. A great deal of the learning from CtG teams in terms of project setup and initiation are in common with tenets of ‘good practice’, for example as set out in PRINCE2 methodologies in relation to good project management. More widely, all CtG teams needed to contend with the key considerations underpinning effective quality improvement interventions more generally.³²

We do not wish to duplicate learning that is, to a large extent, common across quality improvement interventions and good project management practice. Therefore, the remainder of this section gives a brief snapshot of the learning from project planning and initiation that has arisen from this evaluation. These can be considered the essential blocks that need to be in place. However, while these are essential, they are insufficient in and of themselves to bring about changing relationships. To change relationships require a number of enabling mechanisms to be built on top of these essential building blocks (see previous section).

Project initiation

Some of the CtG teams had prior experience of implementing similar projects/interventions in similar contexts. For example the Pathway and Peer Support Worker CtG teams had implemented pilots before applying for funding from the Health Foundation under the CtGtCR programme. CtG teams with prior and specific experience were able to progress more rapidly than others by building on this experience and the learning gained from it. They also benefited from existing connections and relationships with stakeholders involved in, or supporting, delivery.

All CtG teams saw having sufficient time to consider project design and scope, consider options and develop a detailed plan as an important success factor. The M(ums) Power CtG team reflected that they were initially overly idealistic about what they could achieve and did not spend sufficient time considering practical issues, which led to unanticipated barriers later in the project. Likewise, the Speaking Up CtG team reflected on their initial lack of realism.

‘Maybe we shouldn’t have entered into such an enormous piece of work when we had so many other changes to make here to safety and care – [the] timing [was] wrong.’
(Speaking Up CtG team, staff member)

Staff and service user involvement in project design is important to ensure the acceptability and feasibility of the resultant intervention, as experienced by the Peer Support Worker CtG team.

‘It’s been about trying to problem solve together, about sharing in a fairly open and transparent way different perspectives, not being afraid to discuss or debate where

'we are coming from and how we can work out the best agreement or compromise.'
(Peer Support Worker CtG team, staff member)

In all cases, high quality training is important in enthusing and equipping staff to implement change, as witnessed by a CAMHS CtG team member:

'We were fired up and felt energised from the first session.' (CAMHS CtG team, staff member)

Leadership and project management

Strong leadership from senior people who are well respected is well recognised as a project success factor. Likewise, a knowledgeable and effective project manager is seen as a key asset:

'She has a degree of knowledge of renal disease, she has good project management skills, she's good with people, presents herself well, and she stayed like that all the way through. I've been impressed by her all the way through.' (Shared Haemodialysis Care CtG team, team member)

The Shared Haemodialysis Care CtG team recognised the need for clinical and strategic leadership and appointed a project director with a clinical background to work with the project manager. The specific skills and competencies required for leadership and for project management varied from project to project, and these must be considered in direct relation to the objectives of specific interventions. There is no one-size-fits-all approach in defining a 'suitable' leader or project manager in relation to interventions to change relationships.

A key learning was the importance of considering not only the appropriateness of project management expertise and capacity, but also the sustainability of project management arrangements at the early planning stage in order to ensure continuity over the longer term:

'Take it slowly and don't jump in. You need to be methodical and have the right people in place.' (Pathway CtG team, staff member)

Regardless of the type of person or the type of project management arrangement, it was important that appropriate and robust project management structures and process were set up and maintained.

Organisational culture

Successful project implementation requires a culture that values innovation and is receptive to change. Staff need to feel empowered and supported to experiment with new ways of working through appropriate training, tools and incentives:

'It all comes down to resources and capacity and whether people have the mental energy to reflect and take stock' (CAMHS CtG team, staff member)

The myRecord CtG team had direct experience of the impact of differential organisational cultures on the ability to make progress. One of the practices in the project had a positive attitude to innovation and a strong ethos of equality and collaborative working among staff. A second practice had a hierarchical approach to management that did not promote a sense of ownership in staff. As expected, the former practice achieved greater success in terms of meeting project objectives.

Across the NHS more widely, entrenched ways of working can produce formidable barriers to change. The Shared Haemodialysis Care CtG team were hindered by a culture that was slow to make decisions:

'The frustration perhaps was that things take a long time to happen in NHS, we only managed to reach out to relatively small number of units in Yorkshire, and I would have liked to have seen it with more.' (Shared Haemodialysis Care CtG team, staff member)

Staff engagement

Staff need to be engaged and enthusiastic to implement change and are highly influenced by the wider organisational culture as discussed above. Introducing change to staff needs to consider wider issues such as potential job losses, impact on workload and impact on existing roles:

'There was a lot of anxiety about changes in the service and management restructures which set the tone for the away day. People wanted space to think about resilience and dealing with change. Staff were angry and felt it was a waste of time to discuss shared decision making. I don't think it was because people thought we shouldn't be doing it but the timing was wrong.' (CAMHS CtG team, staff member)

Staff who are already overburdened are likely to be resistant to change:

'It's not that people are actively resistant but that they feel so under pressure in their jobs that asking people to do additional things is hard.' (CAMHS CtG team, staff member)

CtG teams recognised the need for communicating clear and accessible messages to engage with staff more widely:

'We felt we needed to communicate much better and hear more from clinicians who used tools in sessions and make their voices much louder to allay fears. We made a video about using the tool to try and spread the message.' (CAMHS CtG team, staff member).

Patient and service user attitudes

CtG teams sought not only to change behaviours of healthcare professionals but also those of patients/service users. The patient's and service user's attitude to change is therefore an important factor influencing a project's success:

'Patients love it, those that have been involved have said "we couldn't have done this without you", they're highly supportive of what's happened.' (Speaking Up CtG team, staff member)

However, simply because an intervention aims to bring about changes that are intended to be beneficial to patients and service users does not mean that these groups are always enthusiastic in engaging. Those from vulnerable backgrounds may be particularly difficult to engage with due to previous negative experiences or expectations of healthcare professionals, as experienced by staff involved in the Pathway CtG project:

'A homeless person's defence is to lash out, so it takes time to gain their trust.'

It is important to understand how and why different patients and service users may have different levels of motivation to engage with interventions. Staff involved in the Shared Haemodialysis Care CtG project found some patients to be more receptive than others based on lifestyle factors:

'Some had a job and then the motivation of self-care seemed like a good idea. People who had some kind of commitment in their life that they wanted to maintain were

'more pro generally ... people with something to gain showed more interest.' (Shared Haemodialysis Care CtG team, staff member)

Likewise, the CAMHS CtG team found that gender and timing could impact on uptake:

'We saw a bit of a gender difference (girls were very interested in being involved and boys less so). There was also a timing challenge as when young people arrive they often aren't in a place where they are able to be involved in that way. It can be a developmental process to get to a position where they want to be involved.' (CAMHS CtG team, staff member)

6 Summary of learning and thoughts for moving forward

This section summarises the learning and reflections from the evaluation and discusses the way forward, not only for CtG projects in terms of sustainability and diffusion but also in terms of lessons more generally for the healthcare sector and beyond.

The CtGtCR programme involved seven very different interventions, implemented in a variety of settings and facing different challenges. The evaluation does not claim that the issues discussed in this report represent the totality of considerations relevant to interventions aimed at changing relationships. Neither does the evaluation assert that the issues discussed here will always and necessarily be relevant or important to every type of intervention aimed at changing relationships. The findings should be interpreted as emergent from the lens through which we have been able to study interventions implemented by the seven CtG teams, in very specific contexts, during a time marked by considerable transformations within the NHS and beyond.

Given where they are at their own particular points in the trajectory of project implementation, it will be naïve to think that the findings presented in this report will necessarily hold true at a later stage of project development. Changes in relationships will take many months and probably years to manifest fully. At the same time, the direction of travel identified in the evaluation may or may not be sustained moving forward as the external context within which each CtG project operates will continue to change, not always in predictable ways. Likewise, the implications for quality improvement will need to be tracked over the longer term.

The above challenges notwithstanding, the evaluation has generated rich learning that has contributed to the development of the evidence base in this area. As mentioned in the beginning of this report, the evidence base lacks in-depth studies that allow us to understand what happens ‘on the ground’, and what the specific barriers and enablers may be in trying to effect relationship change in different contexts.³³

Lessons learned

This evaluation has generated evidence that allows us to flesh out and build on the conceptual model presented by RAND Europe (see Figure 5). We have been able to identify specific examples across the seven CtG teams of:

- how implementation contributed to specific forms of changed relationships (ie pathway B)
- how, subsequently, specific changed relationships can plausibly lead to improved quality in specific domains (ie pathway C, following on from pathway B). However, just because a relationship may have changed does not mean that quality improvement(s) will result
- how implementation leads to improvements in quality in specific domains (ie pathway A)
- how, subsequently, the specific improvements in quality may contribute towards changing relationships (ie pathway D, following on from pathway A). However, quality improvements may not necessarily lead to changing relationships.

Building on the framework presented in Figure 5, the findings generated by this evaluation point to the fact that there are a number of pre-conditions that need to be in place before any intervention to change relationships may be effected. These are the factors and issues that have been widely reported in the literature on quality improvement projects as being essential ingredients.³⁴ However, this evaluation has shown that while these essential

ingredients are key building blocks, their existence does not guarantee that relationships will change. Over and above these key building blocks are four types of ‘enabling mechanisms’ that need to be triggered in order for interventions to have some kind of impact of changing relationships:

- changing patient belief, attitudes, behaviours
- changing health professional beliefs, attitudes, behaviours
- changing systems and processes, and
- changing organisational culture/environment.

These mechanisms are triggered or disabled in different contexts, and also manifest themselves differently in different contexts. The ways through which different enabling mechanisms are played out in different contexts lead to different implications for quality, and vice versa.

The findings from the evaluation have also shed light on what aspect of relationships have changed across the various CtG teams. Using the framework proposed by Wish (1976), we have examined how interventions implemented by CtG teams have, in their totality, demonstrably shifted all four domains described by Wish. While the conventional focus of how these domains are played out in healthcare has been on interactions between healthcare professionals and service users/patients, this evaluation has shown how one or more of these domains may also be changed in relationships among wider groups of healthcare professionals, as well as among groups of service users. The utility of Wish’s framework therefore extends beyond the conventional clinician–patient interface.

In looking at how relationships may have changed, a clear finding from the evaluation points to the fact that relationships are generally easier to change on the individual clinician–patient level. Evidence presented in this report indicates that healthcare professionals and service users/patients generally value the concept of changing relationships and in many specific cases feel that relationships have changed, although often in subtle ways. As one moves outwards onto wider aggregates of healthcare professionals and service users/patients, the task of changing relationships becomes significantly more challenging. Successful relationship change at one level may not translate into wider changes (eg across a healthcare organisation). It is naïve to assume that one will lead to the other. There are different factors being played out at different levels in different contexts.

Looking forward

In moving forward, the CtGtCR programme and other efforts aimed at changing relationships and/or quality can be situated within, and benefit from, two influential schools of thought. These concern, firstly, how new interventions are made workable and integrated into everyday practice in healthcare settings, and secondly, how innovative interventions are spread and sustained in healthcare settings.

Normalisation Process Theory

Normalisation Process Theory (NPT)³⁵ is concerned with understanding (and measuring) social phenomena that promote or inhibit embedding of complex interventions in healthcare practice; defined as ‘*a deliberately initiated attempt to introduce new, or modify existing, patterns of collective action in healthcare*’. NPT proposes that looking at the implementation of complex interventions requires attention not only to the measurement of outcomes and

effectiveness, but also to the social relations and processes related to the work that leads to those outcomes.

There are four main components to NPT. These are not linear, but are in dynamic relationships with each other and with the wider context of the intervention, such as organisational context, social norms, and group processes. The components are as follows.

- **Coherence:** This is the ‘sense making work’ that people do individually or collectively when they are faced with the challenge of operationalising a set of practices within a specific context.
- **Cognitive participation:** This is the ‘relational work’ that people do to engage with and secure the commitment of others.
- **Collection action:** This is the ‘operational work’ that people do to enact a set of new or modified practices.
- **Reflexive monitoring:** This is the ‘appraisal work’ that people do to assess and understand the ways that a new set of practices affect them and others around them.

These components resonate with the findings generated from the evaluation of the CtGtCR programme. Examples from the NPT literature³⁶ provide useful sets of prompts that will be helpful to those engaging in interventions to change relationships (summarised in Figure 7 overleaf).

Figure 7: Questions to consider, using the NPT framework

NPT construct	Questions to consider
Coherence	<ul style="list-style-type: none"> • Does the intervention have a clear purpose for all relevant actors? • Do actors view the intervention as distinct from other interventions? • Do actors have a shared sense of its purpose? • How does it fit with the overall goals and activity of the organisation?
Collective action	<ul style="list-style-type: none"> • How are those involved in designing the intervention engaging with other actors to secure their buy-in and make things happen? • Are other actors prepared to invest time, energy and work in the intervention? • Do patients/service users see the point of the intervention? • Do patients/service users think the intervention is a good idea?
Cognitive participation	<ul style="list-style-type: none"> • How compatible is the intervention with existing work practices? Will it promote or impede these? • What impact does the intervention have on resources, power, responsibility and division of labour between different professional groups? • How do actors build accountability and maintain confidence in new practices and each other? • What training do staff require?

NPT construct	Questions to consider
Reflexive monitoring	<ul style="list-style-type: none"> • How do actors perceive the intervention once it has been in place for a while? • How do actors, individually and collectively, determine how effective and useful the intervention is for them and others? • How do actors appraise the impact of the intervention on the context in which it is delivered? • How are actors modifying the intervention on the basis of experience?

The diffusion of service innovations

An authoritative systematic review on spreading and sustaining innovations in health service delivery and organisations presented a model for considering the diffusion of innovations in health service organisations.³⁷ The model is underpinned by the following evidence-based assumptions.

- Individuals adopt different innovations and then spread them at different rates. Some innovations are never adopted at all; some are subsequently abandoned.
- People are not passive recipients of innovations; rather they experiment with them, evaluate them, seek meaning in them, challenge them, work around them, and modify them.
- Interpersonal influence through social networks is the dominant mechanism for diffusion.
- Different organisations provide wildly differing contexts for innovations – cultural and organisational features of organisations can influence the degree of assimilation.
- Organisations may be amenable to innovation in general but not ready or willing to assimilate a particular innovation.
- An organisation's decision to adopt an innovation and its efforts to implement and sustain it can be influenced by external factors such as political directives and organisational networks.

The conceptual model identifies a wide range of factors which interact to facilitate adoption and diffusion of innovations. These have relevance for interventions aimed at changing relationships and/or quality. To encourage spread and sustainability, those involved in such interventions may wish to consider the following more systematically:

- relative advantage – clear benefits and cost-effectiveness
- compatibility – in sync with adopters' values and perceived needs
- low complexity – perceived simplicity of use bodes well for adoption
- triability – ability for trial experimentation
- observability – benefits need to be easily discernible by adopters
- reinvention – ease of modification, adaptation makes adoption easier
- risk – less risk or uncertainty of outcome favour more certainty of adoption
- task issues – clear potential for work-performance improvement
- knowledge requirements – ease of knowledge transfer within various contexts
- augmentation/support – additional support components (ie training and support staff) favour ease of adoption.

Conclusion

Changing relationships should be understood as deeply contextualised sets of dynamics. While the CtGtCR programme took place within a period of austerity and other significant transformations in the NHS, these macro level drivers can be experienced differently across different localities, leading to different sets of opportunities for and barriers to change.

Any successful intervention aimed at changing relationships needs to be built on a solid foundation of good project management, strong leadership and effective engagement. These are common across quality improvement interventions and good project management practice, and not unique to interventions aimed at changing relationships.

While essential, these per se will not bring about relationship change. Changing relationships require a number of enabling mechanisms to be layered over these essential building blocks. To bring about relationship change and to sustain this effectively, it is critical for key stakeholders to be clear about the relevant change mechanisms and how these may be triggered or disabled in specific contexts. Efforts at changing relationships must not conflate ‘activities’ with ‘change mechanisms’.

Without intending to be exhaustive, this evaluation has identified four ‘enabling mechanisms’, namely:

- a) changes to patient beliefs, attitudes and behaviours;
- b) changes to health professional beliefs, attitudes and behaviours;
- c) changes to systems and processes
- d) changes to organisational culture and environment.

Within each, the specific triggers can look very different in different contexts.

This appreciation of the role of, and distinction between, essential building blocks and enabling mechanisms is important. Even if pre-conditions for successful implementation are established, implementation itself may not always and necessarily be successful. Successful implementation, in itself, may not necessarily change relationships. Likewise, changed relationships may not necessarily lead to improvements in quality. What is supportive of change, and what actually brings about change, are different. Even when change may be triggered in one direction, the trajectory of development may not be linear, as an ‘enabling mechanism’ can be ‘triggered’ as well as ‘disabled’ given the shifting contexts.

Understanding ‘mechanisms-in-context’ is of vital importance to interventions aimed at changing relationships. This evaluation has yielded some evidence to help further our understanding of the mechanisms that bring about relationship change at the level of individual-to-individual interaction (both clinician–patient and clinician–clinician). However, the sustainability of relationship change may be in doubt if changes at the one-to-one level are not embedded within the wider structure. This requires better understanding of the change mechanisms that help relationship change at one level translate into relationship change at another, more systemic, level.

Understanding the different types of ‘mechanisms-in-context’ requires good qualitative data to help stakeholders articulate and surface their own assumptions about how and why things work, and to test these assumptions on an ongoing basis. This performs a formative function, and keeps relationship change ‘alive’. It also contributes towards more relevant and appropriate measurement of outcomes.

Having said this, it is important to acknowledge that the wider system within which interventions aimed at changing relationships have been implemented remains very much ‘activity focused’ or ‘activity driven’. While there are pronouncements around reducing the

target-driven approach within the NHS, the system is nonetheless founded on an entrenched culture and practice of routinely measuring and reporting against certain items, such as bed days, length of stay and waiting time.

What is clear from this evaluation is that measuring such system-based and system-defined outcomes cannot tell us the whole story in terms of the quality of different types of relationships, and the dynamics around interactions in different settings. It also does not tell us anything meaningful about whether and how being more patient focused or more compassionate relates to the various quality outcomes such as efficiency, safety, and others. As long as measurement of relationships remains separate from the measurement of quality, it will remain challenging to maintain the link between improvement and compassion, as they may be perceived and experienced as unrelated entities with different levels of priorities accorded.

It is clear that changing relationships is about fundamental change that requires an explicit and sustained focus. It is not something that can simply be articulated or aspired to, and then left to happen on its own. It cannot simply be assumed that relationships will change just because good intentions exist. Changing relationships is about doing the right types of things in ways that bring about desired changes, purposively.

In order to be purposive and to stay focused, it is vital to:

- make changing relationships an explicit objective, state its centrality, and explain the rationale behind this
- make changing relationships tangible to all key stakeholders in terms of what it looks like in practice. Individuals and groups can then act purposively and reflect on their behaviours on an ongoing basis
- spell out the likely implications of relationship change, and put in place effective plans to capture and disseminate the evidence of benefits as well as to minimise any anticipated or perceived adverse effects.

Appendix 1: Three levels of relationships

The Closing the Gap through Changing Relationships programme focuses on one or more of the following three relationships. Interventions to transform the dynamic between people who use services and those who provide them will inevitably be complex and whole system in their nature. They may focus on one of these areas primarily but may work across all three.

The relationship between communities and the wider healthcare system

Service utilisation varies across communities. Factors such as cultural expectations, knowledge, language and access often act as barriers to people making the best use of the available services. The challenges faced by those from disadvantaged, marginalised and excluded communities in accessing the care they need illustrate many of these issues. For services to be equitable, for support and care to be effective and for the experience of those using services to be characterised by compassion and respect, the people responsible for planning and delivering services need a deep understanding of the communities they serve.

The Health Foundation is interested in approaches to engaging communities that enable local services to be shaped to meet their needs. This may involve approaches such as community engagement and mobilisation, micro-commissioning, building health literacy and developing culturally appropriate services.

The relationship between the person using services and the wider healthcare system

Despite significant developments in recent years, people using services still too often find that the support they need is fragmented, that services lack the capacity to respond to their individual needs and often the responsibility to 'join up' services sits with them rather than those providing the service.

With the complexity of services increasing, it is more important than ever that people using them are equipped to actively manage their care. Similarly, those providing services need systems that can support them in ensuring continuity of care to individual patients. A health system where people have greater control over their care will result in services that are safer, more effective and person-centred.

The Health Foundation is interested in approaches that put individuals in control, giving them the information they need to navigate the system and manage their own care. They are also interested in approaches that give those planning and providing services the information they need to be more responsive to individual needs.

The relationship between the person using the service and those who work in health provision

However person-centred the wider system of health services is, the quality of the interactions between individual patients and providers is fundamental to the overall quality of support and care. Individual interactions are often characterised by an imbalance in power, control and information, and a lack of a shared agenda. For health services to be effective, safe and person-centred, there needs to be a partnership of shared trust and responsibility between clinicians and patients. Putting humanity at the centre of our system requires everyone coming into contact with people who use the services and their families, regardless of

settings, to see 'the person in the patient' and to be supported to deliver assistance and care with compassion and respect.

The Health Foundation is interested in approaches that can address the need for more productive and compassionate interactions between people and those who provide services.

Appendix 2: Summary of self-evaluation support provided

Self-evaluation support was provided to the seven CtG teams for a two-year period from June 2011 until May 2013. Support was bespoke to the needs of individual teams at various points in time over the two years, and was flexible as different teams grappled with different challenges and methodologies. A simple needs assessment was conducted with teams and a menu of support options was formalised, including support for: design; piloting; ethics/governance; service improvement methods; measurement; economic appraisal; data collection and management; methods review and adjustments; analysis; and reporting.

The evaluation team worked closely throughout this period with Berkshire Consultancy and with the Health Foundation to ensure our respective support was ‘joined up’ and made efficient use of resources in ways that do not over burden the CtG teams. Each CtG team was offered five days of self-evaluation support per year (ie a total of 10 days per team over the two years).

Team	Summary of self-evaluation support
Shared decision making in Child and Adolescent Mental Health Services (CAMHS)	<p>Produced paper on suggested self evaluation support</p> <p>Supported with self-evaluation and learning sections in quarterly reports to the Health Foundation</p> <p>Provided project-specific advice on thinking about, and planning for, economic data and for capturing additional outcomes</p> <p>Provided training/delivered two workshops on economic evaluation</p> <p>Provided post-workshop support</p>
M(ums) Power	<p>Explored economic evaluation options through a series of meetings to discuss approaches</p> <p>Revised and agreed logic model</p> <p>Provided feedback on draft self-evaluation tools</p> <p>Supported the team in trialling their interventions</p>
Pathway	<p>Reviewed economic evaluation options including multiple meetings to discuss approaches</p> <p>Identified appropriate sources of data to use</p> <p>Carried out costs-consequence analysis and short report using team data, with recommendations for future economic assessment</p>
myRecord	<p>Produced self-evaluation plan and data collection tools</p> <p>Developed patient interview schema and GP post-consultation feedback questionnaire and interviews schema</p> <p>GP/staff interview schema for ‘switched off’ practices</p>

Team	Summary of self-evaluation support
Peer Support Worker	Scoped economic assessment options and support needed; developed a work plan Economic assessment work, including interviews with peer support workers
Shared Haemodialysis Care	Supported design and development of survey tools Analysis of survey data
Speaking Up	Supported the team in refining logic model and metric mapping in the early phase Designed and facilitated two separate workshop sessions on different economic assessment techniques Provided support in scoping economic assessment options Reviewed outcomes measures

Appendix 3: Brief descriptions of CtG teams

This Appendix provides a brief description of each of the seven projects. For more details of the projects, the improvements they led to and the challenges they encountered, see the improvement stories supplement.

Shared decision making in Child and Adolescent Mental Health Services (CAMHS)

Background

The CAMHS shared decision making project was established by the CAMHS Evidence Based Practice Unit, a partnership between University College London and the Anna Freud Centre.

The project involved working with four CAMHS teams in Bradford, North East Somerset, East Sussex and Southampton, including community and inpatient services. The project aimed to support children/young people and families to become actively involved in decisions about their care and treatment. It also encouraged children/young people and families to develop goals and measure progress alongside their clinician.

Tools and interventions were used to prompt collaborative decision making between children/young people and clinicians during consultations and to place the child/young person at the centre of their own care. Training sessions and bespoke support were provided to support local teams.

What were they trying to do?

The CAMHS shared decision making project aimed to change the relationship between the child or young person and their clinician by encouraging active involvement in decision making. It was felt that by developing a more collaborative relationship, the quality of outcomes achieved by children and young people would improve, alongside their experience of the CAMHS service.

What did they achieve?

The project has resulted in greater collaboration between children and young people and their clinicians in all of the sites. This has included active participation in goal and outcome setting as well as children/young people being able to provide feedback directly to clinicians about the quality of the relationship and what is, and is not, working. Feedback from assessments was discussed directly with children/young people for the first time at some sites, which resulted in increased trust and a strengthened therapeutic alliance.

Children and young people have also been more involved in the design of the service at all points of their journey as their voice and influence has increased within departments. Some sites report that involvement of children and young people has become a more mainstream activity.

Pathway

Background

Pathway is an integrated model of care better connecting primary and secondary care provision for homeless people to reduce the number of admissions and repeat admissions to hospital. The model was developed in 2009 at University College London Hospital (UCLH), and later expanded to the Royal London Hospital in 2011.

By creating a patient-centred ‘care navigator’ role, former homeless people are trained as health support workers to support homeless people to navigate what can otherwise be a complicated health system and help with the coordination of their care. The project also aims to build up the knowledge and competencies of health professionals providing care to homeless people. This is in turn anticipated to result in a measurably improved quality of care.

What were they trying to do?

The project aims to change the dynamic between healthcare staff and homeless people by taking a more compassionate patient-centred approach that puts the service user at the centre of their own care. The project also aims to influence healthcare staff and change their attitudes to homeless people to reshape how the healthcare system cares for them.

What did they achieve?

Despite challenges in collecting evidence, since the programme’s inception the average number of bed days has reduced by 30% compared to when it first started, equating to £200,000–£500,000 pa in savings.

There is also a perception that the project has helped clinicians gain a better understanding of homelessness. One hospital reported to have adopted a more focused approach in treating their homeless service users. The Pathway project has also supported hospitals in achieving their four-hour A&E waiting target. One hospital is now fully funding and extending the service and the project has won a Health Services Journal (HSJ) award for patient-centred care.

M(ums) Power

Background

M(ums) Power is a model of women-centred antenatal healthcare. It seeks to transform the health outcomes of women and improve their experiences by putting them at the centre of their own care, empowering them to make choices and shape the care they receive. The project aims to change the ways of working to optimise the number and timing of antenatal visits to improve pregnancy outcomes. The project was rolled out at University College London Hospital (UCLH) and Newham University Hospital.

What were they trying to do?

The project has focused on improving the quality of care for pregnant women across the following quality domains: person-centredness, effectiveness and efficiency. These improvements are expected to be brought about by transforming the relationship between pregnant women and health professionals, including midwives, consultants, technicians and the wider antenatal team. More widely, the project has sought to change the nature of relationships between pregnant women by improving their connectedness and networks of support as well as access to the wider ‘community’ of information about pregnancy.

What did they achieve?

As a result of the project some staff attitudes shifted, with midwives becoming more willing to engage as they learnt that they could tailor the intervention to their way of working. Over time, the group sessions appeared to work effectively as they were able to de-medicalise the care environment. Findings from implementation at one site also suggest that patient-centredness can effectively be enhanced by providing more scope for interaction between pregnant women and health professionals.

myRecord

Background

The myRecord project was implemented in GP practices across Lewisham and Berkshire East. The original project aims were to change the nature of the patient–clinician relationship by having practices give patients access to their GP medical record online. Efforts were then channelled to create a culture that embraced transparency around information sharing so records access became the norm. It was also expected that patients would benefit by using records access in developing a greater understanding of their condition to support the dialogue with their clinician.

Practices developed and used a variety of approaches to promote records access to their internal staff as well as externally to patients. Patient groups were involved to support implementation of the project and promote it among the patient population.

What were they trying to do?

The myRecord project aimed to improve the patient–clinician relationship as well as improve the quality of patient care. It was expected that patients who were more aware of their medical information and condition would use services more effectively.

What did they achieve?

Records access has given the opportunity to those patients who are motivated and inclined to understand more about their medical history. The project derived key learning around patient attitudes to records access, though there is still a need to qualify this with more substantive evidence. On an individual patient basis, positive feedback suggests the project has improved access to information, focusing consultation time with GPs and supporting self-management and efficiency in booking appointments.

Peer Support Workers in Adult Mental Health

Background

This project involves the training, recruitment and employment of peer support workers (PSWs) to work within Nottinghamshire Healthcare NHS Trust's Adult Mental Health Services (County) directorate. PSWs are people with lived experiences of mental health problems who use those experiences to support service users and help them with their recovery journeys. The project's aims are to improve the recovery orientation of mental health services and improve recovery outcomes for people using those services and, where applicable, their carers.

What were they trying to do?

The project aimed for service users to relate better to the mental health system as a whole and see it as being more accessible, approachable and relevant to their needs. The project also endeavoured to inspire current staff members to be more recovery focused in their approach and see service users more holistically instead of focusing on their presentation of diagnosis and distress.

What did they achieve?

The project has resulted in a more recovery focused culture at the Trust where they have developed a PSW and recovery strategy as well as created 32 new PSW posts. A human resources lead was appointed, and processes and systems will be reviewed to ensure that employment opportunities are easily accessible to people with mental health problems and that current staff with such problems feel sufficiently supported in the workplace.

Relationships between staff and service users appear to have improved as a result of behaviour modelled by PSWs and by staff having the opportunity to observe the positive work done by PSWs. Service users have begun to see the mental health system as more accessible and helpful.

Service users have also been extremely positive about the project: they described having a deeper relationship with PSWs with the confidence to be open and honest with them. They also saw PSWs as 'an embodiment of hope' and by working with them started to believe that they too would be able to recover and do positive things with their lives.

Shared Haemodialysis Care

Background

The Sharing Haemodialysis Care (SHC) programme ran across Yorkshire and Humber's renal network, covering six renal centres responsible for approximately 2,000 patients on haemodialysis. The programme aimed to give patients the opportunity to have a greater role in the management of their own kidney condition.

The programme comprised training courses for nurses to give them the skills to educate patients in aspects of their own dialysis care. This work-based training was cascaded by those who had attended the training course to other nurses. This was supported by educational materials, a patient handbook and a communications work stream to develop relevant information for patients and carers.

What were they trying to do?

The SHC programme aimed to change the relationship between patients and the nursing staff who provide care. It sought to empower patients to be active partners in their care and proactively engage staff to form active partnerships with patients, changing their roles from caregivers to facilitators.

What did they achieve?

The programme has resulted in improved relationships between nurses and patients, with more meaningful discussions and patients more confident to ask questions. In addition, the working culture has transformed with many nurses now very supportive of SHC despite initial concerns relating to time pressures and job losses.

Patients have become more supportive of or open to SHC, often as a result of peer support and patient advocates who worked to address their concerns. Patients are now more knowledgeable about their conditions and in turn are better able to take better care of themselves and manage their condition, improving their self-esteem. This has also meant a better quality of life because of the freedom associated with self-care.

Speaking Up

Background

The Speaking Up project aimed to improve complaints handling within Mid Staffordshire NHS Foundation Trust, generating good practice to disseminate across NHS organisations. The project sought to enable complainants to have their voices heard and support Trusts to translate that into improvements in care. The four key work streams included:

- recruitment of patient champions to deliver a complaint support service
- peer review panels to review samples of complaints handling
- digital stories detailing patient experience to be used as a learning tool
- introduction of a complaints survey for patients and carers.

What were they trying to do?

The Speaking Up project anticipated to change relationships between patients and clinicians, which in turn was expected to lead to improved patient care, as complaints are handled better, quality problems identified and resolved, and inequalities reduced. The project set out to achieve all six of the quality domains in equal measure (efficiency, safety, person-centredness, effectiveness, timeliness and equity).

What did they achieve?

The complaint support service led to a change of 'dynamic' between the Trust and patients, rather than a change of relationship. There was a perception that it put a barrier between the Trust and the complainant. While there are anecdotal reports describing a change in attitude, there is no evidence of changed relationships on a broader scale.

Patients and carers reported that the independence of the complaint support service, and the knowledge of the service lead, increased their confidence and helped them to feel supported. Complaints survey responses indicated a slight improvement in satisfaction with complaints handling. Since implementation, the Trust has also improved its panel scores and made changes to procedures as a result of panel findings. The Francis Report highlighted the good practice standards for complaint handling which were developed as a good practice model for replication elsewhere.³⁸

Appendix 4: Methodology

Evaluation questions

The evaluation aimed to answer three main questions, with corresponding sub-questions:

1. How do actors involved in the process of changing the relationship between people and services experience the change in their roles?
 - 1.1 How does the range of actors (ie clinicians, patients, individuals and communities) experience the changes brought about through the projects' implementation?
 - 1.2 What contributes to or detracts from the acceptability of the new arrangements/roles for different groups?
2. What are the key barriers to and promoters of successfully changing the nature of relationships between people and services?
 - 2.1 What are the key barriers faced by partners delivering the projects?
 - 2.2 Why do these barriers arise, and under what circumstances?
 - 2.3 Do projects manage to overcome barriers and, if so, how?
 - 2.4 What are the key drivers of successful transformation in the projects, and what is the role they play in making projects successful?
3. What is the 'improvement story' of each of the awards?
 - 3.1 What conclusions can be drawn from the available data on the impact of each of the awards in terms of shorter-term outputs and outcomes, and longer-term impacts on quality?
 - 3.2 What are the perceived improvements brought about by the activities?
 - 3.3 What are the narratives regarding what worked and what did not?

The evaluation was not intended to focus on the impact of the CtG teams, *per se*, but rather to understand what implementation would look like that would support the delivery of desired/intended outcomes. Critically, the focus on implementation takes into account how the various actors' roles contribute to success (or how these roles may be reconfigured to contribute to success), and how the various actors experience their involvement and resultant change.

Data collection

Three waves of data capture were undertaken with CtG teams and each wave involved exploratory discussions and interviews with a range of stakeholders (although few patients were included due to the sensitivities about accessing young and/or vulnerable service users). The three waves loosely followed a project trajectory of initiating and then sustaining programmes of change as follows.

- **December 11 – February 2012.** Through the first wave of fieldwork we captured data about setting up a project and the lived experience of the project team members engaged in that process. We also generated information on the key barriers to and promoters of successful change at this stage.
- **July 2012 – August 2012.** The second wave captured data on the early impacts of the interventions and on the lived experience of the actors involved, including clinicians.

Corresponding sets of key barriers to and promoters of successful change at this stage were also identified.

- **March 2013 – April 2013.** The third wave captured data that related to the overall impact of the intervention and on sustainability, the lived experience of those involved, and the key barriers to and promoters of successful change.

Other data sources

The evaluation also drew upon a range of other date sources, including:

- self-evaluation reports produced by the seven CtG projects
- reports generated by Berkshire Consulting in their role as provider of programme support to the CtG teams
- discussion with the personnel from the Health Foundation and Berkshire Consulting about the projects and their progress
- CtGtCR programme learning events hosted by the Health Foundation and contributed to by the seven CtG teams.

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