Building research capacity and capability in clinical practice: The INMPP experience

Dr Kenda Crozier; Dr Jenny Moore; Dr Katharine Kite
What is research capacity building?

- Research capacity building is about producing individuals with the ability to undertake research activity through creating the necessary infrastructure to facilitate this process.
- Includes having a management structure that recognises and supports research activity among nurses, midwives and allied health practitioners.

The aim of this study was to develop an infrastructure for research capacity-building (RCB) in one UK NHS foundation Trust.
Objectives

• To secure funding to enable the project to have a reasonable chance of success
• To support a number of small research projects to be generated from within the hospital staff
• To identify projects with the potential to be externally funded and to support and develop these
Funding

• Initial pre-step was funded by the Trust then SHA funding from NHS East of England enabled project to develop to full potential
Method

• Action research
• pre-step
• Action cycles involved planning, implementing and evaluating
Ethics

• Ethical approval gained from the local Research Ethics Committee (09/H0310/9)
• Relationships between the researchers and all participants is central
• Issues of confidentiality versus anonymity
• Trust Board fully apprised of the study plan
• Access granted by the Chair of Trust Board
Results of pre-step

• Scoping exercise to identify existing structures and processes to support nursing research

• 2 main themes emerged
  – Research activity was not embedded in the culture of the organisation
  – Initiating and undertaking change was a complex process
INMPP Action research project leaders
2 academics, 1 clinical lead

Steering group comprising academics, consultant nurse, matrons, R&D officer

<table>
<thead>
<tr>
<th>Innovation Project 1:1</th>
<th>Innovation Project 1:2</th>
<th>Innovation Project 1:3</th>
</tr>
</thead>
<tbody>
<tr>
<td>key worker role in the orthopaedic department</td>
<td>testing a postoperative checklist</td>
<td>development of a communication tool about deterioration in a patient’s condition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Innovation Project 2:1</th>
<th>Innovation Project 2.2</th>
<th>Innovation Project 2.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>aftercare at the end of breast cancer treatment</td>
<td>supportive antenatal care for pregnant teenagers</td>
<td>experiences of having a family member in intensive care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Innovation Project 3:1</th>
<th>Innovation Project 3:2</th>
<th>Innovation Project 3:3</th>
</tr>
</thead>
<tbody>
<tr>
<td>arterialised Blood gas sampling</td>
<td>dementia care - all about me</td>
<td>A&amp;E nurse assessment</td>
</tr>
</tbody>
</table>
1. Identify talent
2. Identify ideas
3. Sifting and selection
4. Award of time/support
5. Implement
6. Evaluate
7. Disseminate

Each cycle
Support

In preparing proposals for the innovation projects
– one to one
– Group workshops

Support for innovation project while projects were running from individual steering group members
Evaluation

• Each cycle evaluated
  – use of steering group minutes to track decisions and changes made
  – Interviews with steering group members and staff who entered competitions
Analysis

• Data was analysed using a thematic analysis approach,
• Searching for and identifying common threads that extended throughout the set of interviews.
• Two of the lead researchers (KC and JM) analysed the transcribed data separately, then discussed and agreed emergent themes to enhance internal validity.
Key findings

• A slow snowball effect
• Key skills such as leadership, resourcing and time management are required alongside research skills.
• Strong leadership and enthusiasm to drive the agenda.
• Structures and processes need to be clear and transparent as well as supportive at the individual level.
1st Call projects

• Post operative checklist for transfer from recovery to ward led by Jacky Copping
• Fractured neck of femur key worker in orthopaedics led by Barry Pinkney
• RSVP: A communication tool to work as an adjunct to the ABCDE framework led by Cherrell Taylor
2nd Call projects

- The lived experience of coping with rehabilitating a partner who has survived critical illness – Michelle Butt
- Integrated health and social care pathway for young mothers and fathers – Nicola Lovett
- Rejuvenate Breast Care Health Living Programme – Karen Flores
3rd Call projects

• Dementia project – Barry Pinkney
• Evaluation of a nurse assessment process in A&E – Gilly Briej
• Capillary Blood gas Sampling – Fiona Lang
• The lived experience of coping with rehabilitating a partner who has survived critical illness – Michelle Butt
Using INMPP to develop the role of a key worker for patients with a fractured neck of femur

Barry Pinkney – BSc (Hons) DipM DipHE RMN RGN EN Matron Elective Division
March 2010
Aims

• To develop a pathway of care for patients
• To develop, implement and evaluate a dedicated key worker

Method

The project lasted twelve months.
• Evaluation of existing practice took place from April to August 2009.
• The key worker role was implemented in September 2009
• Evaluated between December 2009 and March 2010
In the UK, hip fractures are increasing by 2% annually.

96% aged 65 and over and up to 14,000 people a year die in the UK - bed occupancy is in excess of 1.5 million bed days.

There are 6 national standards for hip fracture care (British Orthopaedic Association, 2007).

The SIGN guidelines Prevention and Management of Hip Fracture in Older People were used to inform the standards adopted for this audit.

Standard 6 of the National Service Framework for Older People (DoH, 2001)

Unclear if National Standards for hip fracture care (BOA, 2007) were being met.
The National Perspective (£)

- Hip fractures – 87% of total cost of all fragility fractures

- 1.2 million NHS bed days per year

- £426 million per year acute care
  - £13 million per PCT acute care
  - £50 million on-going care

- £2.0 billion total care cost
Project Questions

• Do patients with fractured neck of femur admitted via the emergency route at the JPUH benefit from receiving a pathway of care based upon relevant clinical and national standards?

• Do patients with fractured neck of femur admitted via the emergency route at the JPUH benefit from the input of a key worker from admission to discharge?
MONTHLY ADMISSIONS

April: 24
May: 34
June: 29
July: 32
Aug: 20
Sep: 29
Oct: 30
Nov: 35
Dec: 15
Jan: 27
Feb: 24
Mar: 22
## Clinical Standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
<th>2009/10 (n=321)</th>
<th>April 09</th>
<th>March 10</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All patients with hip fractures will be admitted to an acute orthopaedic trauma ward within 4 hours of presentation</td>
<td>49%</td>
<td>29%</td>
<td>50%</td>
<td>67%</td>
<td>29%</td>
</tr>
<tr>
<td>2</td>
<td>Patient with hip fracture who are medically fit should have surgery within 24 hours of admission and during normal working hours</td>
<td>32%</td>
<td>32%</td>
<td>36%</td>
<td>63%</td>
<td>8%</td>
</tr>
<tr>
<td>3</td>
<td>Patient with hip fracture who are medically fit should have surgery within 36 hours of admission and during normal working hours</td>
<td>54%</td>
<td>63%</td>
<td>54%</td>
<td>89%</td>
<td>17%</td>
</tr>
<tr>
<td>4</td>
<td>All patients with hip fractures who are medically fit will have surgery within 48 hours of admission and during normal working hours</td>
<td>77%</td>
<td>90%</td>
<td>63%</td>
<td>92%</td>
<td>68%</td>
</tr>
<tr>
<td>5</td>
<td>All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing pressure ulcers</td>
<td>95%</td>
<td>70%</td>
<td>100%</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>6</td>
<td>All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute Orthogeriatrician medical support within 3 days from time of admission</td>
<td>53%</td>
<td>24%</td>
<td>70%</td>
<td>81%</td>
<td>24%</td>
</tr>
<tr>
<td>8</td>
<td>All patients will receive intravenous (IV) fluids commencing in A&amp;E</td>
<td>47%</td>
<td>21%</td>
<td>59%</td>
<td>83%</td>
<td>21%</td>
</tr>
</tbody>
</table>
# Clinical Standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
<th>2009/10 (n=321)</th>
<th>April 09</th>
<th>March 10</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>All patients will have a pain score documented</td>
<td>44</td>
<td>36</td>
<td>18</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>10.1</td>
<td>All patients will be provided with initial analgesia from time of injury</td>
<td>63</td>
<td>70</td>
<td>77</td>
<td>93</td>
<td>70</td>
</tr>
<tr>
<td>10.2</td>
<td>All patients will be provided with 2nd analgesia</td>
<td>66</td>
<td>22</td>
<td>41</td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td>11</td>
<td>All patients will have a chest x-ray</td>
<td>95</td>
<td>96</td>
<td>91</td>
<td>96</td>
<td>86</td>
</tr>
<tr>
<td>13</td>
<td>All patients will have a Waterlow assessment performed</td>
<td>96</td>
<td>96</td>
<td>82</td>
<td>87</td>
<td>82</td>
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<tr>
<td>14</td>
<td>All patients will have an ECG on admission to A&amp;E</td>
<td>95</td>
<td>96</td>
<td>100</td>
<td>100</td>
<td>86</td>
</tr>
<tr>
<td>15</td>
<td>All patients will be admitted to an orthopaedic trauma ward</td>
<td>93</td>
<td>96</td>
<td>82</td>
<td>100</td>
<td>69</td>
</tr>
<tr>
<td>16</td>
<td>All patients undergoing hip fracture surgery will receive antibiotic prophylaxis</td>
<td>97</td>
<td>100</td>
<td>77</td>
<td>100</td>
<td>91</td>
</tr>
<tr>
<td>17</td>
<td>All patients will receive venous thromboembolism (VTE) prophylaxis</td>
<td>97</td>
<td>96</td>
<td>95</td>
<td>100</td>
<td>93</td>
</tr>
<tr>
<td>18</td>
<td>All patients will be assessed by physiotherapy by day 1 following an operation</td>
<td>23</td>
<td>27</td>
<td>41</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td>19</td>
<td>Patients will be mobilised by day 2 following an operation</td>
<td>43</td>
<td>50</td>
<td>49</td>
<td>67</td>
<td>23</td>
</tr>
</tbody>
</table>
## National Standards

<table>
<thead>
<tr>
<th>Standards met for audit</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep X</th>
<th>Oct X</th>
<th>Nov X</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% patients transferred to ward within 4 hrs of arrival in A&amp;E</td>
<td>29%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>100% patients to receive IV Fluids</td>
<td>21%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>100% Patients to receive prophylactic antibiotics</td>
<td>91%</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>100% Patients to receive VTE</td>
<td>87%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>100% Patients admitted to a dedicated orthopaedic ward</td>
<td>69%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>80% Patients operated on within 36 hrs</td>
<td>33%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>100% Patients assessed by physiotherapy by day 1 following operation</td>
<td>8%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>60% patients mobilised by day 2 following operation</td>
<td>23%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>100% Patients seen by orthogeriatrician within 3 days of admission</td>
<td>24%</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
# Length of Patient Stay

<table>
<thead>
<tr>
<th>Month</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2009</td>
<td>24 days</td>
<td>20 days</td>
<td>10 days</td>
</tr>
<tr>
<td>May 2009</td>
<td>20 days</td>
<td>15 days</td>
<td>11 days</td>
</tr>
<tr>
<td>June 2009</td>
<td>19 days</td>
<td>14 days</td>
<td>7 &amp; 15 days</td>
</tr>
<tr>
<td>July 2009</td>
<td>21 days</td>
<td>17 days</td>
<td>17 days</td>
</tr>
<tr>
<td>August 2009</td>
<td>27 days</td>
<td>14 days</td>
<td>14 days</td>
</tr>
<tr>
<td>September 2009</td>
<td>19 days</td>
<td>16 days</td>
<td>12 &amp; 24 days</td>
</tr>
<tr>
<td>October 2009</td>
<td>20 days</td>
<td>16 days</td>
<td>12 days</td>
</tr>
<tr>
<td>November 2009</td>
<td>16 days</td>
<td>12 days</td>
<td>8 days</td>
</tr>
<tr>
<td>December 2010</td>
<td>14 days</td>
<td>13 days</td>
<td>10, 11, 13 &amp; 17 days</td>
</tr>
<tr>
<td>January 2010</td>
<td>20 days</td>
<td>14 days</td>
<td>8 &amp; 14 days</td>
</tr>
<tr>
<td>February 2010</td>
<td>17 days</td>
<td>16 days</td>
<td>11 &amp; 16 days</td>
</tr>
<tr>
<td>March 2010</td>
<td>16 days</td>
<td>16 days</td>
<td>10, 15, 16, 7 18 days</td>
</tr>
</tbody>
</table>
Key Findings

• LoS from 24 days to 16 days in 3 months
• Cost reduction - £123,000 in 3 months
• Reduction in #NoF - adverse incidents complaints
• Key worker as- catalyst skills educator enhancer of communication
Key Results

• Design and implementation of -
  – An A&E Fast Track Guideline
  – A Fracture Booklet
  – A Hip Fracture Multidiscipline Forum
  – Patient Feedback Cards
• Contribute to National Hip Fracture Database
• Oramorph from medication trolleys
• 4 additional pressure mattresses + air slides
• Femoral Blocks & Pain control
• Ensuring hip fracture management is high on the orthopaedic agenda
Personal Development

The Key Worker

- Personal development – ODP/Ward Team
- Skills
- Importance of gathering data
- Evidence/ Utilising a structure/Methodology

Matron

- Additional Workload! Can this be achieved? - Role of a Matron/Additional Projects
- Evidence/ Utilising a structure/Methodology
- Organisational Psychology/Innovation Culture becomes the Norm
Conclusion

• The INMPP project enabled buy out time to facilitate the project and to employ the key worker.
• The cost savings have been able to demonstrate the need for this new role.
• Existing and new structures and processes in the hospital enabled the project to be supported with involvement from finance department, audit and quality office, research and development and INMPP support.
Using an INMPP award for a Package of antenatal care and education to reduce risk of repeat pregnancy in teenagers. Teenage Kicks

Nicola Lovett RGN, RM, BSc
Background

• Specialist team midwife in post for 18 months
• Work with all under 18’s in Great Yarmouth
• Work in partnership with third sector
• Gap noted in specific teen targeted care and information
• Very difficult to deliver healthcare when social needs have not been met
• INMPP approached
Rationale: Risks associated with teen pregnancy for mother

- Poverty
- Ethnicity
- Partner
- Disengagement from school
- Repeat abortions / pregnancy
- Poor mental health
- Smoking
- Looked after child
- Breastfeeding
- Educational attainment
- Involvement in crime
- Parental aspirations
Risks for baby with teen pregnancy

- Low birth weight
- Infant mortality
- Accidents
- Poverty
- Pre-term
- Behavioural problems

DCSF (2007) Teenage Parents Next Steps
Intended outcomes

• Increased compliance with care
• Improved health outcomes
• Improved breastfeeding rates
• Improved attendance to classes
• Increased multi agency working
• Improved quality of maternity care, and increased cost effectiveness
Action taken

• Specific health and social care pathway written
• Multi agency approach to health and social care started
• Work with third sector and partner agencies to design specific health information for young families
Overview of care pathway

• Low risk – assessed at home, invited to classes, referrals made, care by community midwife, discharged at CaSH

• High risk – assessed at home, care by specialist midwife, social care referral or CAF raised as appropriate, discharged at CaSH
Sexual health pathway

**Rationale:** To increase sexual health awareness, plan contraception and reduce subsequent unplanned pregnancies:

- Commenced by 12 weeks
- Reviewed at 28 weeks and 37 weeks to facilitate choice
- Discharged at CaSH clinic for midwifery discharge and contraception (LARC)
Designing information

- Focus group with young women to plan format of information
- Two art days with photographer and writer, and young women, to develop ideas and design end product
- End product is now completed; in form of magazine
Outcomes

• An audit of clinical outcomes for teenagers was undertaken prior to this study in 2008 (Group 1)

• Data collection for 2010 / 2011 caseload; the study was divided into two groups (Group 2a prior to use of the magazine, and involved in writing. Group 2b who had access to the magazine)
Response to “Teenage Kicks”

• “Good information, local people….”
• “It was written by other parents…..”
• “I like how it tells you everything you need to know about pregnancy and support about giving up smoking. Its good for young people to read, it is not pressurising”.
Breastfeeding
Breastfeeding Initiation

- **2008** - Initiation rate 30%
- **2011 Group 2a** – Initiation rate: 37%
- **2011 Group 2b** – Initiation rate: 62%
Breastfeeding Continuation (to 28/7)

- 2008 - Of those initiating, 30% continuation
- 2011 Group 2a – Of those initiating, 60% continuation
- 2011 Group 2b – Of those initiating, 69% continuation
Social Services Involvement

• 2008 – 45% of women referred to Children’s Services

• 2011 – 32% of women referred to Children’s Services

• 2011 - 22% of women were contained within the Common Assessment Framework (CAF) and avoided involvement with social care
Contraception

- 2008: 45% uptake of contraception
- 2011 Group 2a – 48% uptake of contraception
- 2011 Group 2b – 78% uptake of contraception
Smoking in pregnancy

- During the project, PCT requested smoking data, therefore included in the 2nd half of the study
- 72% of teenage mothers were smoking at booking (national rate 32% Source: Cancer Research 2005)
- 28% of teenage mothers were non-smokers
Smoking Cessation Rates

• 61% of women smoking at booking, subsequently gave up during pregnancy
• “Teenage Kicks” included a section on smoking, which teenagers responded well to
Attendance

• A new clinic venue has been found; multi agency working has led to increased referrals to other agencies

• Work weekly with smoking cessation team, breastfeeding team and nutrition team

• Clinic is full weekly, with noticeable reduction in missed appointments
Conclusion

INMPP has allowed staff finance and freedom to develop a programme of care.

INMPP has supported and guided specialist midwife through this process.

Clinical outcomes such as smoking cessation, increased breastfeeding rates, and increased concordance with care have improved.

Increased referrals and effective multi-agency working, has improved social outcomes.

Long term benefits not yet fully measured are increased uptake of contraception, and subsequent unplanned pregnancies.
Arterialised Capillary Blood Gas Sampling – INMPP

Fiona Lang – Sister EADU
The idea and aim

- To ascertain whether appropriately trained and competent nurses could obtain arterialised capillary blood gas samples, analysis findings and act accordingly.

- An additional aim was to see whether this practice enhanced the timely and effective management for the target patient group.
Past and future

- FROM:
- TO:
Why?

- Under utilised skill
- Less invasive and less painful
- Reduced requirement for repeated Arterial Stabs
- Utilises point of care opportunities
- To enhance timely management of care delivery
- Minimal cost saving however effective utilisation of existing equipment and staffing
Who?

- Contained, Defined and Manageable Patient and Staff Groups:
  - Acute COPDE leading in Type 2 Respiratory managed with Non-Invasive Ventilation
  - Band 6/7 Nurses and Respiratory Specialist Nurses
Where?

- Emergency Admissions Unit of a General District Hospital:
  - 2009/2010: Approx 25000 emergency admissions

- Catchment Population 230000+:
  - High Levels of Health inequality
  - High Levels of Smoking rates and obesity estimates > national average
  - High rates of limiting long-term illness and disability
How and time frame

- PHASE TWO: Educational Programme and Attainment of Competence: Oct 10 – Dec 10
- PHASE THREE: Service Improvement: Jan 11 – April 11
So it began.....
The project so far

PHASE ONE:

- Compared current management with BTS guidelines and trust policy - met criteria of management in 53% (1hr) and 59% (4hrs)
- Average time on non-invasive ventilation – 69.4 hrs
- Average length of stay 8.6 days
The project so far

PHASE TWO:

- Started from scratch
- Best technique, equipment, etc.
- Development and delivery of training package, protocols, policies and procedures
- Networking – Competence for the Trainer
- Support from medical and multi-disciplinary professional colleagues
The project so far

PHASE THREE:

Where challenges began !!!
- Unpresidented levels of acute emergency admissions
- Opportunity to apply new practical skill into practice
- Difficulties in mastering technique

Positives:
- Well received by patient group
- Enhancing timely management
- Comparable to arterial stabs
- Well received by medical colleagues
To date

- 12 nurses received training:
  - 1 x EADU competent
  - 3 x Respiratory Nurses competent
  - 6 x EADU advanced beginners
  - 1 x Respiratory Nurse advanced beginner
  - 1 x EADU nurse employed within different department

- Clinically:
  - Anecdotal evidence that preferred by patients
  - Well received by medical colleagues
  - Improving timely management
  - Expression of interest received from Respiratory Ward and additional professional groups for training
The freedom – in summary

- Project is still on-going
- Early indications suggest improvement in timely management
- Anecdotally – Patients prefer CBG to ABG.
- Valid alternative – Reducing amount of ABGs
- Reduced costs and length of stay yet to be proven
- Without the Innovations in Nursing and Midwifery Practice (INNMP) project there would not have been the time, infrastructure or opportunity to explore and develop the delivery of this clinical skill within this acute environment.
The future

- Competency achievement for remaining 7 nurses who have received training
- Cascade training to senior nurses within Respiratory ward, Hospital at Night, Outpatients
- Utilising skill within Oxygen Assessment and Monitoring both within the Acute Trust and Catchment Locality
- Pre-Discharge CBG and baseline monitoring within Respiratory Outpatients
- Ongoing review of protocol, policies and procedure, educational pack and competency document
Meeting our objectives

- Secured funding for 3 years
- Supported 12 nurses/midwife projects Run 4 cycles
- Directed 2 individuals into research degree studentships/scholarships
- Developed on projects for further funding
Conclusions

• Change of this nature takes time and sustained effort.
• Requires strong leadership, partnership working, a clear infrastructure
• Enabled front-line nurses and midwives to develop, implement and evaluate their own service improvement / research initiatives.
Sustainability

• Funding for future rounds of innovation projects?
• Planned exit strategy to ensure project is self sustaining
• Capability and capacity now at a level where sustainability is possible
• Maintaining strong HEI – Trust links
In summary

• Started cultural change
• Supported nurses and midwives with opportunities otherwise unavailable
• Increased research/organisational development savvy
• A plan to sustain it - £ - HEI
• Improved the care of our patients in a systematic way
Moore J, Crozier K, Kite K An action research approach for developing research and innovation in nursing and midwifery practice: Building research capacity in one NHS foundation trust

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