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Training for and Practicing as Health & Social Care Innovators  
Fanning, A.**

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***A Qualitative Study of UK Community Health Practitioners' Perceptions  
of their Personal and Professional Development after Training for and  
Practicing as Health & Social Care Innovators***

**Agnes Fanning**

A thesis submitted in partial fulfilment of the requirements of the University of  
Westminster for the Professional Doctorate Award in Health & Social Science

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## **Abstract**

This qualitative study explores the personal and professional journey of a group of healthcare professionals who undertook higher education (HE) or training in social innovation and put that learning into practice. Social Innovation is a relatively new concept in the field of health, and research is, in the main, confined to the structural and organisational aspects of innovation. Studies looking at the personal development of the innovators are rare, and no study has researched first-hand the experiences of new healthcare innovators as they learn how to set up and manage their own projects. Twenty-six community health professionals were interviewed. The participants were selected because they had either attended a HE programme or independent training on social innovation and were interested in setting up their own innovation in their clinical practice setting.

Individual interviews were achieved using Skype which proved to be an effective data collection method and allowed for a geographically dispersed sample. Thematic Analysis allowed several key themes to emerge from the data: the importance of personal resilience; increase in confidence; how levels of self-efficacy played a key role in their success; learning to shift from working in glorious isolation to seeking help from influential others. Improved technical skills and becoming better organised were also powerful factors. However, one finding proved pivotal to their success - finding themselves. The majority talked of discovering the 'real me' as a result of their learning, mixing with likeminded others and the first-hand experience of the struggle of developing a project, often in the face of opposition. For many, the positive changes transferred to their personal lives.

The findings suggest that many community health professionals have an inner drive to improve their clinical practice, but do not always know the best way to do this without formalised help. The educational input enhanced their learning and also impacted on their personal development enabling them to proceed with their innovations.

These findings are supported by research in the broader field of industry indicating that, whatever the context, there is a commonality of spirit, an ability to persevere and overcome adversity among innovators. These findings are therefore generalisable to others contemplating innovative projects in health and social care settings. In addition, the health and social professional curricula will benefit from including the subject of innovation within their educational programmes and subsequently staff and managers who work with innovative practitioners will also benefit from working with innovative professionals.

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Finally thank you to the reader for taking time to read this thesis. I hope you enjoy reading it and that you too are inspired by the innovative work that is currently happening in the community.



*Communications Arising*

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*Author's Declaration*

I declare that all the information contained in this thesis is my own work.

### *Definitions*

**Inductive data analysis.** When the meaning of the data is generated from the raw material and theories are developed. The data is not analysis by any predetermined framework.

**Skype interview.** A face to face talk between two people using Skype computer software.

**Innovation.** An idea, object, behaviour or object that is perceived as new by its audience.

**Social Enterprise.** Social enterprise as a phrase came into being to describe commercial organizations which had as their remit social and environmental change.

**Social Innovation.** Social Innovation describes a wide range of activities across the workplace with a philosophy that encourages the joining together of individuals with an innovative concept to propel social change through transformative forces (Fanning 2013: 258 in Sines et al 2013). Social Innovation also refers to new concepts, strategies, ideas and organisations that meet social needs (Oxford Dictionary, 2011).

**Thematic analysis.** An inductive approach to qualitative data analysis that is generic so can be used in a range of studies and is not linked to a particular theoretical perspective. It is a process which first *codes* and labels the material from across all the interviews then identifies broader *themes* from the codes. The themes as the basis for the data interpretation.

**Diffusion of innovation.** A theory that seeks to explain how, why, and at what rate new ideas and technology spread

**Rate of adoption.** The relative speed with which an innovation is adopted by members of a social system. The rate of adoption is a numerical indicator of the steepness of the adoption curve for an innovation.

## **Chapter 1 Introduction**

### *1.1 Background*

This section introduces the background to the study in three key areas. It then provides an overview of the thesis: 1) The origin of the research focus – a social Innovation programme for community health practitioners. 2) A brief history of social innovation. 3) A brief history of social enterprise. This is followed by an outline of the thesis.

The interest in this subject began with the researcher developing and teaching on a Post Graduate programme on social innovation for community practitioners at a University in the South East of England. The concept of social innovation was not familiar to many of the healthcare professionals who had enrolled on the programme but they had expressed interest in the programme because they had ideas about improving practice and were unsure how to put their ideas into action. The programme was a place to start. One of the key initial attractions to the programme, they claimed, was the unique way that it was marketed. Although all students had to be a qualified community health professional, recruitment did not focus on traditional academic level entry, but rather it asked questions such as, 'If you wanted to change anything what would it be?' and 'What is the bravest thing you have ever done?' The programme attracted students from across the country.

It was delivered through action learning sets and experiential learning in two-three day blocks over a period of nine months. This enabled students to build on their knowledge and put their ideas into practice, such as setting up a new initiative or project in their workplace. Key topics covered in the programme were: Reflection, lateral thinking, personal and professional values, creativity, innovation, understanding and reading accounts, economics of business, developing a business plan, implementing a project, dealing with failure, setting up a small business/social enterprise. Established external innovators (mainly in the field of health and social care) were invited to speak to the students, demonstrating that innovation is a real concept which can make a positive difference to patients and clients.

It is important to note that this current study is not an evaluation of the programme, the researcher is not concerned with the students' view of the programme itself, but is an attempt to better understand the impact of the learning experience on the

participants and how it impacted on their behaviour when implementing their own social innovation programme. As the researcher watched individuals grow in confidence both personally and professionally during the programme, it seemed to be a worthy research goal. The researcher had also heard other practitioners speaking at conferences and read about innovative projects that encouraged further investigation into this world of innovators in the community health workforce. Hence the idea for this research came about.

### *1.2 A Brief History of Social Innovation*

Social Innovation describes a wide range of activities across the workplace with a philosophy that encourages the joining together of individuals through an innovative concept to propel social change via transformative forces (Fanning 2013: 258 in Sines et al 2013). Social Innovation also refers to new concepts, strategies, ideas and organisations that meet social needs (Oxford Dictionary, 2011). Social innovation is not a new concept and has been around since the beginning of the seventeenth century, but McSherry & Douglas (2011) recognise that it is relatively new in the health field with the Department of Health investing money to promote innovation in the work place in 2009 (DH, 2009) and since then NHS policies have been promoting innovation (DH, 2010, 2011,2012). Not only in the health field, but nationally there appears to have been a resurgence of social innovation in the second half of the twenty first century with a number of social entrepreneurs who are already waiting and ready to be acknowledged and supported (Clark, 2009). This is particularly evident in the health setting as community health services are being transformed and new ways of working will require support at senior levels to encourage new ideas and new ways of working to be implemented.

The aftermath of the French revolution saw the entry of the term social innovation into the English vocabulary and it has been used extensively in ensuing decades since then (Social Innovation 2012). In Burke's (1790:64) words, '*Innovation is revolution – and revolution is innovation*', confirming that to innovate is not to reform. Outside of the health service evidence of this is seen in social innovations such as the introduction of The Open University and The Big Issue. Both of these innovations

have benefited communities by providing education in non- traditional ways and providing work and an income for the homeless in communities across the UK. It is almost certain that such innovations as the formation of the Franciscan Order in 1209 would suggest that St. Francis of Assisi would be one of the first social entrepreneurs (Bornstein, 2010) as it was an innovative concept to create an environment that met the social, as well as the spiritual needs of people. In 1952, Glidden & Powell (cited in Harris, Bennet & Ross, 2013: 5) spoke about Muriel Powell who was head of the London Teaching Hospital Matrons Association, her approach to patients was to address them as individuals and not refer to their bed number or medical condition. Today this seems a natural approach, but in 1952 this was an innovative way of carrying out holistic patient care. In more recent times, Mulgan (2012) gives further examples of successful innovation – Which Magazine, Healthline and International Alert. These ideas were the brainstorms of individuals which, with support, have grown into very successful global businesses and would come under the auspices of a social enterprise. Health professionals can learn from these innovators as skills used to promote innovation are transferrable to any situation, not just global enterprises and currently there is an emergence of social innovations, particularly in technology, being developed by health professionals (Jiwa et al, 2014, Doyle et al 2014, Fiedler et al, 2014, Sarhan, 2014). Social Innovation is about taking new ideas that meet unmet needs (Mulgan, 2007), of which there are many in community health services, but the process from the initial idea to the implementation of the concept may take some time and collaboration is required to assist in the many boundaries and challenges that may be met along the way (Simpson, 2009). These challenges may come from a variety of sources, such as colleagues, peers, managers and patients themselves. A related term is Social Enterprise (SE) which can be confused with Social Innovation (SI), but SE is different in that a social enterprise is a business that is trading for social and environmental purposes not simply its own and they put their profits back into benefitting the community, whereas Social Innovation refers to new concepts and ideas and is not necessarily linked to profits.

### 1.3. Social Enterprise

Social enterprises in the UK have been in existence since a workers' co-operative was set up in Rochdale in 1844. The idea was to provide quality food in response to what was considered exploitative factory conditions. Gradually these co-operatives developed across the country and in the 1990s the term 'social enterprise' came into being noting that many organisations had been using the power of business to bring about social and environmental change, but there was not an overarching name for this, as such 'Social Enterprise' was established (Social Enterprise, 2010). According to the Small business Survey in 2010 it was claimed that 5.7% of all small and medium-sized enterprises were social enterprises with only a minor percentage health related. The survey identified that there were 68,000 social enterprises in the UK, but Findlay (2012) from the Social Enterprise Mark Company disputed these figures stating that a number of the enterprises had not met the legal requirements to become a social enterprise.

A similar concern was voiced by Social Enterprises UK (2012) which are independent of the state, who were worried that businesses may 'hijack' the term social enterprise when they do not meet the philosophy of a social enterprise. However a further study was carried out in 2013 and suggests that at that time there were approximately 70,000 social enterprises in the UK which contributes £18.5 billion and employing up to one million people (Social Enterprise, 2013). Those businesses whose stated aim to change the world for the better through trading to tackle social problems, improve communities and people's life chances for the environment have the underpinning ethos of a social enterprise as they reinvest their profits back into the business or local community (Bornstein, 2012). So when *they* profit, *society* profits. In brief, a social enterprise is a business that is trading for social and environmental purposes not simply its own efficiency. Small social enterprises can remain connected to large organisations, such as the NHS, without actually being embedded in the chain of management within the organisation (Walsh, 2014) and evidence of this is discovered in the research.

## 1.4 An outline of the thesis

This thesis is made up of eight chapters. Following this introduction, *Chapter 2* reviews the literature on social innovation internationally, nationally and then within the National Health Service. Global innovations and innovations within the United Kingdom will be presented and the role diffusion plays in implementing innovative projects will be discussed. Since the publication of *Our Health, Our Care, Our Say* (DH, 2006) the concept of innovation has been encouraged within the NHS. Numerous small scale successful projects have been set up, but there seems little evidence of these being benchmarked across the sector. There is a tendency for them to remain as individual projects and awareness of these projects are only known in a local context. The NHS is a large institution which relies on managers to support their workforce but there is evidence that lack of support on occasions and other organisational barriers have prevented some innovative projects being implemented (Carr,2010). Staff may be confronted with challenges from a variety of sources, such as colleagues, peers, managers and patients themselves which will be discussed in chapters 2 and 7.

1.4.1 Chapter 3 will address the research approach and methods of the study which was carried out during the period of 2012 -2015. It is divided into six sections: the first outlines the rationale for choosing a qualitative approach for this study. The second section addresses the sampling and recruitment strategies and methods. The third discusses the data collection process, issues arising and how they were overcome. The fourth outlines the specific analytical approach and procedures undertaken, and how they are based on Braun & Clarke's (2006) guidelines. The fifth section focusses on the ethical concerns of the study and the trustworthiness of the findings. Finally, the issues around quality assurance and research governances are discussed.

1.4.2 Chapter 4 presents the first phase of the findings which explore the emerging themes underpinning the individuals' initial desire to step forward and make changes within their organisation for the benefit of their patients and the barriers they faced in doing so. It also identifies some of the participants' personal characteristics which, in part, help drive them forward and their early experiences of working with senior management which went on to influence their later work.



1.4.3 Chapter 5 presents the second part of the findings which demonstrates the personal and professional development reported by the participants as they move forward with their own projects. The change of perception regarding the participants' self-perception shaped this chapter which focussed on '*the real me*'. Participants of the study reported some profound personal changes as they attempted to operationalise what they had learned on their programmes.

1.4.4 Chapter 6 presents an overview of all of the projects that the participants were involved in. Details of four case studies will be presented. Two of the case studies were successful projects and two of the case studies did not progress and the rationale for the success/failure of the projects will be discussed.

1.4.5 Chapter 7 discusses the findings and is divided into four sections. Firstly *confidence and self-efficacy* in the knowledge that the participants knew their specialist subject area was evident. Some had an innate confidence from the onset and the additional understanding of practicing innovatively enhanced their confidence. Others only recognised their confidence when their change in clinical practice demonstrated that they were working more effectively and patient satisfaction was increasing. As their self-belief developed it unravelled a *resilience* which became a distinguishable factor in the findings. The resilience discovered encouraged the participants to work differently experiencing change in the workplace, thus *working differently* was another key factor in the findings. Fourthly, how *post qualifying education* and learning relevant skills to set up an innovative project has enhanced their clinical practice will also be discussed. What additional skills did educational programmes give to participants enabling them to pursue their innovations effectively? Examining everyday discourse used in the nursing and health educational literature identified common attributes, antecedents and the consequence of post qualifying education (Gallagher, 2006). As a result of the findings in this research study the relevance of post qualifying education for health professionals is discussed. This chapter will revisit the findings and will present the recommendations, limitations of the study and finally the conclusions.

1.4.6 Chapter 8 is a reflective account of the researcher's personal journey carrying out this research study. Reflexivity is revisited and discussed as it is central to the theoretical approach adopted. The chapter closes by sharing the personal and

professional development of the researcher of which similar traits seen in the participants are also evident in the characteristic of the researcher.

## **Chapter 2                      Literature Review**

This chapter will look at literature on innovation from a global perspective. It will look at the history of innovation in the NHS and proceed to review Department of Health policies in relation to innovation today. Influences of the diffusion of innovation on community health professionals and the organisations in which they work will be reviewed and the enablers and inhibitors to implementing innovation will be investigated. The bulk of the literature on Social Innovation is written in general terms about why it is a good idea and how to operationalise it, little has been written about the impact becoming an innovator has on individual practitioners. Therefore, given that the focus of this research is the personal and professional development of UK healthcare professionals some who have after undertaken a post graduate course in social innovation and others who have attended programmes where innovation is explored, the impact of continuing professional development for community health professionals will be reviewed. While not focused specifically on innovation, this continuing professional development literature offers general insights into the impact of study on mature students and has value here. Finally the contribution to original knowledge that this study offers is set out.

### *2.1 The global context of social innovation*

Social Innovation is a globally accepted concept relating to the development and implementation of new ways of thinking and working within a wide range of professions in order to promote the wellbeing of society, and the global flow of knowledge, skills and ideas has been a defining feature of human progress (Shamsuzzoha et al, 2013:1). The World Economic Forum is one of its founders, aided by The Social Innovation Exchange (SIE), an international organisation formed in 2008 and located in Australia. Both these organisations have the aim of supporting and inspiring social innovation practitioners worldwide. The SIE which works with a number of social care organisations researching ideas and the practical experiences of existing social innovation projects, offers the following definition of Social Innovation:

*'Innovative activities and services that are motivated by the goal of meeting a social need and that are predominately developed and diffused through organisations whose primary purposes are social'* (Mulgan, 2007: 15).

Further commentary on the topic comes from The Theoretical, Empirical and Policy Foundations for Building Social Innovation in Europe (TEPSIE), (2014:10) who suggest that social innovation is an opportunity to address the challenges that face public institutions such as the NHS, as innovation is an opportunity to modernise and improve the service. They also suggest that there is emerging literature focused on learning from frugal approaches to innovation, which is about improvising solutions to problems using scarce resources, based on a high understanding of local needs.

The two way flow of ideas between emerging and more developed areas of the world encourages innovation across economies. The perception that innovation is a one-way traffic and originates from a developed part of the world is not always the case. 'Innovation blowback' or 'reverse innovation' as a concept is important to understand when reviewing innovation from a global perspective as the innovation may have originated from a developing country prior to spreading to the 'developed world' (Shamsuzzoha et al, 2013:1). One such example is when Procter & Gamble developed a cough medicine in Mexico to treat the local population. It was a success and subsequently it was introduced into Latin America and eventually the United States. There are numerous other examples such as the cardiac machine that was developed in India and is now sold to the United Kingdom where it is located in businesses across the UK. However, Harris et al (2016) suggest that care should be taken when using this term as it suggests a 'cultural arrogance' since 'reverse innovation' resonates differently with each person and is dependent on the context. It could be seen as patronising, particularly if the learning is coming from a low-income country, hence suggesting that this term be replaced with 'learning from others'.

Kaya et al (2015) attests that innovation is the underlying principle of health care services across the world, resulting in significant health improvements for patients, but this is rarely recognised as innovation. In support of Kaya's (2015) findings, literature from outside of the United Kingdom (Welch 2008, Suhonen & Paasivaara 2011) relating to innovation in nursing identifies that it is the knowledge, confidence

and belief in an idea that has enabled projects to be implemented, rather than just the good idea on its own. In addition, several global perspective research studies have also been carried out on social innovation (Goldenberg et al, 2009, Murray et al, 2010, Goldsmith, 2010, Gardener et al, 2007), and one of the key findings was the obvious drive and passion that the practitioners had for their individual innovations. The Department of Health Social Enterprise Investment Fund (DH 2009a, 2012) confirmed this too, claiming that enabling staff to develop their ideas has resulted in better motivated staff who have ownership of their idea, giving them more freedom to be creative with regard to the health needs of their population. There is also a wealth of literature from Canada and USA relating to innovation in health care; the overall findings show that the methods of communication and the culture of the organisation are essential if an innovation is to proceed successfully (Torrie et al, 2009, Dreidger et al, 2010, Lin et al, 2016). In the UK O'Leary (2011) reports the success of a training programme for care home healthcare professionals, enabling them to monitor and review at an early stage patients who are at risk of malnutrition, which prevents hospital admission. This is just one example of many evidence based projects that promote innovation in the NHS (QNI, 2014, Dean, 2011, Adams et al, 2011, Butterworth, 2013, Kendall-Raynor, 2013, Davis, 2011) but since Lord Darzi's policy on promoting innovation in the NHS (2009,) this evidence based information is continuing.

## *2.2 The impact of Social Innovation*

There is an increasing amount of literature on the impact of innovation within the NHS (Trueland, 2014, Davis, 2011, Fitzgerald, 2003, Kendall-Raynor 2013, Brooks et al, 2011, Smit et al, 2013, Lennan et al, 2014, Andrews et al, 2013, Adams et al, 2006), with much of this literature based on technical innovations that are supporting patients to manage their own medical condition (DH,2011b, DH,2011f, Jiwa et al, 2013, Sarhan, 2014, Singh et al, 2010, Gardner et al, 2007, Skinner, 2010). The literature highlights that one of the major factors to be considered when judging the effectiveness of any social innovation intervention is the relative advantages of the innovation over existing practice. The advantages will not be the same for all innovations as some will emphasise the economic benefits whereas others,

particularly 'in the third world', may focus on quality of life (Goldsmith, 2010, Holland et al, 2012, Shamsuzzoha et al, 2013).

Examples of new initiatives that are aiding people living in Africa are: 1) supplying portable water pumps to assist sub-Saharan smallholder farmers to grow crops out of season, 2) a cardio-pad for people who live in rural areas and do not have access to medical services. It is a computer tablet which diagnoses heart disease. It recognises people who are at risk of heart disease or hypertension and they can be treated without having to travel up to 900 kilometres to visit a cardiac specialist, 3) growing sweet potatoes which contain levels of beta carotene six times higher than that contained in a regular sweet potato, to help fight childhood blindness. In Africa it is estimated that 28% of children have Vitamin A deficiency (Holland et al, 2012).

The literature indicates that the measures of success are locally developed and assessed. For example, a reduction in childhood blindness and lower mortality rates for heart disease as mentioned above. Overall the literature shows that as a general concept social innovation is regarded as successful and as a practice it has endured (Bessant et al, 2012, Mulgan, 2012).

*Reflection:*

*It is interesting to note that so much can be learnt from the third world initiatives. There has been a tendency to suggest that it is the UK and other developed countries that are the leaders in innovation, particularly in health. I found it fascinating to learn that the UK have taken on initiatives from third world countries and the literature has proved that where there is a desperate need for change as a means of benefitting society then every avenue needs to be explored. I would like to see this philosophical attitude adopted by staff in the UK health service.*

### *2.3 History of Innovation in the NHS*

Innovation has been constant within the NHS since its formation in 1948 and this has been mostly in the field of research and technology. It is mainly evidenced by the introduction of new drugs, imaging systems and medical devices. However some commentators suggest that 'new software packages or internet sites may be designed to prevent innovations from disrupting the status quo' (Block, 2013:47). Although innovation in health care is sorely needed, most changes bring, at minimum, the need for revised workflow and education, or at maximum, a complete

redesign of longstanding processes (Gosselin et al, 2015). Either way, change creates the need for health professionals to unlearn old practices and procedures which often results in anxiety, uncertainty, and distress for practitioners, confirming Obholzer's (1994) thoughts on increased anxiety.

In 2010 the Department of Health carried out an evaluation of 26 social enterprises across the health and social care sector, demonstrating that social enterprise was a catalyst for delivering services in an innovative and improved way. However, the report looked at social enterprise from an organisational point of view only, as does Obholzer (1994); neither looked at the individual perspective of the innovator. Two studies that did begin to address this are Bettencourt (2010) and Gibson & Kelly (2010) who stress that innovation in practice will only happen if an organisation has a clear vision which frequently includes a rethinking of health care roles and a change in the way people are allowed to practice.

The need for innovation is indeed urgent as indicated by Bessant, Kunne & Moslen (2012) with increased concerns over the economy of the health care system in the UK, a view which is also supported by Jiwa et al (2012:5) claiming that 'healthcare systems in the early 21<sup>st</sup> century are facing a crisis'. Over the last decade UK governments have had to manage the increasing demands on the National Health Service, and have recognised that providers will need to deliver their services differently – more effectively and at less cost. Therefore, the significance of social enterprise and innovation within health care has grown in importance. Lord Darzi's *NHS Next Stage Review* (2009) was aimed at stimulating innovation in the NHS working with the Health Innovation Council to act as 'guardian' for innovation and to provide guidance and strategic advice (NHS, 2009). He promoted innovation across the NHS, claiming that an innovative culture cannot be led from the centre and would be best placed in localities ((NHS, 2009). Additional government funding of £220 million was divided equally across the ten strategic health authorities (localities) with the emphasis placed on health improvement and patient empowerment and engagement (NHS, 2009).

A year later the White Paper (DH,2010), which promotes innovation and supports the Big Society agenda (Govt.agency, 2010) in two ways, recommended firstly that the bureaucratic and hierarchical management model be challenged by devolving power

to local organisations in order to design the best responses to public health issues. Secondly, it suggested putting the patient at the heart of the process with clinicians, nurses and allied health professionals playing an essential mediation role in working with patients, communities, GPs and local authorities to deliver improved health and public health outcomes.

It is noteworthy, that like the international research, the literature on the NHS promotion of innovation paid little attention to the personal development and impact of new processes on individual practitioners.

The Queen's Nursing Institute who have been supporting nurse-led projects since 1990 have seen a massive expansion of projects that are improving patient outcomes within the NHS since the emphasis on innovation has increased (QNI 2010, 2012, 2014). The outcome of such nurse-led projects evidenced in the QNI impact reports (2011, 2012, 2014) underpin The NHS Institute for Innovation and the Improvement and National Innovation Centre (2011) claims, that most innovation actually comes from staff working close to the patient and not, as many people suggest, that the innovation comes from policy makers and senior physicians.

The intention of the NHS is to raise the scale of innovation in the UK and, to support this, they have developed an innovation team to act as internal expert consultants (NHS, 2015). However, the NHS policies that are promoting innovation look at this from an operational perspective, not giving attention to additional education or training that might be required to support the staff working in the NHS. Since 2006 there has been a drive within the NHS to promote social enterprise (DH, 2006) and with the publication of *Our Health, Our Care, Our Say* (DH, 2006) there is evidence of more nurse-led innovations being set up (QNI, 2014, Dean, 2011, Adams et al, 2011, Butterworth, 2013, Kendall-Raynor, 2013, O'Leary, 2011, Davis 2011). This list is not exhaustive as many small scale innovations are in place, but the findings have not yet been published. The impact that has been demonstrated in the literature to date has proved there are better outcomes for the patient and greater autonomy for the practitioners. This is positive news, and Davis' (2011:6) article demonstrated how a 'chronic illness case-management service for community nursing achieved a total saving over a nine month period of more than £400,000, with an average cost reduction of almost £1,500 per patient, as well as greater satisfaction'. O'Leary



(2011) spoke about an oral nutritional supplement prescribing review which focused on patients who were potentially at risk of malnutrition. Community staff and care home staff were trained to screen, treat, monitor and review patients at risk of malnutrition. With the implementation of this initiative it is estimated that the saving to the clinical commissioning group would be up to £200,000. Another example discussed by O'Leary (2011) was a review of the transport services for patients requiring haemodialysis, whereby patients were grouped according to their postcode and where possible their day for dialysis changed to fall in line with their postcode group, giving rise to an estimated saving of up to £164,000 for the clinical commissioning group. These examples are not to be disregarded, but what is not known about these innovative projects is what the drivers were that made these innovations succeed. These are excellent examples of good practice but it would be interesting to know whether any of the clinicians behind these innovations had received education or training in how to set up a social enterprise or develop a successful innovation. The literature does not give background educational information about these individuals, only details of the clinical area in which they worked.

#### *2.4 Direction of Innovation in the NHS*

As this evidence of innovation continues to grow, Sir David Nicholson, Chief Executive of NHS England, said that 'Innovation must become core business for the NHS (DH, 2012a) suggesting that NHS commissioning boards must promote innovation. This statement builds upon Lord Darzi's views put forward in the report '*High Quality Care for All*' (DH, 2008) where he presented a vision for the future of the NHS with a key aspect of the report promoting an escalation of innovation in the NHS. This is followed in 2009 by the NHS Constitution (DH, 2009) which promised a commitment to innovation. This commitment involved the Health Service Management Centre (HSMC) recommending ways that innovation could be supported, which involved; factoring time for leaders and managers to attend training and to visit areas of innovative practice, providing support to build on previous experience of what does and does not work, valuing innovators through incentives, using techniques to share knowledge and to nurture individuals who are demonstrating innovation (Skinner, 2010). The DH policies generally make broad

statements about promoting innovation such as 'Increasing access to healthcare, maintaining wellness and reducing the cost of treatment' (Jiwa, 2013), but in this time of low morale within the workforce policies should be seen to be actively promoting innovation and directing staff to ways of implementing innovation into their everyday practice, which unfortunately the directives from government are not doing. Currently the NHS is relying on individuals to drive innovation forward, rather than encouraging all staff to become innovative in their ways of thinking, which is contrary to what the Department of Health is suggesting.

Another factor to consider when reviewing the Department of Health policies is that the drive towards innovation does veer towards those in higher positions such as consultants who are in a position to negotiate at a strategic level, rather than the frontline workforce of nurses and allied health professionals. *The Five Year Forward View* (DH, 2014) reaffirms this as it talks about new forms of integrated care being the blueprint of the NHS as a whole. This cannot happen from frontline staff alone; it has to become a directive from senior management and all staff should work together to implement these changes. *The Five Year Forward View* (DH, 2014) also refers to technical innovation and large-scale projects which require input from senior clinicians and technical staff and not necessarily front line staff. NHS England (2017) currently sends out monthly bulletins informing health trusts what is happening in the world of technology and how it is impacting on patients and workload. It is an excellent way of informing staff of what progress is being made in relation to patient technology, but it would be extremely helpful if there was additional information for staff on how to use the technology.

A further means of promoting innovation is the joining forces of academics and clinicians to form an Academic Health Science Network (AHSN); the aim being to develop innovation in localities. Once again, there is an expectation that new initiatives that result from the AHSN are disseminated across all levels of the workforce.

Front line staff working in a specific area, such as diabetes may be involved in the innovation as it requires a multi-disciplinary approach. Also patients who are at the interface of nurse-led care have spoken out in favour of innovative practitioners (QNI, 2014). Contrary to this view Gibson & Kelly (2010) deliberate whether it is right

to expect frontline staff to change practice, whilst balancing all of the responsibilities of their clinical roles. Disputing Gibson & Kelly's (2010) view, Lansley (2012b) promotes the notion that innovation should come from front-line health care professionals, '*putting the patient first*' and challenging the top-down, target driven culture that underlies the current NHS system. The Department of Health (DH, 2009a: 43) claimed that it would '*align its entire work programme to support NHS organisations to meet the challenges ahead*'. It is obvious then, that community health professionals will require knowledge and resilience to be able to deal with the challenges that they will be confronted with in attempting to implement any new initiative. This approach is also reinforced by Lansley's controversial, yet insightful view that '*the National Health Service requires healthy competition, which potentially will result in innovation*' (Lansley, 2012). Research in this area is therefore required to inform managers and participants of the effectiveness of the current mode of delivery, and without further research and additional knowledge and education in becoming an innovator, innovations will become vulnerable to the vagaries of policy changes.

*Reflection:*

*Emphasis is on the importance of vision and it is obvious from literature that practitioners may have vision but they do not always have the relevant skills and knowledge to do anything about this. It is distressing to read that in many cases, unless a manager shares this vision innovations may not develop. The message by Nicholson in 2012 saying that innovation must be at the core of health business has not been emphasised enough to managers who are frequently either the enablers or the inhibitors of an innovation.*

*It has been frustrating reading the literature as there is a lot of emphasis on innovation in the health service, particularly since the publication of *Our Health, Our Care, Our Say* (DH, 2006) yet this message is not being recognised by the front line staff who frequently see this as just another change. There remains a gap in the literature regarding how to implement an innovative project and how to get heard. O'Leary (2011) talks about gaps in knowledge, but does not delve into any explanation how to fill this gap. I also anticipated that there would be more literature on the evaluations of projects which has not been evident. These are two areas where further research could be carried out.*

## *2.5 The future of innovation within healthcare*

The health policy at the time of the coalition government (2010-2015) saw major health reforms, mainly driven by the health minister Andrew Lansley whereby he

promoted innovation despite the rigidity and bureaucracy within the NHS. He wanted to remove the numerous layers of senior management and devolve the power to the general practitioners. At the same time The Darzi Report (2010) was recommending care closer to home and increased patient choice which placed community practitioners central to driving innovation forward by providing an increased service to patients in the community and also promoting health promotion and prevention of hospital admissions. It says that more innovation should come from the front-line of nursing and other allied health professionals. This would enable innovative services to be developed that 'put the patient first' and challenge the top-down, target driven culture that underlies the low morale found in so many parts of the NHS. Yet, Lansley (2012) claims that what the NHS requires is a healthy competition, claiming this will result in innovation. Lansley's views are not welcomed by all though, as the Kings Fund published a review in 2015 which claims that Lansley was forcing the NHS to reform itself, ignoring traditional hierarchical roles and traditions which in essence was a disaster waiting to happen. However, they suggest that Jeremy Hunt, the current health minister should not veer away from new reforms, but make sure any new reforms are implemented and executed correctly. Additional suggestions include placing less emphasis on regulation and more on supporting leaders and staff to improve care. In essence this is not dissimilar to Lansley's policy as both health ministers speak about bottom-up changes to the NHS with an emphasis on quality of care.

### *2.6 Innovation in Care Closer to Home*

Staff working in the NHS have witnessed a political drive to deliver health care closer to home (DH, 2010) and at less cost. With the move of health care services being delivered in Primary Care, traditional practices must therefore be challenged to make way for innovative approaches to care (Sines et al 2009). Established community health care delivery is defined as an ongoing process of improving people's lives and alleviating the underlying socioeconomic conditions that contribute to poor health (WHO, 2012). Key professionals involved in promoting this care would include district nurses, health visitors, school nurses, community children's nurses, community mental health nurses, learning disability nurses and allied health professionals such as occupational therapists, speech therapists and

physiotherapists and members of these wider teams. With the decline in health care staff numbers, in particular district nurses where there has been a decrease of over 40% in the past decade (QNI, 2013), the reduction in numbers has caused widespread concern regarding the capacity to deliver quality care. In June 2013, for example, over 20% of district nursing courses in England did not have any students enrolled on their programmes (QNI, 2013). However, at the same time with the merging of organisations which deliver the care, staff are being encouraged to be creative in their practice, yet remain within the boundaries of their professionalism. Pesut (2013) suggests that if health care professionals are provided with innovative models of service delivery and resources this will assist them to think more creatively, enabling them to work more effectively (reducing costs while maintaining or improving the quality of care) within the health care system.

### *2.7 Intrinsic and external factors in relation to innovation*

Although challenging, it is thought that working with innovative models of care can be achieved, but will require a radical shake up of established ways of working and additional staff training within the NHS and wider field of social care (Lansley, 2012c, Goodwin et al, 2013). With the current changes of transforming community services and the Five Year Forward View (NHS, 2014) many community health professionals will be in a position to present new ways of working, but it will be essential to have management support to drive any new initiative forward. A systematic review carried out by Chaudoir, Dugan and Barr in 2013 suggests that effective leadership cannot be disregarded and the culture and the emphasis placed on evidence-based practice within an organisation will play a crucial role in whether innovation is prioritised within an organisation.

Overall, the underlying thrust of Social innovation is to encourage the participation of an entrepreneur to work with individuals and communities in the promotion of well-being not only *for* the community but also *with* them (Hubert, 2010), identifying new ways of working and participating with the local community for a positive social outcome. It is not meant to be a replacement for services already in place, but should be seen as supportive in introducing innovation to an already existing service that may not be reaching its full potential, but applying an idea to produce something new and useful' (Paterson et al, 2009). Murray et al (2010) however points out that a

successful social innovation project should take account of a number of changes such as organisational, financial and any relationships with stakeholders and territories. Considering this viewpoint, no solution has been provided as to how innovators can develop these additional skills in finance, communicating with stakeholders and commissioning services. In recognising a number of constructs that represent aspects of any innovation Chaudoir et al (2013) state that the social, political context must be clear and the scope and purpose of any stakeholder involvement, patient benefit and management support must be understood if the innovation is to be implemented successfully. They also mention that the innovation should be supported by policy and have the relevant funds to see the innovation through. Nevertheless, innovations may not always have these structures in place, which may be why there may be difficulty for some in getting their innovations supported by their organisation.

A key factor in support of innovation as suggested by O'Leary (2011) is to target learning where there are gaps in knowledge by staff wanting to be involved in an innovation in the clinical practice setting. However, O'Leary does seem to suggest that this is referring to clinical knowledge and not the wider skills required, such as financial acumen to set up a project. When implementing innovation in practice Smit et al (2013) stress the importance of characteristics and attitude, claiming that a positive attitude is a major attribute required, also suggesting that self-efficacy as a construct plays an important role in promoting innovation.

There also appears to be some cynicism regarding nurse innovators, as views such as Cheater's (2009) claim there is little evidence available on the impact that nurse-led innovations have had on community services. Nonetheless, the examples mentioned in an earlier paragraph demonstrate the worth and value of nurse-led innovation but there is a need for further evaluations to look at how innovation has impacted on the service provision and also on the individual health professional implementing the innovation. Also what skill set and knowledge was required to set up the innovation and how did the practitioners acquire these skills?

## *2.8 Setting up an innovative project*

The traditional perception of individuals involved in social innovation (often called social entrepreneurs) is that they may be a little eccentric, often a loner, but passionate about making a change to society aiming to systematically transform an unfair societal position (Martin and Osberg, 2015). Previously mentioned is the conception of *The Big Issue* which was founded by John Bird & Gordon Roddick (1991) as a means of offering homeless people the opportunity to earn a legitimate income. They are examples of individuals who had a strong belief in their idea. Their way of achieving the fulfilment this passion was to observe people and learn from them and they had the ability to visualise a better life for the homeless. This particular innovation project has gone on to improve the lives of many homeless people, easing a social problem and is still going strong 20 years on. What was it that made this such a success? It was an observed gap in social provision and the belief that they could make a positive difference to society. Bird & Roddick filled this gap in social provision but what is not known is what additional support was required to set this up. How was their business case presented? Where did the funding come from? There remains a gap in the market regarding the skill set and support mechanisms in place for innovators in the health and social care sector of community provision.

## *2.9 From theory to developing a skills base - Enablers & Barriers*

The philosophy of social innovation encourages the joining together of individuals by an innovative concept (Fanning, in Sines et al, 2013). It is an expectation that all practitioners and team members will be encouraged to work within this concept to enable the 'idea' to become a reality. Notwithstanding these facts there remains a requirement for better understanding of how teams within an organisation can either support or hinder an innovation (Strating and Nieboer, 2010), therefore as the transformation of the social innovation takes place it may change the way people relate to each other. Individuals will need to work through this process to make this happen, whilst recognising that taking a notion through from *idea* (concept) to *actual* (practical application) suggests that an element of risk is probable as innovation and

risk are inextricably linked according to Fleming and Kinder(2015). Risk can be determined by the social structural factors of the organisation and individual characteristics. However, according to Robinson (2014), there are a number of characteristics evident in entrepreneurs that are essential for an idea to succeed, these being, tenacity, passion, tolerance of ambiguity, vision, self-belief, flexibility and rule breaking which are essential to tolerate risk. He suggests that tenacity is the most crucial element as it deals with the notion of 'failing' so the innovators need to have the strength to learn from this. It will almost definitely require a change to the 4Ws – Who, What, When or Where of service delivery (NHS, 2009). Nevertheless, even with this understanding of taking risks it is estimated that approximately 50% of innovation projects within the public sector fail (Tidd and Bessant, 2009). There appears to be little evidence about how management accept risk.

There are concerns in this unstable economic climate where jobs are being lost and constant spending cuts are threatened that individuals might consider that developing any innovation is a risk (Cheater, 2009). Changes in the way services are delivered must be managed diplomatically as potentially these may cause some disagreement amongst teams and management. Nevertheless, in view of Lansley's (2010) recommendation to promote innovation and integrate practice, education and research this provides an opportunity for community practitioners to be vocal in their attempt to promote this new way of working as they plan, develop and put their ideas into practice (Bornstein, 2007:22). In doing so, organisations such as community trusts, independent service providers and policy makers become aware of the benefits of working with social innovators, thus breaking down many of the barriers that exist today between public sector organisations and social enterprises. To this end Innovation should become a way of life at all levels of clinical practice as suggested by Nicholson (2015), but in some instances this might prove difficult as clinicians may not be willing to change their behaviour and the organisations themselves may not want to change, suggesting that 'the combination of these factors could potentially inhibit learning and generating ideas' (Gopaldasamy 2010: 5). However, if a culture of leadership practice, whereby having a stake in a venture increases, both organisational and individual commitment to the 'idea' (Raelin, 2010) could potentially promote learning and the generation of new ideas across organisations. Yet, traditionally, the public sector as an organisation tends to be



averse to risk (OECD, 2015), possibly because innovation implies a certain amount of experimentation and inherent challenges associated with innovations in public health services which requires an 'understanding of the art and science around the actual innovation and the organisational context where it occurs' (Joseph, 2015:172). It is therefore advisable to pay attention to those health professionals who are actively trying to get their voices heard in driving innovation forward. Yet, Davis (2011) has commented that nurse managers are in a unique position to support staff and that this vantage point enables them to identify challenges and how to deal with them so that they can drive efficiency and innovation forward.

*Reflection:*

*I was surprised to read that many practitioners did not want to rock the boat and be seen as trouble makers which potentially has meant that some innovations have not been taken forward. On the other hand the transformation agenda for community services is creating a vulnerability amongst the workforce which has seen a 'business as usual' attitude rather than looking at new ways of working. Telehealth is an interesting concept and has been given a lot of recognition. Yet, in the wider context, as technology is advancing at a rapid speed it could be argued that it is inevitable that technology would be used in the health service and as such is not innovative but is an essential means of progression.*

*Communication is a theme that runs throughout most nursing and allied health professional programmes yet many of the barriers identified in the literature have come about due to poor communication. It was not surprising to note that some managers may be wary of their staff having more knowledge in certain areas and thus feel more threatened. It is essential therefore that managers are given tools to assist them in assisting others in reaching their potential.*

## *2.10 Skills for successful innovation*

Reportedly, innovators typically have a *vision* of a better service provision and have that inner drive and passion to act on it whilst there is a need for the change (Brookes et al, 2011, Nieboer et al, 2012, Pekkarinen et al, 2011). Their main focus is to improve quality of care for their patient/client. Drucker (1957:45) was a great follower of social innovation and supports social innovation, claiming that we require social innovation more than we require technical innovation and that it is a part of a theory of social change (Bornstein, 2007:27). However, the amount of technical innovation that has occurred within the NHS has seen greater interest and investment than those innovations not involving technology (Hellstrom et al, 2002, Oborn et al, 2011, Bacigalupe et al, 2013, Jiwa et al, 2013). Telehealth has seen a

surge of interest as more patients and staff are using this to monitor patient care and medicine management (Sarhan, 2014, NHS, 2017) and Bacigalupe et al (2013: 248) discusses the emerging information and communication technologies (ICT) as new ways of archiving and searching for health information.

Rogers (1962) in a seminal piece of work recognises that innovators are individuals who have an idea and are motivated to become a change agent and not afraid to take risks. As an activity social innovation was often regarded with negative views, and frequently was considered to lead to risks with negative consequences, such as investing in an idea which does not succeed, resulting in a financial loss (Godin, 2015). This view is supported by a study carried out in 2010 by the Centre for Innovation in Health Management, signifying the importance of choosing an innovation carefully in order for organisations to benefit, stressing that it is not just the innovation that needs to be considered, but how it is actually managed (Gopaldasamy, 2010). However, other thoughts were that 'Great events may, and do spring from the most trifling causes' (Godin 2013). Consideration has therefore been given to the additional skills and knowledge required to plan and implement an innovation in the community setting. Consequently this research study is the first to address the lack of innovation incorporated within educational programmes for community health professionals.

### *2.11 Educational Support for Innovators*

The underpinning philosophy of any educational programme addressing innovation will provide the skills mentioned above and should be designed to enable changes to happen by equipping students with the knowledge, confidence and skills to promote change and innovation in their practice areas. A recent programme developed by NHS England (2015) focusses on the knowledge- based skills mentioned above and is initially targeting doctors in training who are developing clinical innovation.

Dependent on the success with this group of people it will extend to allied health professionals. Other programmes such as the University of Oxford Management in Medicine programme and the NHS Leadership programme do not cover the entrepreneurial skills required to set up a project, but rather provide management skills to support such an initiative.

Promises are being made to support innovation in the clinical setting and as recently as 2015 Sir Bruce Keogh launched a Clinician Entrepreneurs programme at the Health and Care Innovation EXPO. The programme will be the first national level training programme for clinician entrepreneurs and will become a global beacon creating a 'brain gain' effect, attracting and retaining the brightest talent for the NHS. Protected time for innovation as part of professional clinical training and the creation of substantive clinician entrepreneur posts across the whole healthcare landscape will enable medics, nurses, AHP and scientists to directly influence the fast-changing environment they work in.

Education generally for post qualifying health professionals has identified similar concerns whether it is looking at promoting innovation or developing competencies within a particular clinical area. A study carried out by Weglicki et al (2015) looking at the continuing professional development needs of nursing and allied health professionals responsible for prescribing found that the key themes were: personal anxiety and lack of confidence in their own competence, external barriers that prevented them working effectively, lack of support and recognising their personal way of learning. A further study by Baldacchino (2011) looked at the perceived impact on qualified nurses of teaching spirituality and the findings showed that the students had a heightened self-awareness which also impacted on their personal development. These findings were also proved by Pool et al (2015) when they looked at strategies for continuing professional development amongst nurses. Holland & Lauder's study (2012:61) suggests that the delivery of care is dependent on the knowledge and skills of the workforce and that in developing more supportive learning environments this was leading to increased innovative practice. They stress that correct leadership and commitment are requirements for a successful transformation of nursing care.

The literature reviewed supports post qualifying education and particularly in view of recent investigations in Mid Staffordshire Trust recommendations are to increase the focus of nurse education to improve the theory-practice gap. Leonard et al (2016:150) comment that nursing practice is homogenous, yet it is multi-faceted and requires a diversity of skills and knowledge. Education is knowledge and knowledge strengthens the power to promote confidence in health professionals so that innovation in practice will be encouraged throughout the workforce.

## 2.12 Diffusion of Innovation

Diffusion of innovations is a theoretical model, with roots in rural sociology. It is a multidisciplinary theory of planned social change (Goss, 1979) and it addresses how the structure and function of a social system changes (Rogers, 1995, cited in Haider & Kreps, 2004).

*“To get the bad customs of a country changed and new ones, though better, introduced, it is necessary first to remove the prejudices of the people, enlighten their ignorance, and convince them that their interests will be promoted by the proposed changes; and this is not the work of a day”* Benjamin Franklin (1781).

One of the key factors of diffusion is about removing prejudices so that innovators can move forward. Doyle et al (2014) carried out a literature review which explored the use of Rogers' Diffusion of Innovation model as a framework to guide implementation of mobile devices into nursing curricula, which they found supported the planning, implementation and adoption of these technologies. Numerous other researchers (Leggott et al, 2015, Block, 2013, Romero et al, 2011, Hayes et al 2014, Vedel et al, 2013, Schleien et al, 2010, Andrews et al, 2013, Geibert, 2010, Lin et al, 2016, Denis et al, 2002, Jordan et al, 2014, Haider et al, 2004, Jahanmir & Lages, 2015) have adopted Rogers Diffusion of Innovation theory to support their introduction and implementation of new ideas in practice. Rogers' (1995) five key factors of successful diffusion are outlined below:

- *Innovators* are those individuals who have an idea and are motivated to become a change agent and they are not afraid to take risks.
- *Early adopters* are frequently people in senior leadership positions who can make things happen so can work with the critical mass to approve a change. They may take on board the original idea from the innovator and make their own adoption decisions
- *Early majority* are slower than the early adopters but are willing to make a change. They are generally members of a team and not the leader of a team. These make up about one third of all members of a system.

- *Late majority* view innovation with wariness and require a lot of encouragement to take the innovation on board. They tend to accept the innovation after everyone else around them has accepted it
- *Laggards* tend to be averse to change and like to work within the safety net of familiarity and tradition. They are the last to adopt an innovation.

Caution should be taken when using these five characteristics to diffuse an innovation as innovators may be so enthusiastic about an idea that they overrule any other consideration and over adopt.

*Reflection:*

*It was interesting for me to discover that studies by Weglicki et al (2015) and Pool et al (2015) highlight that students on post qualifying programmes have low self-esteem and lack confidence, yet many were in senior clinical positions. Is this a cultural phenomenon? Would the same findings be discovered if a similar research was carried out on non- health care professionals? Learning about diffusion of innovation was also interesting and retrospectively as a past community health professional and also in my current role I have been able to categorise people and recognise their traits as described by Rogers (1995).*

However there are synergies between the use of diffusion in third world countries and the concepts for diffusion in health care in the UK. As Blaut (1993: 388, cited in McMaster & Wastell, 2005) proposes, diffusion is about making sense of the world and the commonality across the world is the explanation of 'progress'. He suggests that there are core axioms, the centre being progressive and innovative and the periphery being traditional and stagnant. The innovation will commence at the centre and merge into the periphery, as 'air flows into vacuum'. Within the UK Health care system the nurse or allied health professional will be at the centre and influence those managers and team members who are on the periphery.

### *2.13 Adoption of Innovation*

In a longitudinal qualitative study looking at diffusion of a collaborative care model in primary care, carried out by Vedel et al in 2013, they stress the importance of

diffusion being communicated across all parties, ensuring that a critical mass of those involved adopt the innovation for it to have any chance of success. Their study identified that adopting innovation took time and it was the nurses that attained a critical mass faster than other members of the primary care team. Those that were early adopters demonstrated positive traits and the laggards generally found it very hard to break old habits and practise in a different way.

The cultural dimension of innovation looks at how to motivate and encourage people to innovate. While pay does not seem to be a significant motivator of innovation in the public sector, other extrinsic rewards such as recognition, career advancement, special assignments and competitions may play a role. Intrinsic factors such as observing the value and impact of one's work and learning new skills can also be a strong incentive (Blackwell, 2014, Lambrou et al 2010).

There is also the possibility that an adopter may want to make the change to gain social status (Roger1995, 2003). This may be due to wanting to 'fit in' with the innovators and not necessarily that they are in full agreement with the innovation. However within health the researcher would argue that the patient's best interest is central to an innovation being adapted and it would be an added bonus if, coincidentally, the successful innovation led to promotion for the individual.

In December 2011 the Department of Health published an executive summary in response to their invitation calling for evidence and ideas about how the adoption and diffusion of innovations can be accelerated across the NHS. The response claimed that it is a sign of strength to make a commitment to building an economy driven by entrepreneurs who are creating innovative health solutions, facing the challenges of social cohesion, finding solutions to poverty, climate change and sustainability. It means building an innovation agenda that is truly holistic and recognises and supports social innovation and social entrepreneurs as a part of an integrated strategy (DH 2011)

#### *2.14 Innovation and change management*

*"There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new order of things ..... Whenever his enemies have occasion to attack the innovator they do so with the passion of*

*partisans, while the others defend him sluggishly so that the innovator and his party alike are vulnerable”* Niccolo Machiavelli, *The Prince* (1523)

Introducing an idea may be accepted but may also take some time even if it is known to have advantages (Rogers, 1983, 1995, 2003). Those working within the NHS over the past twenty years and beyond will have worked through change processes on a number of occasions and therefore will have noted that much of the literature around change management within the NHS is linked to innovation. They are, however, two distinctly different concepts. Change Management incorporates organisational tools that can be utilised to help individuals make successful personal transitions resulting in the adoption and realisation of change (Creasey, 2007). Whereas innovation is an idea, service or product that is new or applied differently, which significantly improves the quality of health and care (DH, 2010: 9). The distinction between traditional change management and social innovation can be a grey area as the two are often aligned, but they differ in at least one key quality. This being that change management is not necessarily aiming to improve society, but rather focuses on ways of developing a workforce or systems for the good of an organisation; while social enterprises have the improvement of society as their primary goal. A study by Redfern and Harris (2011) claims that innovation in nursing requires the support of the managers and that nurses need to be skilled in driving innovation forward.

Nonetheless, the importance of supportive management and training were emphasised as key if innovation is going to be encouraged and to succeed (Block, 2013). Paradoxically government is promoting innovation and this is an ideal opportunity for healthcare professionals to make a stand and display some of their original and possibly unconventional tactics, yet often when innovation is introduced within an organisation it is turned down because senior managers are not comfortable with what might be perceived as rebellious behaviour. If innovation is to flourish, then support mechanisms are required to maintain and develop these initiatives (DH, 2011) which at times can be risky. This is a view that Mullahy & Boling (2008) support as they remark that, to be entrepreneurs, professionals must be prepared to accept and also to be able to say ‘No’ when they are advocating for their patients, in some instances this may mean that risks will be taken. Alongside this they suggest that perseverance and optimism are attributes required to confidently take risks.

Douglas et al (2016:3) wrote about the diffusion of a management innovation and stated that this is frequently driven by dissatisfaction with the inability to maintain the status quo and suggested that the overall success will depend on whether the innovation fits with the plans of the organisation. Frequently restructuring of an organisation is required and when looking at improving performance they introduced a top-down approach which was practised across the whole of the organisation but did not result in all staff being early adopters. There were various stages of adopting the innovation, with some laggards unable to accept the changes. These individuals were given more time to gain an understanding, eventually buying into the change.

The NHS is noted for working to procedures and processes which can make change difficult to manage. Nevertheless Carr & Clarke (2010) assert that Nurse Managers are pivotal in improving services and promoting innovation. They identify the importance of organisational learning as a means of sharing knowledge and applying and transforming practice to improve patient care. It is acknowledged that there is a link between learning and change and refers to 'double-loop' learning where individuals' assumptions and beliefs are tested. Carr & Clarke (2010) stress the significance of exchanging knowledge and an effective manager will acknowledge that frequently knowledge is not disseminated and remains the possession of one individual in an organisation. This is not conducive to promoting innovation and they conclude that organisations facilitating learning at both an individual and organisational level improve the health and social needs of their population and service innovation achievements.

McEwan et al (2010) stress the significance that empowerment has on organisational change and recognise that change takes time and does not always follow a linear pattern. Through the process of change individuals may encounter personal growth; frequently this results in an increase in confidence and the ability to challenge new ideas as they are presented. However, Joseph (2015:172) suggests that innovation requires organisational commitment to allow employees to inquire and question organisational practices. Nurses are seen to be able to promote innovation by providing creative solutions, thus making a difference to patients and the organisation (ICN, 2009).



*Reflection:*

*There is a gap in the literature on the topic of innovation and it was not surprising to find that innovation as a topic did not form part of change management literature.*

### *2.15 The experience of social innovators*

With health policy driving changes to the way the community workforce provide their services there is limited evidence to determine how community practitioners are being prepared for their role as innovators, either at the point of initial post registration training or later in their career. The impact of such demands will require practitioners to address the government's drive to bring care closer to home through demonstration of innovative practice such as the PACE project (Post-acute Care Enablement) which is in operation at the Royal Free NHS Foundation Trust in London. This project aims to provide complex care in the patients' home, focussing on the community provision and the ability to lead the safe and appropriate transfer of patients from acute bed-based models of care to community settings, which had traditionally been poorly delivered. This required a collaborative partnership approach with health and social care to deliver cost and quality outcomes as part of a 'supply-chain' model of reform (Hails, Steadman, Walls, 2010). It is a cross-organisational service model that offers medically stable hospital patients the opportunity to be cared for at home through the provision of integrated acute, community and social care. The aim is to reduce costs, and provide more comfort for the patient and their families. The evaluation of the project proved that PACE patients spend an average of three fewer days in hospital and consistently report an 85% level of satisfaction with the care they receive from the PACE team (Hails et al, 2010:3). This model has now been replicated in other regions, for example Edinburgh and Bromley. This team recognised that they were challenged to gain skills unfamiliar to them as they had no previous training in management or operationalising projects. (Hails et al, 2010:81). This current research will review this aspect to see if education or training in innovation assists practitioners who want to carry out projects such as this, without the difficulties that this team experienced.

The introduction of the NHS Institute for Innovation and Improvement (2005) has given immense assistance to practitioners wanting to support the transformation of

the NHS through innovation (Butterworth, 2013). The researcher argues that if there was more support, education and awareness of how to execute an innovative idea then this would further support the transformation of the community service agenda (DH, 2011, 2015).

For many people working within a bureaucratic system, such as the National Health Service, displays of 'thinking outside the box' have not been encouraged; conversely, employees have been expected to follow the rules and guidelines which are often target driven (Keogh, 2015). Even though patient safety has, in theory, always been high on the government agenda (National Patient Safety Agency, 2010) up until very recently even reporting incidents of poor practice have been left unreported because of an attitude and fear that individual jobs could be jeopardised. Yet, since recognising the need for a policy on 'whistleblowing' this has encouraged a 'climate of openness' (DH, 2010). Whilst one of the main reasons for introducing this policy was to safeguard the public by staff having 'permission' to report bad practice it also gave staff working within the NHS a platform to be heard. There has been a culture of fear within the NHS which leaves staff not wanting to put their head above the parapet. It transpired in the Baby P case that there were grounds for such concern as the consultant paediatrician who reported poor record keeping and understaffing had employment laws used to gag her (Butler, 2011).

### *2.16 The gap between policy, practice and staff training*

NHS policies are clearly promoting innovation within clinical practice (DH, 2010, 2015) but these potential opportunities will only come to fruition if there is support available from managers as it is essential for a member of staff to be heard if they want changes to happen. The Department for Innovation, Universities & Skills (DIUS) White Paper 'Innovation Nation' (2008) provides an ambitious new direction for UK innovation policy. However, current evidence indicates that organisations need to understand how to identify the characteristics and behaviours of innovative people and consequently, how to promote and encourage innovative working within organisations.

## *2.17 Community Healthcare Innovation Education/Training in the UK*

It is an expectation that innovation in nursing is pivotal to the delivery and maintenance of evidence based care whether it is in a hospital setting or a patient's home (DH, 2008, Apekey et al 2011, Ross et al, 2011). Therefore to influence change across the healthcare sector, evidence of how community health professionals have impacted on service delivery must be demonstrated. A number of the innovations in the 'Transforming Health & Social Care' (DH, 2009b) document have looked at whole organisations developing innovation and change in their community. However, there appears to be little research available which investigates how community health professionals are prepared for the role and the impact of their innovative practice on the individual client groups. One of the few is a study carried out by Ross et al in 2011, which looked at the professional and personal features, mechanisms on innovation and outcomes in nursing which claimed a link between a supportive employing organisation and individual personal characteristics as being influencing factors when working together to implement an innovation. It reports that innovation in nursing requires the support of the managers and that nurses need to be skilled in driving innovation forward. Trueland (2014) reports that the one stop clinic delivered in the Forth Valley Royal Hospital is successful because since the conception the service has had the full support of the multi-disciplinary team and is not reliant on just one individual to lead the service. The importance of knowledge brokering as a means of disseminating best practice, stresses that there must be links between clinical practice, research and policy makers (Gerrish et al 2011). Knowledge acquired by the practitioners in the study is focussed on evidence based practice as a result of studying clinical courses. However, frequently, nurses and allied health professionals are directed towards management courses to further their leadership skills, and often these have a tendency to focus on motivating staff and giving training on working effectively in teams (Frankel, 2008). Crucially, however, these leadership and management programmes do not tackle the issue of innovation in sufficient depth to enable health professionals to have a noticeable impact on practice. These thoughts are replicated by Frymire (2006:11) who argues that one of the biggest challenges is hiring people with the brainpower (both natural and trained) to be able to think creatively. The view of Cash (2000) is that there is conflict between education, practice and management, leaving health professionals to make

a stand in 'arguing for the virtues of good clinical and educational practice' (Cash, 2000:p.258). Hence researching the effect and impact of the inclusion of innovation as a topic within nursing and allied health professional programmes, and how this would support and aid community health practitioners, service users and the organisations concerned, is of paramount importance.

### *2.18 A gap in the literature*

The research reviewed presented research on technical innovation and innovative practices led by medical practitioners. A selection of literature identified small scale practical innovations within clinical practice but there appears to be no published research which looks at what effect the process of being an innovator has on the individuals concerned or the impact that education has had on how they drive the innovation forward. It is clear from the literature reviewed, that a crucial feature of successful healthcare delivery is the human factor - systems will only go so far in the delivery of competent care. However, a preliminary overview of literature demonstrated that despite much being written about social innovation in its many forms, there is a lack of research showing what support is in place for those individuals wanting to promote innovation in the workplace, together with lack of research identifying where innovation is included within health professional education. There is a gap in the research literature which this study aims to go some way to address.

Therefore, with a view to capturing this information the aims and objectives of this study are:

### *2.19 The Aim:*

To undertake a qualitative investigation of the personal and professional development of a group of community healthcare professionals who, after training in social innovation, instigated and managed their own innovative community healthcare initiatives.

## *Objectives*

1. To explore and identify the personal qualities, knowledge and skills required of health care innovators when setting up and managing a social innovation project
2. To identify the difficulties encountered within individuals themselves and the external factors within their organisations that have impacted on the development of their project
3. To look at the impact of education and training on the progress of these participants.
4. To inform potential innovators about what they can expect to encounter as they proceed with their own project

### *Reflection:*

*The literature accessed to date has seen an increase of attention given to innovation in the workplace, but it has also shown that much of this is lip service and no additional resources have been allocated to enable innovations to be implemented. Additional resources, either financial or manpower, are not always required but there is no evidence shown that shows 'time to think and reflect' is given to support innovation in the workplace. No literature has been accessed that tackles the issue of personal and professional development of health and social care innovators either and I am hopeful that the participants involved in this study will give some insight into what are the key drivers, enablers, inhibitors and also the impact, if any, education has had on them as clinical practitioners trying to introduce an innovation into their practice area.*

## Chapter 3

## Methods

This chapter sets out an overview of the research process carried out during the period of 2012 – 2015. It is divided into six sections: the first outlines the rationale for choosing a qualitative approach for this study. The second section addresses the sampling and recruitment strategies and methods. The third discusses the data collection process, issues arising and how they were overcome. The fourth outlines the specific analytical approach and procedures undertaken, and how they are based on Braun & Clarke's (2006) guidelines. The fifth section focusses on the ethical concerns of the study and the trustworthiness of the findings described and established. Finally, the issues around quality assurance and research governance are discussed.

### *3.1 A qualitative research approach*

This is a qualitative research study. The aims of qualitative research are to seek answers to questions about the 'what', 'how' or 'why' of a phenomenon, rather than questions about 'how many' or 'how much' (Green and Thorogood, 2004:5). The purpose of this study is to understand the personal and professional journey undertaken by a cohort of community health professionals after completing a Post Graduate course with the aim of developing their social innovation knowledge and skills. This study will elicit information about the key drivers observed in these professionals that enabled them to be proactive in promoting new healthcare initiatives in their workplace. The journey described here covers what was considered to be important to these individuals when seeking to improve their organisation's service delivery; how they try to achieve their goals, and how the course impacted on their ability to set up an innovative project within their professional domain. A 'critical realist' research approach has been adopted. The work of Ritchie et al (2013) has been influential in selecting this approach because of their long record of research within healthcare. Their approach is that of being broadly 'critical realists' (Robson, 2002, Bhaskar, 1978, cited in Ritchie et al, 2009). Ritchie (2013: 21) states that 'ontologically, we see reality as something that exists independently of those who observe it but is only accessible through the perceptions and interpretations of individuals'. We recognise the critical importance

of participants' own interpretations of the issues researched and believe that their varying vantage points will yield different types of understanding. The reality of healthcare delivery in all its forms exists independently, but it is through the words of the research subjects that we have a unique access to it and, in this case, their desire to instigate change and improvement in professional practice.

Ritchie (2013) further defines this position 'as being within a broadly interpretative framework which emphasises the importance of understanding people's perspectives in the context of the conditions and circumstances of their lives' (Ritchie, 2013:22). This sums up very neatly the aim of this study which is to explore how the thinking of the professionals has been shaped by the variety of circumstances that they are working in. The aim here will be to identify common themes related to attitude and interpretation of their personal experiences in setting up an innovative project within their clinical practice. There is, according to Ritchie (2013:22), 'a strong requirement for any interpretation to be heavily grounded in and supported by the data'. This level of openness to the thoughts and idea of the participants required an inductive approach to the data analysis (the meaning of the material emerges from the participants themselves rather than from a predetermined theory) which has been achieved, using the guidelines for data analysis of Braun and Clarke (2006). This study is not, therefore, embedded within any major theoretical research tradition, but rather aims to achieve 'empathic neutrality' (Ritchie et al, 2008:22) with the researcher doing her best to be unbiased, and neutral in her data collection.

### *3.2 Other research approaches considered but rejected*

This section will look at other qualitative research approaches that were considered but rejected the first being grounded theory which is frequently used within the field of health and social science; indeed, it had its origins in a study of dying patients in a hospital setting (Glaser & Strauss, 1965). It was contemplated, then rejected because researchers develop inductive theoretical analysis from their data as they go along and continue to collate further data, collecting and analysing data simultaneously (Silverman, 2011). This protracted method of data collection was not considered necessary here as 'one off' interviews were all that was considered practicable and would be sufficient. It is not the aim of this study to create a new

theory of social innovation from the data but rather, as the topic of the personal journey and experiences of social innovators is little researched, simply carry out a descriptive study which may in time lead to a larger piece of research in this area.

An ethnographic research approach was also considered because the researcher was previously a District Nurse, therefore arguably she could be referred to as a 'native' rather than a 'stranger' to the participants, thus potentially enabling the researcher to prioritise and rationalise the findings as they are seen through the eyes of the insider. However, the 'stranger' element of the role would require a conscious effort to enable naïve questions to be asked and to analyse social life from a theoretical perspective (Green & Thorogood, 2004:136). Ethnography in the truest sense is carried out 'in the field' and the focus of this study did not revolve around field observation so for that reason this approach was discarded.

Narrative analysis which focuses on the stories that participants share involving aspects of their lives (Robson, 2011) was also considered. While at first glance this was appealing as this research explores the participants' journey towards becoming successful innovators, in essence there was a story to be told. However, although the data received from the interviews were comprehensive and demonstrated individual personal development, the structure of the interviews did not encourage 'story telling' (Robson 2011), but rather a synopsis of how education, training and becoming an innovator impacted on them, thus falling short of a true narrative approach. Narrative approaches have been used to provide rich and detailed accounts of the social formations shaping subjective experiences of health and well-being (Riessman, 2007), but the use of narrative analysis would detract from the structured approach required for this study, so this approach was rejected also.

### *3.3 Data Collection Methods*

Initially focus groups were considered to be the most effective means of gathering data. However, due to the difficulties experienced in gathering focus groups together this method was discarded and preparations had to be made for the unexpected (Krueger & Casey, 2009). Qualitative research can often use only one interview method but as Deakin & Wakefield (2013:2) observe 'it is increasingly likely that one or more types of interview are employed'. For that reason, alternative methods of



interviewing were considered as the participants came from different locations and the prospect of travelling to Scotland, Wales, Northern Ireland and across numerous counties in England for individual interviews had also to be justified in the light of possible poor response rates. Resources, finances and time factors had to be taken into consideration also. Conducting face to face interviews for those participants who had agreed to participate would be too time consuming and expensive due to the geographical distances, a view supported by Deakin & Wakefield (2013, Sedgwick & Spiers, 2009). Therefore alternative qualitative approaches were appraised and the eventual mechanism of gathering data was semi-structured interviews in the form of individual Skype interviews. Skype interviewing has for some time been accepted as an effective way of managing verbal exchanges and is considered to be a 'conversation with a structure and a purpose' (Cohen et al, 2007). This notion of it being a 'conversation' is apt, as this is how the respondents clearly viewed it. Rich, free flowing data was obtained from each participant which was why semi-structured interviewing was considered to be more effective with these busy, but very enthusiastic, participants rather than a survey questionnaire which relies largely on closed questions (Robson, 2004, Silverman, 2011), not enabling them to speak freely about their experiences. Having met several of these participants as students or as presenters at conferences, it was apparent that their characteristics showed them to generally be people with a passion for their work and a willingness to share their innovative ideas to a wider audience. Because the participants by nature were willing to veer from traditional practices, they were eager to participate in Skype interviewing, thus supporting the views of Edward & Holland (2013:95), who state that 'there have been dramatic changes in communication technology and qualitative interviewing must adapt if it is to survive'.

### *3.4 Sampling and Recruitment*

This section details the two sampling methods used: *purposeful* and *opportunistic* or *emergent* sampling, how the participants were recruited and their demographic details. A purposive sample of twenty community health professionals from regions across the United Kingdom (UK) were selected, together with an additional six participants whose contribution was achieved using convenience and opportunistic sampling as the study progressed. The sample frame for the majority of the

participants was the enrolment data set for the Post Graduate Diploma in Social Innovation course they had studied.

The intention of this study was to talk with people who could produce rich, well informed material about their personal experiences when setting up and managing innovative projects in clinical practice. The participants were selected on the grounds of preparing to start their own project following the course, or their extensive involvement with an existing project of their own. The samples identified sufficient diversity, which according to Patton (1990) yields two kinds of findings; a) samples of a high quality and b) identifying shared patterns across the data which emerged out of heterogeneity (Patton, 1990: 172).

#### 3.4.1 Purposive sampling

The researcher had developed and taught on the Post Graduate Diploma in Social Innovation at a university in the South of England and watching the students develop professionally, and, most importantly, personally was the catalyst that prompted this research. These students were an ideal sample for the purpose because of their diversity and ease of contact, therefore the purposive sample was identified and the researcher approached two cohorts of students. It was straightforward to contact this group as the researcher was able to acquire all of their email contacts from the university administrator. Qualitative inquiry generally focuses on small samples which have been purposefully selected (Patton, 1990:169) so this was an ideal sample for the purpose. Forty people in the initial phase of the study were contacted to ask if they would be willing to participate and twenty seven responses were received. This resulted in twenty recruits. Seven of the initial responders did not respond to subsequent emails so the researcher did not pursue them further. As the fifty percent response rate included participants from across the UK and from a range of professional backgrounds, the researcher reasoned that this was a sufficient sample to proceed with the research (Blaikie, 2011).

#### 3.4.2 Opportunistic sampling

The additional six respondents were approached after hearing them speak at various conferences or after reading about their projects in the professional literature. The

inclusion of the opportunistic respondents captured a broad range of innovation project experience and reduced any potential for bias by not only including the researcher's own students but also participants who had studied elsewhere or participants who had successfully implemented an innovative project in their clinical practice. Initially, there had been no intention of seeking more participants other than the students from the researcher's university, but having heard the presentations of the additional participants the researcher was of the opinion that their experience would add strength to this study. Including these extra participants did not incur any further expenditure and they were very willing to participate, so all that was required was additional time to interview them, which would enlarge the data set (Roller & Lavrakas, 2015, Patton, 1990).

The first two additional participants were identified at a conference in London in 2014 where they spoke about setting up a social enterprise in their General Practice surgery. The project was a lymphedema service offered to the local community which prevented long waiting lists for hospital lymphedema clinics. The researcher approached them and asked if they would be willing to participate in this research study which they were happy to be involved in. Another two participants were approached at a conference in 2015. One practitioner had developed a General Practice and Community Development programme which was targeted at general practice nurses and district nurses; this had improved the service provision for communities in a rural community. The second practitioner was a community matron responsible for care homes in her local area who was concerned about the high infection rate among patients. She developed a training session for staff and since her input there has been a 70% reduction of infection related admissions to hospital

A further two participants were approached after the researcher read about their innovative projects. One project was 'Community at Risk (CART) Tool'. A prediction tool to assess vulnerable patients in the community was developed and those predicted to be highest at risk of adverse outcomes were offered individualized care pathways. This saw a reduction of emergency admissions to hospital. The second project was a Community Cardiac Rehabilitation Women's Walk Group; the aim of this project was to improve the physical activity levels of women referred to the cardiac rehabilitation team. The patients' quality of life indicators were improved and their blood pressure was maintained at an optimal level. Both of these projects were

of interest to the researcher, mainly because they were simple, cost effective and there was evidence of improved patient outcomes.

Permission was sought from the six participants and they were sent the same information as the purposive sample, which included information about the research and a consent form (Appendices 2 & 3). They all agreed to take part in the study and Skype interviews were arranged for two of the participants and four of the participants agreed to a face to face interview where they were provided with the same information (Appendices 2 & 3) prior to their individual interviews.

### *3.5 Recruitment*

The twenty respondents were given an information sheet about the study (Appendix 2), and a consent form with information sheet regarding confidentiality and storing of information along with detailed instructions should they decide to opt out of the study at a later date (Appendix 3). Personal demographic was collected and information about the type of innovative projects the participants are engaged with was also collected to provide a detailed picture of the various community needs that they are attempting to address. Agreement to partake in the study was granted (no one refused) from them all prior to being interviewed.

The sample included male and female participants but it was intriguing and noteworthy that the respondents were predominantly white British females with only two male participants. This narrow demographic spread is surprising. Although three quarters of the NHS workforce are women, the percentage of males participating in the study is a little below expectation. In addition, considering the NHS workforce is ethnically diverse, it is curious that only two participants were not British. It may be a reflection of research findings on ethnic diversity across the NHS and the proportionately unbalanced representation of all groups throughout the NHS hierarchy (Rao, 2014). This is an area that may warrant further research in relation to who takes up places on social innovation courses. The group had a mean age of 43yrs (table 1).

Table 1

<b>Sociodemographic details of the sample of 26 community health professionals</b>	
<b>Occupation</b>	<b>Number of Participants</b>
Health Visitor	5
District Nurse	6
Specialist Nurse	5
Community Matron	2
Learning Disability Nurse	2
Mental Health Nurse	2
Dietitian	1
Midwife	1
Occupational Therapist	1
School Nurse	1
<b>NHS Agenda For Change Banding</b>	<b>Grade of Participants</b>
Band 5	0
Band 6	18
Band 7	6
Band 8+	2
<b>Age</b>	<b>Age of Participants</b>
25-29	0
30-39	8
40-49	10
50-59	6
60+	2
<b>Location</b>	<b>Location of Clinical Practice</b>
South West England	6
South East England	7
North West England	6
North East England	5
Scotland	1
Highlands of Scotland	1

The geographic locations of the participants' clinical practice spanned the UK.

Participants were selected from the following groups:

- Twenty participants who had enrolled onto a course at the researcher's area of work
- Four participants were selected after hearing them speaking at conferences about their innovation
- Two participants were selected after reading about an innovative project in a nursing journal

The details in Table 1 show that most of the participants have a background in nursing, with just two from allied health professional disciplines which reflect the community nursing and allied health workforce. Allied health professionals make up six percent of the workforce whereas nurses make up sixty percent (Dorning & Bardsley, 2014, Unison, 2015). These details are representative of the current workforce. Christie & Co. (2015) claim that 21% are between the ages of 30-39, 30% are between the ages of 40-49, 17% between the ages of 50-54 and 20% being over 55 years of age.

None of the participants, with the exception of the two who had set up their own social enterprise, were in positions above a Band 7 according to the NHS pay 'Agenda for Change' grading. All registered nurses upon qualification are awarded a Band 5. Allied health professionals normally are awarded a Band 6 upon qualification. This is due to the fact that allied health professionals have always been a graduate profession, whereas nurse education has only been an all graduate profession since 2009.

The purposeful sample consisted of students who had been recruited nationally onto the post graduate diploma in social innovation which had enrolled students from across the UK and been delivered in two locations, one in the South and the second in the North of England. The conferences and literature attracted delegates and publications from across the UK. The wide diversity of the participants enabled the researcher to consider how innovation impacts on the various populations across the country.

### *3.6 Data collection*

This section will cover the method of data collection employed: Skype interviews and face to face interviews which enabled the exploration of unanticipated issues as they emerged (Ritchie and Lewis, 2009:47).

### 3.6.1 Interviews

The interview guide was developed in three stages. Stage one, the exploration stage, involved brainstorming with work colleagues, phrasing and rephrasing the questions and working with peers to sequence and estimate time for each question (Krueger & Casey, 2009). Stage two, the interview schedule, was then tested on students who had undertaken a leadership module at the researcher's university, their feedback informed the next stage of the interview development. Stage three: suggestions from peers and students were collated and a pilot interview schedule was developed which was tested on a third cohort who had not yet completed the course on social innovation. They were half way through the course so they were able to give relevant feedback and suggestions. One example was to suggest that a question was rephrased so that it was an open ended question. The pilot question originally read – 'Did you benefit from the course you attended?' The amended version reads 'Having been on a course how has your practice changed?' The suggestions and feedback were reviewed and the questionnaire was refined to enable the participants to explore their own personal journeys. The rephrasing of the questions also enabled the questionnaire (Appendix 4) to be used on respondents who had attended any course on innovation, not just those who had been studying at the researcher's University.

The purposive sample interviews were undertaken from September 2014 to June 2015 and the opportunistic sampling occurred over a period of fifteen months from September 2014 to December 2015. The participants came from various allied health professional backgrounds and twenty two of them had studied some form of educational course that promoted innovation in practice. Two of the participants had never been on any educational course yet had been successful in promoting innovation in their clinical practice. Twenty of the participants had been students on a course at the researcher's university; a further two participants had been on an NHS leadership programme which had promoted innovation, two had been on training days which looked at enhancing clinical practice, and the remaining two participants had not attended any such course, programme or training days.

Table 2

The Education/Training in innovation the participants had received.		
Type of Education/Training	Length of Education/ Training	Number of participants
Accredited course/ programme at M level	12 months	20
Non accredited course/programme	12 days across 12 months	2
Study day	2 days	2
No education/training in innovation		2

### 3.7 Focus Groups – difficulties encountered

The purpose of arranging focus groups was a way of gathering similar minded people together to discuss factors and determine feelings, views and perceptions pertaining to the study (Cresswell, 2011, Krueger & Casey, 2009, Silverman, 2011). This means of data collection is frequently used when a researcher is looking for a diverse and comprehensive range of ideas or feelings that people have about a specific topic (Krueger & Casey, 2009:19).

It has already been established that the participants came from various regions across the UK so focus groups were arranged in two major cities, London in the South and Manchester in the North. The first focus group in London had an anticipated eight participants, however only two participants attended. They had changed their working schedule to attend so individual face to face interviews were undertaken as two participants were not sufficient to run a focus group. Each participant waited in an adjoining office whilst the other was being interviewed. The location was in a basement office in the surgery of one of the participants. It was spacious and airy and the atmosphere was calm, promoting a relaxed environment (Ritchie & Rallis, 2009). The participants had already signed the permission to participate in the study and the confidentiality form so the interviews commenced and were recorded with the researcher sitting at one side of a coffee table and the interviewee sitting opposite. These seating arrangements promoted a positive interaction between the participant and the researcher while the researcher was asking questions (Ritchie & Rallis, 2009). Unknown to the researcher there was a railway line next to the surgery and ten minutes into the first interview a train passed



by shaking the room and interfering with the recording. Each time a train went by the interview was paused. The two interviews lasted 105 minutes, due to these interruptions.

The second focus group in Manchester was arranged for a week later, but this was cancelled at the last minute due to several participants being unable to attend. This was a dilemma that looked difficult to resolve. Knowing the positive reaction received from the requests to partake in the study, the researcher was fully aware that the reasons for poor attendance and cancellations were not due to apathy, but to work commitments. This was one of the concerns held by Krueger & Casey (2009) who mentioned that logistics was a key concern when planning focus groups.

### *3.8 The move to Skype interviewing*

Clearly another method had to be considered. Qualitative research frequently uses only one interview method, but as Deakin & Wakefield (2013:2) observe “it is increasingly likely that one or more types of interview are employed”. For that reason, alternative methods of interviewing were considered. The prospect of travelling to Scotland, Wales, Northern Ireland and across numerous counties in England for individual interviews was difficult to justify in the light of possible poor showings. Resources and time factors also had to be taken into consideration. Therefore with the increasing availability of digital technology (Weller, 2015) Skype interviewing was chosen as a way of gathering data from the participants from the purposive sample and two participants from the opportunistic sample also agreed to be interviewed via Skype.

All remaining participants were approached giving them the opportunity to take part in, or decline, a Skype and video recording. Although O’Connor (2008, cited in Deaken & Wakefield, 2013:3) implies that the non-verbal cues that help contextualize the interviewee in a face to face interview could decrease the interviewer effect in Skype interviewing.

On one occasion the video recording was not compatible with the participant’s computer so only an audio interview took place. This did not seem to detract from the interview, possibly because the participant was known to the researcher, so a familiarity already existed and the interview continued ensuring the participant was

not disadvantaged by the technical failure. Nevertheless, this sort of incident was identified as a concern by Sullivan (2012) claiming that technology may not always be reliable so a back-up plan should be available. This was not required, but telephone details of each participant were available and the researcher had the iPhone voice memo recording device ready should it be required.

Taking all of these factors into account the 'benefits of using Skype as a method of data collection...., definitely outweighs the drawbacks' (Sullivan, 2012: 59), whilst also proving to be the most cost effective approach owing to the limited resources available for this research study. The interviews encouraged the participants to draw on their current clinical expertise and the interviews came alive with the participants' enthusiasm and expert knowledge. As a result each interview lasted at least 45 minutes with one interview lasting one hour and fifteen minutes. From the researcher's perspective it prompted the participants to share their personal development and it reduced the anxiety of travelling, taking time away from work and there were no cost implications; these views were supported by the participants also and had previously been experienced by Hanna (2012) in his own doctoral research studies.

To date, as a research method, Skype interviewing has not been used extensively in research but there is now a consensus of opinion that it offers researchers a novel interview method as a means of collecting qualitative data, according to Deakin & Wakefield (2013, cited in Janghorban, Roudsari, Taghipour 2014:1). Since 2000 there has been an increase of internet use by 36.2% and the use of Skype as a research method is far more viable now and due to the significant amount of internet usage such as broadband it is far more accessible (Deakin & Wakefield, 2013).

### *3.9 Authenticity of response*

Qualitative research is sometimes questioned as to whether participants are actually being genuine in their responses: are they presenting an authentic self? (Sullivan, 2012). At one level this is impossible to know, but the researcher has a duty to design an interview experience that is as stress free and private as possible, thereby raising the likelihood that the participant has no reason to be anything other than themselves and honest with the interviewer with no anticipation of repercussions.

Skype helped with this goal; the participants were interviewed at times that fitted their schedule, at a location chosen by themselves away from any influencing factors in their work environment. In fact one participant requested to be interviewed on a Saturday morning in the relaxed domain of their home. When the interview commenced it was apparent that she was wearing pyjamas and drinking tea. This was the 'authentic self' so contraindicates what Sullivan has been suggesting. At the same time Sullivan (2012) purports that Skype mimics face to face interviews, which enhanced confidence in commencing the Skype interviews. Bargh et al (2002; Ellison et al, 2006: 418) suggest:

*"In comparison to face-to-face interactions, Internet interactions allow individuals to better express aspects of their true selves – aspects of themselves that they wanted to express but felt unable to"*

A factor evident during the Skype interviews was the generosity of the participants' time. Even though the majority of the interviews lasted no longer than one hour the participants were all eager to share their experience and time was not a factor. The researcher concluded each interview, with many participants offering to participate in further Skype interviews if further information was required at a later stage. This was actually taken up, as a further four questions were asked of the participants later in the study after the key themes had been identified (Appendix 5)

Contrary to the traditional face to face interviewing which is seen as the 'gold standard' method of interviewing, Madge and O'Connor (2004) proclaim that Skype interviewing may promote reflection, especially when approaching sensitive topics. These experiences cannot always be anticipated, but Deakin and Wakefield (2013, Edwards and Holland 2013, cited in Weller 2015:28) suggest that the physical distance between the researcher and participant might make some feel more at ease when discussing sensitive issues. The researcher experienced this during a number of the Skype interviews. An excerpt from one of the participant's interview stated:

*"As an Occupational Therapist I would look at how things were being done and say to myself I wouldn't do it that way, but I never had the confidence to challenge colleagues' practice. I look back and think if I had, the patients would possibly have been discharged earlier"*

Seitz's (2015, cited in Weller, 2015:28) view is that Skype interviewing presents an emotional barrier but this was not the experience of the researcher as many of the participants were relaxed and disclosed sensitive issues which added a richness to the data obtained. One extreme example was that of a participant being 'emotionally bullied' by the organisation as a result of her determination to change practice. She volunteered this information freely and mentioned that the interview had enabled her to reflect on her responses and see things from the organisation's point of view.

### *3.10 Face to face interviews*

The remaining four participants of the opportunistic sample agreed to face to face interviews which were carried out in a quiet convenient location. These were recorded with each participant's permission and notes were also taken. The interviews were structured in line with the Skype interviews so that there was consistency in gathering data. The nature of the questions enabled the participants to respond freely (Rossman & Rallis, 2012).

### *3.11 Data Analysis*

Thematic analysis was recognised as a suitable approach for the type of data expected to be generated by the methods employed and this study design. First introduced in the 1970s, it was used in a variety of ways but inconsistently (Braun & Clarke, 2014). In 1998 Boyatzis wrote a key text on 'coding and theme development' that laid down specifications and guidelines which was the catalyst that prompted 'thematic analysis' to prosper, particularly in the health and social science field. One of the attractions of thematic analysis is that it is theoretically flexible, not linked to any particular epistemological or ontological framework. Nevertheless, the underpinning epistemology is an essentialist/realist approach whereby motivation, experience and meaning is explored in a meaningful but straightforward way, contextualising and giving the participants 'a voice' to each individual story (Sobh & Perry, 2006).

Thematic analysis identifies, analyses and reports patterns (themes) within data. It minimally organises and describes a data set in rich detail, Braun & Clarke (2006) argue that there have been various approaches to using thematic analysis which

may confuse a new researcher, so they developed a flexible, yet structured process to collecting and analysing data which was relevant to this particular research study. It enables the researcher to revisit responses and build on them, suggesting that this should be seen as a foundational method for qualitative analysis (Braun & Clarke, 2006: 78).

This version collates qualitative data to seek themes which are then used for coding to identify patterns across the dataset in relation to the research question. The question of what 'level' patterns are sought, and what interpretations are made of those patterns, are left to the researcher to provide a robust, systematic framework for coding. It offers a theoretically flexible approach; whereas others (e.g., Boyatzis, 1998; Guest et al, 2012; Joffe, 2011) position thematic analysis implicitly or explicitly within more realist/post positivist paradigms (Braun & Clark, 2014).

Braun & Clark's (2006:5) six-phase process for thematic analysis was used. This involved the researcher becoming immersed with the data in order to generate the initial codes, followed by searching for major and sub themes, reviewing the themes and defining and naming them.

### *3.12 Data management*

Each case was numbered and initialled to maintain confidentiality. A key was developed which matched the name with a case number and was stored securely and separately from the transcripts. The researcher began transcribing the first two interview recordings but the recording was very faint and it was interrupted by the noise of the train. It was difficult to decipher the interviews as one of the participants spoke softly so, added to the sound interference, the recording was jeopardised. However, notes had been taken at the time of the interview and were used as support to familiarise myself with the material. Agreement was sought from both participants to ask if their recording could be sent to a technical advisor as it was difficult to retrieve the complete content of the interview and they both agreed to this action. The transcripts were then sent to the two participants to ensure that the information was accurate, both responded positively, but also added further information that they had not thought of at the time of the interview or that may have

been misinterpreted when transcribed. This reinforces the importance of reviewing the data with the participants involved in the study.

### 3.13. Transcribing

To capture all of the data in a timely way a professional transcriber was employed to transcribe the remaining interviews. Ensuring confidentiality was maintained as the transcriber signed a confidentiality agreement (Appendix 8).

The purposive sample interviews were arranged over a period of six months. Knowing that the interviews were detailed, displaying the participants' sometimes flamboyant characteristics, the interviews were sent to the transcriber approximately four at a time. As a validity check the transcripts were sent to the participants to confirm accuracy. This enabled the findings to be turned around without delay.

The transcriptions were verbatim, each utterance, hesitation and casual phrase was included in the returned transcripts as is considered good practice (Green & Thorogood, 2004). Whilst reading the transcripts, notes were made of any 'word or brief phrase that captures the essence of why you think a particular bit of data may be useful' as recommended by Braun & Clarke (2013:207). This assisted with the initial coding as key phrases were highlighted such as "*I feel more confident*", "*I am a knowledgeable practitioner*", "*we learn from failure*". Such comments and similar statements were common throughout the responses.

### 3.14 Coding

The analysis was data driven and this process of coding was challenging as many of the codes seemed to stand in isolation and, on occasions, did not seem to slot into any specific established theme that had been identified from the coding process. One such phrase used by a Health Visitor (participant 4) "*I think innovation is an incredibly lonely road, and it's like walking down a street listening to your own footsteps*" was so profound but did not sit with any other code. When other statements were made that stood out but were felt to be of importance they were given a separate code. As the codes became more apparent some of the 'one off' statements merged into a particular theme.

Table 3

Codes & Themes

**Codes:** Professional development, thinking outside the box, taking measured risk, improve services, maintain excellence, lack of vision, value for money, communication, lack of recognition, career aspirations, confidence in my ability, career aspirations



**Theme 1: Better is possible – a perceived need to save time & resources**

**Codes:** Self-belief, lack of vision, confidence, frustration, self-doubt, perseverance, barriers, lack of support, change, challenges



**Theme 2: Swimming against the stream – the challenges faced when setting out ideas for improvement**

**Codes:** Lack of confidence, barriers, uncertainty, involve others, tenacity, education, perseverance, networking, motivation, flexibility, doing things differently, opportunities



**Theme 3: Can't do it alone – recognition of the need for further training and support**

**Codes:** Confidence in myself, self-belief, take action, personal development, fun, expertise, caring, intuition, networking, professional development, resilience, working in isolation



**Theme 4: The Real Me – finding a professional home**

**Codes:** Opportunities, opened up avenues, involve others early, recognition from others, clear direction, confidence in myself, confidence working with others, caring, motivation, taking risks, determination



**Theme 5: The Real Me in Action - Early Involvement of others**

**Codes:** Others believing in me, having fun, embracing failure, education, working strategically, networking, thinking bigger, support from others, knowledgeable practitioner, professional skills personal skills, life experience, leadership & management, perseverance



**Theme 6: Development of the Real Me - The impact of learning**

Using Braun & Clarke's (2006) six phases of analysis the researcher familiarised herself with the data and then commenced to code them. As the data became familiar it became easier to code them into particular themes. Having identified & streamlined the codes sub-themes were then defined to develop major themes. These frequently encompassed codes that interlinked across the themes (Table 3).

The themes were subsequently reviewed and specifics of each theme were refined and linked to generate propositions and associations (Grbich, 1999, Braun & Clarke, 2006 in Silverman, 2011: 274-275), resulting in a logical division of themes. The themes were then reviewed to ensure that they met the overall aim of this research study.

### *3.15 Patterns & Themes*

Braun & Clarke, (2006) claim that analysing data in this way will lose some depth and complexity of data, but this did not seem to detract or reduce quality of this data, in fact it generated a rich material. Each interview was read over three times and at each reading a new or more refined version of an original theme would emerge. Once the key themes were identified the data set was reviewed again ensuring that all the key messages had been identified and noted.

### *3.16 Themes and sub-themes*

Many items of interest emerged. On occasions a single statement was made by one participant and was not raised by others, so did not fall under the premise of being a theme, nevertheless, a number of 'single participant' issues were identified and stored. However, many emergent topics and issues arose which were shared across several cases. To reduce the large number of individual comments and to make them meaningful broader categories and major themes were developed.

Some themes were obvious right away, such as '*developing confidence*' while others required more consideration. Interestingly, Braun & Clarke (2006) suggest that as data is revisited it can become boring and frustrating, but the researcher would not agree as she found the whole process compelling.



To work through the various themes and sub themes to create connections a mind map was used and gradually key patterns were defined (Table 4). This gave the analysis more structure and enabled a clear link between the main theme and the sub themes.

The mind map identified key gaps in the interview material elicited such as why were participants not supported in moving their innovations forward, what were the drivers and characteristics that enabled them to pursue their innovations and what additional skills and knowledge were required to effectively get their innovations acknowledged. Therefore it was decided that the same respondents would be contacted again and further questions asked (Appendix 5) No one refused the invitation and people were generous with their time. The established process of transcription and member feedback was undertaken. This material was included in the mind map and did indeed enhance and elaborate the findings.

Table 4

Key Patterns		
Confidence	Individual	Thinking outside the box
Resilience	Motivation	Strategy
Knowledge	Embrace Failure	Finance
Self -Belief	Academic Credibility	Improved patient outcomes

### *3.17 Reflexivity and the Researcher's position*

As course leader for the Post Graduate Diploma in Social Innovation on which the participants were enrolled, and knowing them as students, the researcher's position has been considered in terms of being an 'insider' or 'outsider' researcher. Both positions have implications for the reliability and validity of the research data. An insider researcher is one whose research is conducted within a population of which they are also a member, they may share an identity, language, and experiential base (Asselin, 2003). Two key advantages of this position can be an already established level of trust and the speedy establishment of communications. However, issues of preconceived assumptions about the meaning of the data or the motives of participants also need to be considered.

Conversely, an 'outsider' researcher refers to one who has little or no connection with the group studied. The advantage here is one of naivety and being uncontaminated by local knowledge; however, trust can take longer to build and subtleties within the context may go unobserved. A further position is offered by Corbin Dwyer (2009), relating to the notion of occupying 'the space between'. She argues that the researcher need not sit at one position but rather be part of each, that insider or outsider is too simplistic. This more fluid position is what was achieved here. The researcher's professional background includes having been a community health professional (District Nurse) thus having a first-hand understanding of the world that many of the participants come from. In addition, being involved with the course, the researcher can be said to have insider knowledge and some understanding of the contexts the participants operate within. But the researcher has no knowledge of undertaking such a course, or of setting up an innovative project at work. In some ways this is an ideal position as it offers sufficient familiarity of the world and work of the subjects, but with enough distance to enjoy the advantages of the naive questioner.

### *3.18 Ethical Issues*

Ethical approval was obtained from the researcher's place of employment (Appendix 7) and from the University of Westminster (Appendix 8) as it is obligatory that the research meets the requirements of both higher education institutions (Blaikie, 2011; 27). Also it was essential that the Nursing & Midwifery Code (NMC, 2015) was upheld throughout the research process. The Code acts as a framework to promote professional standards of practice and behavior in all aspects of work through practicing effectively and prioritizing people, preserving safety and promoting professionalism and trust. This was evident by ensuring that the initial focus groups had been set up in a safe environment and subsequent skype interviews were carried out in the safety of the individual participant's home. The research was structured and participants were informed of the various stages of the research process and the needs and availability of the participants were always prioritized ensuring that the trust and the professionalism of the researcher was constant throughout the research process. Pawson's (2003) TAPUPAS framework (Table 5)

was also used as a guide providing a transparent process resulting in a clear audit trail.

### *3.19 Confidentiality*

In line with the NMC Code (2015) confidentiality was maintained at all times and participants were assured that their replies would remain confidential and their interviews would remain anonymous. They would be able to withdraw from the study should they wish to, without penalty. Although the questions being asked were not deemed to be sensitive, the potential of sensitive issues arising had to be considered, therefore a gentle approach was used throughout the interviewing, allowing participants to process the questions and give timely responses. One participant became emotional, not by the questions, but in answering the questions as she realised how far her personal journey had been and she was in awe of herself about what she had achieved. The interview continued with an increased passion and enthusiasm, adding to the richness of data being gathered.

### *3.20 Informed consent*

Participants were given an information sheet (Appendix 2) and a consent form (Appendix 3) to sign. The researcher took full responsibility to ensure that the participants were able to fully comprehend and interpret the content of the information sheet (Ritchie & Lewis, 2009).

Care was taken to ensure that no participating organisation could be identified and permission to use direct quotes was gained. Participants were free to say they did not want their direct quotes used, however no participant refused. Participants were also informed that any identification of unsafe practice revealed by them cannot be ignored and would have to be reported to the relevant professional body. These issues were all stated on the consent form (Appendix 3). The face to face interviews were i-recorded on a digital tape recorder and notes were also taken to aid prompting where required. The Skype interviews were all recorded directly onto the personal computer of the researcher which was password protected and always stored securely in a locked drawer.

At this stage the raw data remained the intellectual property of each participant in that they could add/delete/alter any of the data. The feedback was often humorous and many added facts that they had forgotten when first interviewed. Nothing was deleted, which was encouraging to know that the transcription had been carried out accurately. Participants were informed that the data from the face to face and Skype interviews have been stored in a safely secured password protected personal computer. All participants were informed that the transcripts would be destroyed following the successful completion and submission of the research study.

### *3.21 Quality Assurance*

This section will address the data management practice followed.

#### 3.21.1 The validity and reliability of the data

To ensure the validity of the data the transcribed material from each interview was sent back to the participants for verification or 'member checking' (Porter, 2007, Robson, 2011). This gave all participants the opportunity to revisit their responses and to clarify any misinterpretations perceived by the researcher. It also gave the participants ownership of their 'voice' and the opportunity to continue their involvement in the study (Braun & Clarke, 2006). Reliability can be established through transparency and openness by the researcher about their theoretical perspective and by allowing interviewees to comment on interpretations drawn from interview analysis as suggested by Newton (2010). Hammersley (1992, cited in Richie & Lewis, 2004: 276) 'argues that it is not always possible to ascertain whether the accounts are true and accurate as there is no independent, reliable access to reality'. Therefore reliance is on feedback from the participants.

Table 5

<b>TAPUPAS</b>
<p><b>Transparency:</b> <i>Is the process of knowledge generation open to outside scrutiny?</i></p> <p>All research evidence has adhered to quality and ethical procedures, ensuring a clear audit trail is available.</p>
<p><b>Accuracy:</b> <i>Are the claims made based on relevant and appropriate information?</i></p> <p>All claims are based on relevant and appropriate information that has been acquired from participants involved in the study.</p>
<p><b>Purposivity:</b> <i>Are the methods used fit for purpose?</i></p> <p>A variety of research methods were considered, however thematic analysis was deemed an appropriate method for this research study.</p> <p><b>Utility:</b> <i>Are the knowledge claims appropriate to the needs of the practitioner?</i></p> <p>The knowledge gained from the research is beneficial to all community health professionals and is transferable for all health professionals to learn from.</p>
<p><b>Propriety:</b> <i>Has the research been conducted ethically and legally?</i></p> <p>All research governance and ethical processes have been followed in line with the procedures of both Universities.</p>
<p><b>Accessibility:</b> <i>Is the research presented in a style that is accessible to the practitioner?</i></p> <p>The research findings will be written in a format that health practitioners will be able to understand. Participants will be sent an executive summary of the findings on completion of the research.</p>
<p><b>Specificity:</b> <i>Does the knowledge generated reach source-specific standards?</i></p> <p>The knowledge generated is evidence based and can be presented at conferences where managers can be exposed to the findings and there is sufficient evidence to potentially influence future educational programmes for community health professionals.</p> <p>(Proctor, 2007: 85)</p>

A set of criteria was followed which was developed by Pawson (2003), see table 5. It not only looks at the validity of the research, but accessibility and ethics. The acronym **TAPUPAS** as described by Pawson (2003) sets out the criteria and this framework was used as a reaffirmation that accurate processes had been followed as outlined above.

### *3.22 Summary*

The original plan to run a series of small focus groups across the United Kingdom proved to be more difficult than anticipated. Individual interviews at the respondents' location were considered, but due to the geographical distances this was excluded. Having been influenced by Sullivan's (2013) opinion on the success of using Skype interviews, serious thought was given to this method. Installing additional audio/video equipment to the computer meant that it would be possible to view the participants during the Skype interviews so Skype interviews were chosen as an appropriate method, which proved to be an excellent decision. Whilst no research method is without its flaws, the researcher was aware that many of the participants were known to her and to each other, and took account of Feig's (2006) view that emotions are the 'hot buttons' of behaviour and may influence behaviour and could be challenging, particularly having insight into how important improving practice was to the participants. By using Skype and face to face interviews it enabled each participant to have an equal voice and their individual responses to be scrutinised.

Since the research study commenced, a considerable amount of literature has been published on the subject of innovation in the health service and there has been renewed interest in this subject (Davis, 2011, Kendall-Raynor, 2013, Butterworth, 2013, DH, 2015, Sarhan, 2014) as a result there were opportunities to approach other community health professionals and involve them in this research study, therefore opportunistic as well as purposive samples were interviewed.

Skype interviewing has proved to be an appropriate method in acquiring valuable information and the researcher would promote the use of Skype interviewing as an effective way of gathering data.

## Chapter 4 Findings part one

*“Knowing yourself is the beginning of all wisdom” (Aristotle)*

### 4.1 Introduction

This chapter reports on the material gathered from the 26 research subjects and explores the early days of their involvement with social innovation. As the aim of the research is not to evaluate a course, no distinction has been made between those participants who undertook the post graduate course outlined in an earlier chapter, and those who undertook other types of training linked to social innovation. It could be regarded that attending training was the way that they became involved with the research, becoming one of the sample, but here it simply provides a context against which their subsequent actions, attitudes and values can be understood. The changes within themselves that they express are at times seen as ‘before and after’ the educational experiences, but for these individuals it was putting their new knowledge, as a result of the education, into action that has appeared to have had the lasting impact.

The long and difficult journey towards becoming a socially innovative practitioner began for these participants as a slow burn stretching over months or even years. It became apparent very quickly when reading the transcripts that the participants were describing something active, not an event, but a series of processes. These included the process of implementing change within their organisations but also, perhaps more importantly, that an internal process had been ignited somewhere along the line. Their personal development had been progressive, with one event leading to another; they had needed to have gone through an experience before being able to move on, and therefore the notion of a *journey* is the first theme to surface. With this established, the other themes fit into place.

As information emerged from the data it became clear that that their journeys were diverse and wide-ranging. The fuel for the burn varied, but common themes emerged across their wide range of clinical experiences. This chapter will explore the main themes and supporting sub-themes, which underpinned the individuals’ desire to step forward and make changes within their organisation for the benefit of their

patients as well as the barriers they faced in doing so. It will also identify some of the participants' personal characteristics which, in part, help drive them forward and their early experiences of working with senior management which went on to influence their later work.

#### 4.1.1 Four principal themes emerged from the data:

Table 6

Key Themes, incorporating sub themes:

**Better is possible – a perceived need to raise standards of health care delivery above and beyond current practice:** - Saving time & resources, improving clinical outcomes, poor communication of risk, lack of specialist services, lack of imagination from organisations to understand the need for change, maintaining excellence in clinical practice

**Swimming against the stream – the challenges faced when setting out ideas for improvement:** - Organisational lack of recognising existing problems, lack of vision, frustration, self-doubt

**Can't do it alone – recognition of the need for further training and support:** - identifying a lack of budgeting/financial skills, how education influenced motivation and perseverance, confidence in own clinical skills, lack of confidence in knowing how to make change happen

**The real me – finding a professional home:** - Permission to think and develop the 'self', self-belief

Many of the participants reported that although not dangerous, certainly sub-optimal professional practice was witnessed. However, what was key to these participants is that it was generally not acknowledged as a problem by their organisation. They were working in environments which, in many cases, adhered to the minimum quality standards policy required and they felt that there were areas that could be improved upon to enhance the care of their patients and client groups. Many participants held the view that their organisations could work with them if they wished to implement the suggested changes, but frequently their innovations were ignored and the ideas were shelved.

Most of the participants had been in clinical practice for over twenty years and had seen numerous changes and cut backs in NHS resources during that time. Yet, they seemed to feel that against a backdrop of uncertainty with regard to provision of care and change of job roles, this uncertainty was in fact a driver demanding intervention. Rather than focusing on problems resulting from the uncertainty and instability of the



organisations, the participants saw this as an opportunity to introduce solutions towards improving services. Necessity, they really did think, was the mother of invention. As health professionals, reflective practice is an essential way of working. It is core to any health professional's practice and through reflection this group have uncovered a number of factors that have either hindered or enhanced their ability to act therapeutically with their patients. Some of their key reflective observations are outlined in the themes below. Interestingly, they did not report observing gross misconduct or high levels of risky care, but they became concerned by the unquestioned way sub-optimal routines and ineffective models of delivery went unchallenged. For some it was the opportunity to make a difference through making changes by shifting care from the more expensive secondary facilities to help closer to the patient's home.

#### *4.2 Theme 1 - Better is possible - a perceived need to raise standards above and beyond current practice*

This theme is broad and complex and consists of sub-themes which together paint a clear picture of a need to raise standards in some aspects of patient care. The themes are a mix of practical issues and entrenched attitudes, some institutional and some local. They are: 1) A perceived need to save time and resources, 2) Improving clinical outcomes, 3) Poor communication of risk, 4) Lack of Specialist Services, 5) Lack of imagination from managers in understanding the need for change, 6) maintaining experience in clinical practice.

##### 4.2 .1 A perceived need to save time and resources

Nationally, set against the ongoing economic crisis within the NHS, there is a demand for increased local efficiency whilst at the same time reducing clinical posts. It is particularly noticeable when looking at integration across services within local communities. This is a challenge against a background of staff cuts, rising caseloads and less time for patient need. Service changes, high staff sickness rates, vacancies left unfilled and uncertainty surrounding reduction in posts was causing low staff morale and lack of motivation within community teams. Unlike the hospital setting where teams, which are usually inter-professional, are predominantly located on one ward, the community teams were dispersed and not always located physically in the

same building which created additional difficulties in promoting a positive working environment. The occupational therapist, dietitian and specialist nurses participating in the study were particularly isolated as their core team usually consisted of themselves (specialist nurses) and in the case of the occupational therapist and the dietitian there was maybe one other team member who in most instances was their manager.

Throughout this turmoil and uncertainty, many participants were witnessing inappropriate use of resources. One such example provided by a participant was that of a duplication of services from the District Nursing Service and the Multiple Sclerosis (MS) Specialist Nurse, where both were visiting patients and duplicating advice (sometimes conflicting). The participant did not feel that this was a good experience for the patient as it frequently left them questioning which advice they should adhere to. The Specialist Nurse (participant 8) developed a plan whereby the Specialist team visited patients weekly and would only involve the District Nursing service if their skill set was required. This resulted in a reduced case-load for the District Nursing service and an improved patient experience.

*“This small change in service delivery has totally transformed the provision of care for MS care closer to home, there has been enhanced patient satisfaction and it reduced costs substantially. It enhanced the MS nurse role and the GP’s were extremely satisfied” (Specialist nurse, participant 8)*

The core community teams, such as District Nurses and Health Visitors were under pressure to deliver more for less so they had to begin to look at how services could continue to be delivered without compromising patient care. This required thinking differently and looking at what services they had and how to use them more effectively. District Nurses in particular were being asked to take on new patients, increasing their caseload on a daily basis. Unlike in a ward, where staff can say ‘there are no more beds’, when caring for patients in the home it is not an issue about bed occupancy, but the staff resources available to visit them at home. The District Nurse participants were recognising that their caseloads were beyond full capacity and were reaching unsafe levels of practice. This presented ethical dilemmas as they did not have any policy whereby they could ‘close their books’ so had to take on the additional patients. It was at this point that they began to consider

delivering their services more effectively, without compromising quality of service provision.

A further example is given by a Community Matron (participant 20) who wanted to improve the referral experience for patients by consolidating existing points of access into a unified point of access.

*“I want to stop referrals being made to clinicians whilst they are visiting other patients as it is not always sent to the appropriate clinician and it is not professional practice to be receiving such calls whilst visiting patients. Currently duplicate referrals are being made to different services within Primary Care which causes confusion and also wastes time”* (participant 20)

It was evident that no additional resources were going to be added to their workforce to ease this burden, but quality of care had to be maintained so something within the current structure had to develop.

#### 4.2.2 Improving clinical outcomes

The participants also wanted to address what is necessary in terms of outcomes that are meaningful to patients and their communities. Amidst the confusion of service provision and limited staff resources it was imperative that the patient remained at the centre of any decision being made. The primary motivation expressed by all the participants was the desire to improve clinical outcomes as well as the patient experience. Some of the participants recognised that their client group were disadvantaged by the very nature of their physical disability, such as having a learning disability or physically not being able to access a leg ulcer clinic. These participants who were at the front line of service delivery were at the receiving end of anecdotal statements such as *“Why are there so many people visiting me asking the same questions?”* or *“Why can't I be seen at a clinic near me?”* Whilst this was not concrete evidence it gave the participants the opportunity to investigate some of these concerns.

One such example was where patients suffering from epilepsy were waiting months to see a neurologist and during this time their anxiety levels would increase. A Specialist Nurse (participant 16) recognised this and set up a nurse led clinic

alongside the consultant neurologist outpatient clinic. This reduced waiting lists, prevented a duplication of assessments and also meant that she could seek advice from the neurologist if it was needed.

*“Since developing this service we have seen a drop in accident and emergency admissions and the neurologists accept our expertise and have noted that their clinics are dealing with the more complex neurological conditions now. The patients are less anxious as they are seen quicker and their medications can be amended accordingly as I am a Nurse Prescriber also”.*

A Specialist Respiratory Nurse (participant 17) working in a rural location implied that it was impractical for her to travel long distances for potentially a ten minute consultation. However her caseload consisted of mainly people over the age of 70 years who were unable to travel to her monthly clinic. She spoke with the local bus company and spoke to her GPs and commissioners and her project has been funded for 12 months. The bus company will pick up patients at agreed stops and bring them to the clinic and bring them back home again. She commented:

*“I am already seeing improved clinical outcomes with my patients because they arrive at my clinic relaxed, not breathless, and also energised as they have been socialising on the bus coming in”*

#### 4.2.3 Poor communication of risk

The sharing of knowledge is essential to the success of any organisation and with reference to the NHS and other patient facing organisations sharing of knowledge will also impact on patient care. Sharing of best practice is encouraged across all sectors within the NHS but despite this expectation the participants were not experiencing this. They found that senior managers, in many cases, were not aware of some of the resource conditions which resulted in hazardous consequences for care standards. Frequently community trusts are managed by non- clinicians who do not fully comprehend the complexities and skills required when visiting patients in their homes. One example of this is where a band 4 health care assistant had been allocated to visit patients that should have been seen by a qualified district nurse who would have had the relevant skills to assess patients at risk. The District Nurse (participant 1) who was concerned about this said:

*“We have no team leader so the manager of the community service is overseeing our team, she only seems interested in looking at numbers of patients visited and not which member of the team visits the individual patients or what medical condition the patient has” (participant 1)*

Working as an autonomous lone worker can have its risks as practitioners may not always be part of the communication chain and on occasions referrals will go direct to the manager and not the clinical teams. However all the participants were very aware of the Queen’s Nurse Campaign: ‘*Right nurse, Right skills*’, so when they allocate staff to visit patients this knowledge can prevent potential problems. It seemed to these participants that managers frequently were not in a position to defuse difficult situations as they arose, due to the seeming lack of leadership within some of these organisations. In addition, at times, there was little recognition around the feelings of stress and negativity that was being felt by their employees as a result of being under managed.

This perceived lack of risk awareness, had a knock on effect for any staff member who voiced concerns or promoted a new way of working. A number of these participants had wanted to take the next step and develop their service, but encountered weak management support and, most importantly, felt they had no one to turn to when the pressure was on, so frequently their ideas had to be put on hold. When communication about risk was entered into with senior staff, participants were, at times, met with criticism rather than support.

*“The organisation I worked for was very risk averse – I was offered another job elsewhere so I jumped ship and I feel that the people I am working with now accept the fact that I don’t take things lying down any more. I am inclined to quietly reflect and then quietly professionally challenge what I am being asked to do and why. I have been able to negotiate some things to say ‘I don’t think this suggestion is a good one, I would rather we did this based on the experiences I have had in the past”*

#### 4.2.4 Lack of Specialist Services

One specialist wound care nurse explained that she was not supported to provide a leg ulcer clinic to both North and South areas of her borough. This left patients in the

South missing out on a weekly leg ulcer clinic as they were, due to their condition, unable to travel by public transport to the North of the area and they were unable to afford a taxi, therefore their care was compromised with the potential of worsening their leg ulcer. The lack of parity across services due to staff reductions and geography caused worry and concern for the specialist nurse, she said:

*“No one knows what is happening behind closed doors (the patient’s home) if there is not quality monitoring and communication between services across locations”*

Similar examples were given by other participants claiming that interruption of services meant that a patient could be without any contact (other than emergency call out services) particularly between the hours of 18.00 and 08.00 leaving a gap in access to services, particularly relevant to specialist services. This interruption of services leads to unsafe practice within organisations and poor patient experience, which was particularly evident in end of life situations. Patients may have requested to die at home but often, particularly towards the last weeks of life, if no community support is available the patient will be admitted to hospital against their wishes. A participant who is a learning disability nurse (participant 18) working with patients receiving end of life care, felt very strongly about this gap of service provision as it is stressful and frightening being at this stage of an illness, but it is magnified if either the patient or a family member has a learning disability.

*“Despite patients’ preferred place of care being at home there are still an unacceptable number of unnecessary out of hours admissions to hospice or hospital of patients at end of life who have expressed a wish to die at home, this makes them even more distressed” (Specialist Nurse)*

#### 4.2.5 Lack of imagination from organisations to understand the need for change

A difficulty often encountered was lack of vision from within their employer organisation. Each participant highlighted an aspect of their work that could have been enhanced if people were able to look beyond the ‘normal’ service delivery. Parts of the NHS in particular were experienced by these care workers as entrenched within old systems and processes making creating and sustaining any vision harder to achieve. Three of the participants recognised that they were constrained and valuable time was taken away from enabling them to use their

creative skills so looked outside the NHS where there were more opportunities to be creative, interestingly, instilling a love of their work once again. Two set up a social enterprise together providing a unique lymphedema service and another set up a social enterprise providing support for looked after children. Both social enterprises continue to thrive and have drawn on other creative innovative practitioners to join their workforce.

*“It wasn’t just about doing a service differently, it is also about us as leaders still being clinical and leading a social enterprise. So, we have introduced yoga for patients, and that was through negotiating with public health and having funding through a service level agreement, so far the feedback has been good”*

*(Lymphedema Specialist Nurse)*

The health visitor said:

*“I am now working the way holistic care can be given – I work in an integrated service where the children are supported by the most appropriate professional”*

Innovative practitioners, by the very nature of looking at doing things differently, are proactive when looking at solutions to improving service delivery. Many found that the reactionary approach of large organisations such as the NHS was stifling and left them feeling devalued and frustrated at the lack of vision and short sightedness. Observing poor management and lack of recognition that delivering a service in a different way, yet in line with the organisation’s vision, would enhance service and inevitably patient satisfaction was a major concern for the participants. One such example came from families who were able to access the NF1 support service which was introduced by one of the participants after recognising that many NF1 patients and families were feeling isolated; a number of comments were made from families who said their lives were improved through communicating with families who have children with the same condition.

#### 4.2.6 Maintaining excellence in clinical practice

In contrast to large organisations such as the NHS, which can at times adopt a mindset of achieving day-to-day mundane (but necessary) targets, these participants were striving for excellence. However, they were witnessing complacency and,

occasionally, professional jealousy by colleagues who were suspicious of anyone challenging the status quo. Yet many felt that they had no choice but to work with colleagues who displayed characteristics of apathy and social acceptance, lacking in enthusiasm by just wanting to 'get the job done'.

*"I try to get the team on board to share my vision, but this is not always possible, so I have to work to the best of my ability with those who are willing to work differently"*  
(District Nurse)

#### *4.3 Theme 2 -Swimming against the stream - the challenges faced when setting out to improve clinical practice and patient experience*

This section is composed of a group of sub-themes which describe the different challenges, professional and personal, faced by these 'would be' innovators when they tried to implement their ideas. While the themes identify separate issues they are characterised by a sense of doing protracted battle with established practice and finally the impact of the struggle on the participants. The sub-themes are:

1) Organisational lack of recognition of the existence of a problem, 2) Lack of vision to try for better, 3) Frustration – this is how we do things around here, and 4) Self-doubt – have I really understood the problem?

##### 4.3.1 Organisational lack of recognising existing problems

The majority of the participants said that they observed a lack of insight by the organisations to consider the need for change to happen. There was an acceptance of current practice which did not consider any change of service delivery being required. The participants had the relevant knowledge and skills that could be called upon to implement such a change, but their experience and skill set was, in general, not acknowledged by their organisations. This was commonly thought to be because the organisations had not received any complaint about their service so they did not see the need to do things differently. One example was that given by a School Nurse who was writing a book on sexual health which was written in terminology frequently used by teenagers. She had also planned workshops in the format of competitions, which enabled teenagers to speak freely in a safe environment where they would not be intimidated or judged. Local clubs or halls offered their space to run the



workshops, which is quite different to the traditional school nursing service delivery where the School Nurse visits the school and offers 'drop in' sessions. The School Nurse said that:

*"In general, I don't think that people understand enough about contraception and sexual health, either as healthcare professionals, teachers or students – and they should to maintain their health as not everything is covered by the school teachers and this could be supportive material for the school nursing service."*

Her employer organisation did not view her project as a public health initiative and claimed that her project was already being covered in schools, they did not accept that it was aimed at those marginalised groups who often have dropped out of education so would not be getting this information. Unfortunately the book has not been approved as a resource by the NHS so an educational minister from the Caribbean, who was known to the School Nurse, was contacted and her book is now used as a resource in the Caribbean and comments to date have proved that it has been accepted by the school and students positively. The workshops have not been implemented at the moment as the staff will need training in facilitating such workshops.

At least fifty percent of participants said that the reason their organisations were not supportive was because they were unsure of what the expected outcomes of the proposed initiatives would be and in some cases they did not understand the rationale for implementing a particular idea. The proposed outcome or goal for the school nursing initiative mentioned above would be to reduce the amount of sexually transmitted diseases and also reduce teenage pregnancies and promote wellbeing in adolescents. However, the organisations were, in her view, short sighted and did not have a long term vision of the benefits of such a service. A way of monitoring this would be to develop a database of adolescents acquiring a sexually transmitted disease (STD) and also look at the number of unplanned teenage pregnancies that had occurred over a period of time (eg, 12/24 months) and subsequently pilot the project and monitor these same conditions over a further period of time. She has suggested this to her manager and at the time of the research interview this was being considered. She was pleased at this response as she feels that if the statistics

show a high rate of pregnancies and STDs then her book may be considered at a later date.

#### 4.3.2 Lack of vision – to try for better

Lack of vision on the part of their employer was claimed to have been experienced by many of the participants, particularly those working in larger organisations such as the NHS. However, an example of the desired visionary thinking was related by a Specialist Nurse who works with patients suffering with prostate cancer. She explained that her service was unable to deliver the government targets of offering an initial out-patient clinic within 2 weeks of diagnosis because they were still seeing patients who had been on the system for years as they would have out-patient appointments 'for life'. Fortunately, she worked with a department with vision and together they developed a remote follow up service which she said was the first of its kind in the UK. This then released appointment times for newly diagnosed patients to be seen. This service was also evaluated positively by patients receiving this service and it is hoped that the service will be viewed as 'gold standard' treatment for patients with prostate cancer and will be replicated across the UK.

The prostate cancer telephone follow up provision and support systems for NF1 sufferers are examples of how ideas can become a reality if there is agreement from line managers. In instances where the lead of the organisation supports the vision this can make the operational functioning of a new service easier. However, not all clinical areas are fortunate enough to have such support.

The Occupational Therapist (participant 14), involved in this study had been trying to implement a pro-active falls service targeting people who were potentially at risk of a fall. He made the following statement:

*'Most patients that have a fall will spend at least one night in hospital and many do not recover to previous functional level which means a longer stay in hospital. The local ambulance service has reported a 3 fold increase in falls over the past few years.'*

His idea was to deliver a comprehensive falls prevention service, utilising a Falls Prevention Champion, to deliver an effective but brief one-stop holistic assessment

and treatment for anyone referred into the project in order to prevent falls in the community. Patients, families or carers, health, partner agencies or adult social care staff, with the patient's consent, would be able to refer to the team for advice, assessment of needs, provision of equipment or walking aids and property risk assessment.

The comment above highlights how a small change to service provision could reduce hospital admissions and provide a holistic approach to care. He spoke of an 80 year old lady who had purchased a walking stick and a shopping trolley independently as she was not aware of any services that could assist her. She subsequently fell because the walking stick was not the correct height for her, resulting in her fracturing her hip and spending five weeks in hospital. Over £25,000 was spent on ambulance service, hospital admission, a five weeks stay, surgery, community follow up, social support, GP visits, daily living equipment and medication. Such lack of vision within organisations has caused frustration amongst the insightful participants who could envisage a more cost effective patient centred service.

However, much of the reason for the 'lack of vision' some participants acknowledged may be due to the NHS processes that are set up to safeguard patients within the NHS. For example, in clinical practice, if an individual makes changes without consulting the senior management team then they are often singled out and their change may frequently be blocked. This may come across to some as bullying as this District Nurse said "*the NHS has a culture of work place bullying and blocking of innovation*". The '*blame culture*' has been referred to by at least seventy percent of the participants and it was the fuel that for some ignited their frustration. In some cases this actually resulted in one of the participants being put on a disciplinary charge and another leaving the service.

*"At all times the patient's safety was paramount, but because I acted as an autonomous practitioner and made a decision that was not in line with the organisation's policy I was witch hunted and a disciplinary was made against me and I was suspended on full pay!"* (participant 6)

Such actions can be short sighted leaving an already under resourced service to deliver care, potentially resulting in sub-optimal care. This particular organisation went months with one member of staff down impacting on the delivery of the service

and patient experience. It also resulted in a very strong willed practitioner becoming more determined that her decision was correct so a battle of wills commenced. The organisation was not successful in upholding the disciplinary claim and the participant returned to work, but promptly resigned and has now set up a new service in an area where there are more visionary managers. In instances there is evidence of a '*lack of long term thinking by management*' and participants stated that in their view there was a '*blame culture*' amongst the senior members of their organisation which was something that they could hide behind when confronted with their decision.

#### 4.3.3 Frustration – this is how we do things around here

Frustration was frequently mentioned by the participants and this was mainly due to working with people who, in their view, were content to remain working at the pace they were familiar with and not sharing the passion to the extent that the participants did. This is not to say that the service provision was not of an acceptable standard, but opportunities were missed with no consequences or even a desire to revisit these missed opportunities. It is at this time that reflection should be practised, however staff are frequently only focussing on the task in hand and not taking a step back to reflect if things could be done differently. In support of this statement those participants working in the NHS continued to state that they were working in a bureaucratic, top-down culture which constantly frustrated them. A learning disability nurse (participant 19) made the following comment about her organisation saying:

*“They are unable to recognise that an add on service could improve patient care dramatically”*

She wanted to introduce a befriending service to patients with a learning disability which would increase their social interaction, promote their independence and potentially reduce hospital admissions. Often these patients end up at accident and emergency because they are lonely and want to communicate with someone, not necessarily having a medical ailment.

This is not a new phenomenon in the NHS as accident and emergency units are frequently visited by patients who may be lonely or who have a mental health condition. However no service has been provided to care for them, so in order to

gain attention or to seek help they will turn up at the accident and emergency, which is very often inappropriate, and staff do not always have the expert skills to care for them.

#### 4.3.4 Self- Doubt - do I really understand the problem?

Whilst the majority of participants displayed a substantial amount of confidence and determination a significant minority talked of self-doubt when they observed what changes and innovations were happening around them and seeing what others had achieved. These particular participants stated that they were '*out of their comfort zone*'. One of the Health Visitors said:

*"I lack experience to expand services and don't think I have the correct skill set to put my ideas into action"*

Individuals entering the caring profession do not necessarily commence their career with thoughts of changing service provision, in many instances the underlying reason for training as a nurse or an allied health professional is to care for patients/clients. However, as they progress in their career their confidence grows and for some they have the ability to make changes; others find it difficult and in the words of a Mental Health Nurse:

*"My own fears to try something different stops me, I am frequently faced with challenges and I know in my heart what should be done, but I don't always believe in myself"*

The majority of the participants were over 45 years and had been trained on average for twenty years. Training in those days was delivered through facts and case studies where critical thinking and enquiry was not encouraged so therefore when they began to critique a service their self-doubt would surface. On the other hand this group of participants had witnessed and worked with health professionals who had been trained to think critically and to ask questions and recognised that they had knowledge of their clinical areas and so they also gradually began to question practice. Working in a caring profession is unlike other careers as these professionals are having a direct influence on patient and client care and a

miscalculation could have life threatening consequences. This may be a further reason for the self-doubt that some participants displayed.

Those participants who displayed greater confidence and self-assurance were very happy to take a calculated risk; this was particularly evident in services where they had pro-active ideas. One example of this was an idea that was developed by a District Nurse who wanted to integrate health, social care and voluntary sector services to reduce the risk of inappropriate hospital admissions. In doing so it is anticipated that this would improve co-ordination of quality care, increase the dignity and well-being of older people and consequently reduce the demand on community services, in particular District Nursing. The idea was supported by the local clinical commissioning group and a local national branch of a charity funded the project. This resulted in some initial challenges around the organisational change with the development of a new integrated role within an established workforce, in particular the District Nursing workforce. However, at the time of the interviews the pilot scheme, which had identified 100 patients who had met the criteria for the service, had been in force for twelve months and the challenges had been overcome with the hospital admission rate for the over 75 year group being reduced by 50%.

This particular example was pertinent to this study as the District Nurse who implemented this pilot had been a student on the programme that was delivered by the researcher. She had commenced the programme at a time when she was at a crossroads in her career and she was frustrated with the service being delivered to the over 75 year group. She also doubted her ability to do anything to change the service. However, attending a programme where she was able to share her frustrations and her vision with other like-minded people added to her belief that something needed to be done to enhance this service delivery. She commented that one of the lectures on the programme posed the question '*What will your workforce look like in nine months' time .... We need to break down the barriers between health and social care to focus upon integration for any changes to be successful*'. This statement had resonated with her and she said:

*"At that moment I recognised the opportunity I had and what a privilege it would be to make a difference through making a change within my community setting"*

This was the turning point for a District Nurse (participant 1) who had started her journey with little confidence and an abundance of self-doubt. She went on to say that:

*“On a personal level I have discovered that stripping away all things I have no control over has enabled me to direct all my energy in setting clear examples for senior managers and commissioners of quick win-wins in relation to achieving small goals and positive outcomes with patient care that we can celebrate”*

#### *4.4 Theme 3 - Can't do it alone - recognition of the need for further training and support*

Lifelong learning is a concept that is encouraged within nursing and allied health professional careers and the use of evidence based practice is evolutionary, therefore it is generally looked upon as an opportunity to advance knowledge in their professional field, which in some instances may also open the door to a career promotion. However, the participants in this study had acquired knowledge and advanced educational training within their specialist field of practice, but without exception, all participants identified the need for even further training of a different kind if they were to get their projects off the ground. The themes identified are: 1) Identifying a lack of skill around finance, 2) How education influences motivation and persistence, 3) Confidence in their own clinical skills, 4) Lack of confidence in knowing how to make changes happen.

##### 4.4.1 Identifying a lack of budgeting/financial skills

For example, to have a greater understanding of financing a new project and the various financial elements that would make it successful was a need recognised by the participants. Economics and finance is not an area that is covered in nursing or allied health professional training so there was an identified gap and recognition for further training and support in this area. As the NHS has become more target driven over recent years the health professionals have had to recognise the significance that finance plays across the roles of all health professionals. Every service being provided has to account for the revenue it is bringing in and the expenditure required in delivering the service. In previous years this was the responsibility of the

manager, but frequently this responsibility is now passed to front-line staff. It is essential, therefore, for anyone developing a project to be able to present a business plan that will reflect the benefits and outcomes of a project. Whilst this caused a certain amount of anxiety it also gave the participants 'ownership' of their idea which fuelled their enthusiasm, along with some anxiety. A school nurse (participant 3) felt that she had some understanding of project finances as she had worked with publishers to write and produce a book, but what she couldn't do was publicise the use of her book effectively and raise the money required.

*"I can work with balance sheets and finance I just need to know how to bring the money in and get people interested in my project"* (participant 3)

This was a very different aspect of financial acumen which sits alongside marketing an idea and was new to her. It is an illustration of how working in isolation is not the best option when trying to generate an interest in an idea or project. Another example is that of the two specialist nurses (participants 11 & 12) who set up their own social enterprise in order to improve the lives of patients suffering with lymphedema. They provided specialised care to these patients, providing clinical expertise, health promotion and yoga classes to improve the well-being of patients. They understood their market but wanted to know how to generate an interest in their service and make the wider GP population and hospice services aware of their service provision. Their initial starting point was to work with the hospice and Macmillan service to introduce their new service. Their expert provision became widely known and they are now receiving referrals direct from the GPs, releasing space in the hospice for others. Support and understanding from the organisation of the employer, or organisations utilising a service is essential to move any idea or project forward at a reasonable pace.

#### 4.4.2 How education influenced motivation and perseverance

These participants, it appears, also developed a keen sense of perseverance over this period helping them learn new business processes which in turn gave them a new perspective and understanding of the importance of being business savvy as well as just having a good idea. The new skills resulted in growing confidence which in turn, many claimed, made them more determined in their aim and willing to take



on new challenges or new aspects to their roles. For example, they now understand the importance and relevance of preparing a business plan before making any changes within service delivery.

*“If you have the determination and the will to do something don’t let others squash you. Don’t let them take ideas from you. If you can’t get there using one route use another.... But don’t give up” (participant 26, a mental health nurse)*

The feeling of being ‘done to’ rather than being part of the decision making process was felt by a large percentage of the participants and an occupational therapist said:

*“Just because somebody says ‘No’ don’t take no for an answer.....find another person who you can influence ....Over the past nine months I have been told ‘No’ lots of times when I talk about the change I want to implement, but I will look at new ways...I will not give up”*

The NHS is going through many changes and challenges at the current time and it is impossible for staff not to be affected by this. These are times of uncertainty and low morale is rife amongst staff yet despite this a learning disability nurse said:

*“There is a lot of flatness amongst practitioners and people lose motivation. People are just going through the motions because they feel that there are no opportunities or they don’t feel supported. The post graduate programme gave us these tools to sort of take responsibility for our own actions and be accountable, it keeps me motivated. So no matter what hurdles or challenges that you have to face..... I have become more motivated, and happier to persevere and keep pressing on and that helps practice definitely”*

Upon reflection of their practice, a number of the respondents recognised that they had courage and tenacity and a resilience and perseverance within themselves that they were not aware of. A dietitian commented:

*“The whole idea of seeing ideas becoming a reality rather than just a dream increased my confidence and I realised that the determination to do this was worth it”*

At least sixty percent of the participants said that prior to coming onto their chosen programme they would possibly have given up on an idea if it was rejected.

Perseverance is now central to their attitude when they contemplate any changes.

*“Everything starts and ends with me now and this has been a big, big improvement in my working life – I take responsibility for any changes and persevere if I am faced with resistance” (Specialist Nurse)*

Another respondent said:

*“When I go into a boardroom now I am not at all intimidated – I am persistent in my approach and I am respected by the CEO and senior managers – I rock that boardroom now!”(Learning Disability Nurse)*

When faced with a negative response about an idea the responses were unanimous, they would persist but they needed to understand the reasoning behind the ‘No’ response. It is due to their sheer determination and perseverance that this understanding can be found. It takes time to challenge, question and investigate other angles and to come up with potential solutions.

Discussions with the participants showed that they now dealt with perseverance in positive ways and that a much more subtle approach was taken to look at the reasons why an idea was being rejected. The midwife participating in the study said that, if rejected, she would ask:

*“Why are they doing that, where is that coming from?”*

Using this tactic has prevented her from taking any comments personally and she now tries to see the reasons from the other persons’ perspective, particularly from the perspective of her manager, suggesting that they ‘*might be frightened of where your comments are going or where your thoughts are going*’.

At the time that the research was being carried out the participants were open and transparent about their feelings. As the responses began to unfold the concept of perseverance began to emerge. The participants were of the opinion that the programme they had attended had helped them to recognise this inner drive which they had not previously been conscious of.

*“I think what the course really made me realise was that there are lots of tactics that people around you will use to try and distract you, or pull you away, or you know that sort of thing. And you really can’t be disillusioned and you can’t let them get to you. You just have to keep your... true to yourself really” (Community Matron)*

#### 4.4.3 Confidence in their own clinical skills

The difficulties mentioned above can be contrasted with the confidence that the participants had in their own clinical skills. Many of the participants were over the age of 45 years so they also brought to the table life skills which are not measured by attending a course or a programme, but draw on the experiences they have had to date which makes them the person they are today.

One participant, who was over the age of 60 years, said that her life experience had provided a 'richness' to what she could contribute to both the programme and to her clinical practice. Another Specialist Nurse said:

*"My life skills have enhanced my professional practice and the experiences I have had along the way have made me the person I am and I am richer for this"*

While self-belief and confidence was present in most of the participants, it was having had the opportunity to share their thoughts and frustrations with like-minded people that enabled them to pursue their ambitions. Many of the participants made comments about a renewed sense of 'knowing their own potential'. One of the Health Visitor participants said:

*"The programme has given credence and confidence to what I do. I now believe in myself as a change merchant, and to recognise that ok, I can be whacky but equally that's actually sometimes how the best ideas start".*

Similar comments made in support of growing confidence identified by the participants:

*"I am much more focused on goals and aims that I am seeking to achieve. Also, it has made me realise that when you have an idea that ... you really go for that Idea. Actually to follow through can be very hard and quite often things will get kicked into the long grass but you just have to keep on going" (Specialist Nurse)*

#### 4.4.4 Lack of confidence in knowing how to make changes happen

While there was a general consensus among participants that their ideas were innovative, creative and would save their organisations money, as a result of previous unsuccessful attempts to get a project off the ground there were feelings of uncertainty all round. Participants were unsure who to approach for constructive advice so often went in circles for a while waiting for the right person to talk their ideas through.

*“ I’m the sort of person that I have ideas I can get to the preliminary stage of things and then I find it quite difficult to move to that next stage of getting people to really take interest in real terms, in a strategic way. People are very nice at a low level way, and are very complimentary and think things have a value to them for patient use, but in my personal experience I’m not good at taking it to that next stag” (Specialist Nurse)*

*“I can think big, but I cannot act big because of the restrictions to my role”.*  
*(Occupational Therapist).*

One key factor that helped many was the opportunity to network with well-informed others and also to hear prominent speakers at conferences; the participants gained and refined their ideas and were given advice on how to approach senior members of their organisation to get a project noticed. The support enabled them to work through any feelings of inadequacy and any past experiences that were stifling their creativity.

*“I felt that I was working in a straightjacket as my ideas were constantly being rejected without any rationale.....once I was able to bounce these frustrations onto a colleague I began to see clearly” (District Nurse).*

Due to conflict within the workplace, confidence was compromised and feelings of inadequacy were creeping in for some of the participants, but again the support network helped them through.

*“Talking to someone who has been through the same experience as I have confirms that I know what I am doing and they know that I always have the patient’s welfare at*

*the core of everything I do and other people do not have the vision that I have, so I say to myself go on do it your way” (District Nurse)*

Networking was not an aspect that initially came to mind when looking at how to make change happen, but it ranked highly as an essential part of supporting this change. Sixteen of the participants confirmed that they would contact someone they had met on the programme to seek advice.

*“...One of the main areas was meeting up with people in similar situations doing similar things, trying to make a difference...and sometimes if there are queries there or we need to run something past someone we will email each other for support” (Occupational Therapist)*

As has already been mentioned, not all the participants had supportive work environments where they could express ideas freely so the programmes provided a venue for that. For those who were able to speak freely without judgement they were able to work through any fears with key work colleagues. Interestingly, after they were some way into the course, some found that once they were honest and opened up about how they felt, they gained support from managers and other professional colleagues. On occasions some claimed to ‘*take emotional risks*’ to be heard and the determination and resilience that they saw in others inspired them to keep going.

#### *4.5 Theme 4 – The real me - finding a professional home*

A change of perspective with regard to the participants’ self-perception was a key finding. Indeed, the emergence of the construct of ‘*the real me*’ surfaced for many after they had started their post qualifying programme. The culture of the programmes provided the opportunity to share their experiences in a safe environment with other like-minded people without being judged. This was a sharp contrast to their working life where, if an idea had failed, many of them felt judged and frequently did not attempt to try again. They reported some profound personal changes as they worked through their programme. It is noteworthy that it was not long into their programme before some shifts in perception were evident, suggesting that being amongst people who had similar traits and beliefs had given them the confidence to voice their concerns or misgivings about what they were witnessing in

practice. The sub-themes here are: 1) Permission to think and develop the 'self', 2) Self- belief – beyond work,

#### 4.5.1 Permission to think and develop the 'self'

For many working in healthcare it is like living in the fast lane, this is particularly so for staff working in an organisation such as the NHS where all their time was taken up executing their duties leaving little time or energy to think laterally. Therefore, one of the key findings was recognising that while they knew they had the skills and knowledge to carry out an initiative they needed protected time to reflect and to visualise what 'success' might look like. Many said the programmes allowed them to give themselves '*permission to think*'. In the words of a dietitian it gave time to '*value myself and accept the past, overcoming my self-doubt*'. Other participants said that it also enabled them the opportunity to '*work through fear*'.

Arguably it is not common practice to be seen actively '*thinking*' as nursing and other allied health professionals are renowned for being '*doers*', therefore this change in culture took some time to adjust to without a feeling of guilt for some. A District Nurse said:

*"Why give others the power to spend your time – use your time effectively and efficiently"*

She was a self-confessed '*deviant*' but she had a '*can do*' attitude and sought out positive minded people to work with. So with protected space and a safe environment, considerable constructive thinking went on.

A Specialist Nurse said that she puts a 'Do Not Disturb' sign on her door as this is her '*thinking*' time. Everyone at the Practice where she works accepts this and when she surfaces they ask her, '*What bright idea have you come up with this time?*' The acknowledgement that this is good use of time has given her the opportunity to bring new ideas to the practice and the patients and staff are seeing the benefit of this.

#### 4.5.2 Self-belief – beyond work

One common theme that emerged from the data was the strengthening of their self-belief. Comments were made from both younger and older participants:

*“I didn’t realise that I was capable of doing this”*

*“I feel people are seeing the real me for the first time”*

One of the younger learning disability nurses said:

*“I don’t have the fear I had before” (participant 18 )*

This eight word phrase sums up the difficulties that many of the participants had been faced with but were now able to deal with; this is mainly due to the support of colleagues and the inner confidence that they discovered whilst on their journey. As the midwife in the study claimed:

*“There is a lot of change happening for me and I have lots of ideas swimming in my head. Once upon a time I would have thought that my career is over. Now I know that if my job goes I am good at my job and I will be able to get another”*

It had been obvious from comments made that many of the participants did not feel they belonged within their organisation as they were frequently referred to as being a ‘difficult’ member of the team, frequently ostracised when decisions were being made. This resulted for some in a weakening of their self-esteem and a feeling of not having a professional home. However, once on their programme, knowing that they are not alone in their way of thinking gave them the confidence required to continue with their quest to introduce new ideas to their work place.

*‘Learning to believe in yourself’* was mentioned in various ways by several participants as a District Nurse (participant 2) claimed:

*“I think I have a rosy future whichever way it goes because I believe in myself”*

In contrast, another District Nurse (participant 5) said that:

*“To believe in yourself is the hardest thing”*

She was working in a team of very experienced District Nurses who were uncompromising in how they provided care to patients in their homes, thereby disabling her belief in herself as she frequently suggested alternative ways of providing care. She remained working in the team until she saw an opportunity to work for a more visionary team of heart specialist nurses and she joined their team where she felt she could apply some of her ideas for improving patient satisfaction and care for people with long term conditions.

Many of the participants were finding it difficult to be themselves and fit in with the corporate image and, in many instances bureaucratic systems. However, on occasions when a manager spent time and listened to their ideas, as a learning disability nurse said: *“a chink of light appeared”* and all was possible.

Some of the participants said that the self-belief that they discovered went beyond their working life into their personal life. For example, one of the School Nurses (participant 25) had been approached to set up a Parish Nurse Service, which would involve the integration of nursing with the beliefs of her religious community. This is a relatively new concept in the UK, originating from the USA. It involves physical and spiritual health (of any denomination) through working with the ‘whole’ person and the wider community. At the time of being asked about this she did not have much knowledge of parish nursing, but she accepted the offer and said:

*“So this is another exciting endeavour and I believe I can do this”*

One of the factors that helped participants to recognise their own individual skills was the Myers-Briggs Type Indicator (MBTI) Personality Test that they were asked to participate in during their studies on the Post Graduate Certificate in Social Innovation and also on the NHS Leadership programme. The general consensus was that it helped them to understand themselves, but the added bonus was that it also helped them understand how others reacted and worked. This improved both their working and personal life because they were able to recognise some of the traits that they had learnt about in the psychometric testing. One of the self-confessed shy participants commented:

*“Knowing my own characteristic – ISTJ (Introversion, Sensing, thinking, Judgement)..... acknowledging that not only extroverts will get things done,*



*introverts will go about it in a different way, yet as effective, but they must be seen, therefore relationships must be built”*

Another comment made by a Health Visitor (participant 13) suggests that the approach and sensitivity used when working with patients/clients is guided by the values and characteristics displayed by the professional. Frequently she deals with families and children at risk and she reiterates the importance of transparency, sensitivity and professional attitudes when working with this group, she says:

*‘People don’t buy what you do, but why you do something and therefore values are taken into consideration’ (participant 13)*

#### *4.6 Summary of findings of the first stage of the journey*

This chapter covers the first part of the participants’ journey towards becoming an innovative practitioner within their area of healthcare. A wealth of material was elicited from the interviews showing complex sets of perceptions about the experience; some were what might be expected, others more surprising. The common themes of the observation of sub-optimal care or simply a lack of vision and poor communication acted as drivers for these individuals and were consistent with findings from the literature review which have shown that the support of managers is essential if change is to happen. The literature has also shown that post qualifying education stirs up further questioning and practitioners are more confident to challenge and are ready to face obstacles experienced when suggesting a service improvement where there is a lack of recognition of need, or the admission of a problem with service delivery and, in their view, unwarranted contentment with adequate care. However, some of the personal themes that emerged were unexpected. While appearing confident in their professional skills and knowledge and with many years of experience behind them, it was surprising to hear of the degree of self-doubt and lack of confidence that emerged when they began to organise themselves for action. Interestingly, although very real, the self-doubt did not stop these professionals from pursuing their goals. Some felt irrationally daunted and out of their comfort zone but gradually this feeling disappeared and an inner confidence surfaced as they spent more time on their specific programme. The self-belief and the knowledge of their specialist areas prevailed, whilst also the crucial

acknowledgment was made that further support and education was required particularly in the field of planning for and managing the financial aspects of their projects.

Two of the less expected themes were that when they started the course a sense of belonging occurred and the feeling that they were discovering the 'real me'. Being able to express their views in a safe environment was a powerful factor in their shifting self-perception, almost as if their ideas had been locked away and not allowed to be released. A linked theme, which was clear from several interviews, was the concern that they had been seen by others in their employing organisation, and to some extent saw themselves, as 'outsiders', and as 'deviant' in some way. However, attendance on their course enabled them to spend time talking with like-minded people and over time these negative perceptions disappeared.

The next chapter continues their journey as it looks at the full impact of the training experience as they gain skills and develop as confident innovative professionals.

## **Chapter 5 Findings part two**

The findings in the previous chapter looked at the first part of the participants' journey beginning with their recognition of a need for better healthcare delivery in their professional area; the difficulties they encountered during their initial efforts to improve practice; the recognition that they could not succeed unaided and finally, for a significant number, the discovery of a new 'self', a real me. Although the participants had very different working environments, clinical interests and experience, issues emerged from the data so frequently that they became themes. They included varying levels of personal and professional confidence, frustrations with managements' responsiveness and a sometimes belated acknowledgement of the limitations of the knowledge and skills required to successfully become a healthcare innovator with a view to improving care delivery.

### *5.1 The Journey part two: the complex road to becoming an innovator*

This chapter will look at the impact of participation in the post graduate course, the NHS leadership course and training days attended by the participants. It will identify the additional skills they developed and how they enhanced their effectiveness when becoming an innovative professional.

This second part of the journey looks at how these courses broadened their knowledge and skills base, reinvigorated their capacity to 'learn' and also how it contributed to their personal development. On joining their respective course the participants were suddenly with like-minded people who were able to support their views but would also challenge them constructively - in contrast to the lack of support many claimed they experienced in their work place. Being with like-minded, innovative and creative people and working in a focused way on their own project had a profound impact on many of the participants. The results are reported here in two sections 1) the 'real me' post education, and 2) the impact of learning

### *5.2 Theme 5 – The Real Me in Action – Early involvement of others*

In the previous chapter the theme of the 'real me' which identified subtle changes in the thinking of the participants, had been influenced by some key factors which

helped the participants find themselves: having permission to think creatively, being supported by like-minded people and, most importantly, not being the outsider or 'difficult' member of their team – always wanting to do things differently. This resulted in the strengthening of aspects of their character for many participants. In some instances participants themselves have stated that they did not recognise themselves, never believing that they would be capable of making some of the difficult decisions and organisational changes they did. In making these changes their revised perspective on how they approached their work had a major impact resulting in these changes.

Table 7

Key themes incorporating sub themes:

**The Real Me in Action - Early involvement of others:** No man ( or woman) is an island, seeking support from further afield, working differently & change of perspective, increased confidence in own professional judgement, personal development

**Development of the 'Real Me' & The Impact of Learning:** individual strengths, listening to others, skills in finance, business plans, negotiating, working strategically, seizing opportunities – finding new courage, not frightened of failure

### 5.2.1 No man (or woman) is an Island

Many community health professionals are lone workers, they work independently, often in isolation, which is the nature of working as a community health care professional. However, some have now expressed an interest in working differently in future; in particular through involving others in the early days of their plans for caring for their clients/patients. Though frequently visiting patients and clients on their own, these community health professionals acknowledge that they are part of a bigger community team and they will consider involving other members of their team in the provision of care, as lone working may not now meet their patients more complex needs.

One early finding reported was that participants shifted their view and developed a new understanding of the advantages of making more effort to remain part of a multidisciplinary team, to bring others with them, and not to isolate themselves even in the face of indifference to their plans for better practice.

Recognising that there are people in their organisation who could potentially help them promote their idea prompted several participants to involve selected colleagues. A mental health practitioner (participant 4) stated:

*“I would try and get more influential people on board sooner rather than later ..... but it is hard to find people in the NHS with a long term outlook”*

A Specialist Nurse (participant 8) had similar views:

*“Get buy-in early on. Find an influential person in the organisation who can support and fight your corner”*

Interestingly, it was apparent that the rationale for involving others was not necessarily about requiring more money, but about having influential people on their side with their greater and different experience and access to senior figures that several concluded could assist in driving their ideas forward. Alongside these influential people specific departments also needed to be brought on board. The participants recognised that it would be favourable if particular departments or individuals working in these departments expressed an interest in their ideas. Business and finance departments were acknowledged as being significant allies in their drive to push an idea forward as without the support of these areas within an organisation it would be difficult to proceed with any new initiative.

It was not only within their employer organisation that help was sought; some who had successfully set up their own social enterprises already saw the advantage and clearly stated that they would *‘enlist the support from other social enterprises/Community Interest Companies to help with the social return on investment’* (participant 13).

This particular Health visitor had set up a small specialist service in an Accident and Emergency department and she had been clear from the onset that the expected outcomes of this service was to improve the care and service provision for looked

after children in her geographical area. She recognised that she would have to involve other agencies such as Social Services, together with the General Practitioners, from the onset if this service was to be successful. The early involvement of these agencies did in fact prove to be beneficial in the overall social and clinical success of the service provision.

However, not all the participants had acknowledged the importance of involving other professionals early in implementation of their idea. They had to learn this fact later in the process. For example, a participant working as a specialist wound care nurse (participant 9) across a number of general practices said that she would have brought colleagues on board much sooner had she known how supportive they would turn out to be:

*“I would have approached the GPs much sooner as they have funded the pilot with little question,.....they have already referred most of the current caseload”*

The only occupational therapist involved in the research stressed that it was important not to try to accomplish the project without the support of their immediate manager. He had initially struggled to get support as his project did not meet the manager’s aspirations for the department that year so he adapted his plans to meet part of the manager’s plans for the next year.

### 5.2.2 Seeking support from further afield

In addition to eliciting the support of colleagues with an interest in their innovation, seeking support from a coach or a mentor early on in the process was perceived to be beneficial. This was particularly relevant for the health care professionals who were new to promoting their ideas and were aware of how much they lacked confidence or knowledge about the process. Those participants who had access to a mentor or coach from outside their organisation claimed that it gave them the opportunity to discuss their ideas objectively.

*“It was so liberating to be able to speak to someone who was not going to judge me by my pecking order within the organisation .....I was able to speak freely without the fear that my job might be in jeopardy” (participant 19)*

However, for at least one participant, the relationship with the mentor was more important than whether they were part of the organisation or not. A learning disability nurse was mentored by a manager in her organisation who initially was against changing anything within the service.

*“Initially I was really concerned because this particular manager was really against me making any changes to the learning disability service and he was initially very obstructive when I went over his head to share my idea with the Chief Executive of the organisation”* (participant 18)

Nevertheless, once they were able to remove themselves from the business of the clinical environment and were able to meet over a casual cup of coffee she was able to lay out what the outcomes of her innovation were to be and how they could be achieved with minimum extra input from staff. It was a matter of doing things differently which in the initial stages of conversation the manager had not appreciated. Her anxieties were overcome when she found that she was able to seek support from the manager who was open to listening to her ideas and he was also able to assist her in developing strategies to put her idea into action. This particular learning disability nurse was aiming to improve the end of life care for families with a learning disability.

### 5.2.3 Working Differently

Alongside bringing others in to their ideas early on in the cycle of their innovation, participants also claimed that they were working differently in other ways. A significant number acknowledged that their perspective had changed in recognising alternative ways of approaching their clinical practice and working across the sector. Prior to attending their course, many of the participants felt that their idea could, and should, only be implemented ‘their way’. Several shared that, at times, when their opinion was challenged with an alternative perspective on their identified area of poor practice from another interested professional, they felt that they were being undermined and their confidence floundered. The dietician in the research study provides an example:

*“I wanted to review the uptake of prescriptions for supplement drinks by interviewing my patients, but my manager suggested that I review the prescription data from surgery which would give me quantitative data for that surgery”* (participant 2)

She went on to say that she felt that this would be too small a sample and it wouldn't give her the complete picture. However, she took the advice and realised that this was a much more effective way of collecting data as she was now able to obtain data from all of the surgeries in her geographical area and it gave her a clearer idea of who was using supplement drinks.

However, this struggle with self-doubt and a feeling of being almost 'got at' was managed and receded in the light of a positive outcome leading from the other person's advice. For many of the participants the recognition that working differently and having the ability to look at ideas and suggestions from another person's point of view actually enhanced their way of working was a big step forward in their development. It enabled them to keep their idea central, but to also take on suggestions from people who have experience in working on projects at a larger scale. Appreciation of these additional skills has been slow at times as some of the participants felt challenged and threatened until recognising that there are different ways of delivering a better service. A Community Matron comments that listening to the views of other professionals has helped her to develop her one stop service for patients in the community:

*“I was managing an integrated service and always felt that I had the ability to see things from other professionals' view point, but when we eventually sat down and looked at how I was delegating workload I realised that I was still looking at things from my professional point of view and had not considered the physiotherapist or pharmacist's point of view”.* (participant 20)

#### 5.2.4 Increased Confidence in own professional judgement

The example above of the learning disability nurse who went over the head of the manager and spoke directly to the Chief Executive of the Trust displays how her confidence increased the more obstruction was put in her way. She was determined to share her vision with someone who would initially listen and then hopefully support her:



*“I never thought I had it in me to go over the head of my manager, but I had fire in my belly and I had to be heard – I knew my idea would benefit all learning disability patients/clients, whether they are the patient or a family member”* (participant 18)

The theme of increased confidence was displayed by the majority of the participants. Comments such as these were common:

*“I now have confidence in my instincts ....I no longer think I am not clever enough and I protect my ideas and don't let others think they can do better than me with my ideas”* (participant 6)

One of the District Nurse participants said:

*“I am not going to beat myself up ... I can do that...Nothing is impossible now – there is potential everywhere and there is not a final ‘no’”* (participant 1)

One of the specialist nurses recognised that her confidence had increased but she still felt stressed about whether she was doing her job properly. Since attending one of the educational programmes on innovation she realises that this does not mean she lacks confidence. She now realises that stress is how she deals with situations:

*“Stress can be productive for me but it doesn't mean that I am not confident in what I am doing”* (participant 24)

From the quotes above and revisiting the interviews it was apparent that all participants were aware of their expert knowledge in their specific area and, importantly, their clinical expertise was never doubted by others. It is interesting, therefore, to consider why there were so many references to self-doubt within the data. It seemed to manifest itself when the participants were required to move beyond their comfortable, well-practised professional routine with patients, to being required to present their knowledge to an audience of colleagues and senior managers. Not only did they have to show their own capabilities, but to state that they had the insight and courage to identify areas of weak practice within their immediate professional environment, even if it meant implied criticism of close colleagues and line managers, took significant courage. This would test most people's self-confidence so it seemed that it was not only the struggle itself, but the battle with authority that strengthened their resolve.

### 5.2.5 Personal Development

Whilst the participants did not elaborate on how their increased professional confidence had transferred into their personal life, a number said that they now felt more confident in all walks of life as a result of putting their additional education and training into practice. They related incidences of a stronger self being demonstrated in a variety of ways, one being that having a sense of fun has shown a different perspective in dealing with stress at work.

*“The sense of fun, working with others and testing things out ... that tremendous sense of fun.... The fun had a profound impact on me both personally and professionally” (participant 20)*

This statement was made by a very experienced Community Matron who was one of the older participants and she had made reference to how she did not take herself so seriously anymore and that sharing her experiences with other like-minded people had enabled her to laugh at herself when things went wrong, without feeling a failure.

The following comment was made by a District Nurse who spends much of their time dealing with sensitive issues, such as working with patients at the end of life and patients and families who have life threatening conditions.

*“Laughter is a tonic in the right context.....a lot of our work can be quite challenging and demanding but I think a sense of humour and ability publicly to say ‘I didn’t quite get this right’ you know ‘ I got it wrong this time, but hey-ho let’s keep trying’. That sense of being real, and being a person, and being more alongside the patients and the public in the first line I think is what the course has really enabled me to have” (participant 5)*

The comment below sums up the feelings mentioned and implied by the majority of the participants:

*“My whole life has changed in a way because of my own personal development”*

### *5.3 Summary of the 'the real me' in action*

In summary, these participants reported several developments within themselves as a result of engaging with the whole social innovation experience; not just the education but the struggle in operationalising what they had learnt. Key lessons learned by these participants has shown that involvement of others supports improved team working and introduces others to the positive impact innovation has on improving service delivery for their patient/client group.

Recognising individual strengths has promoted an increased confidence and growth in personal development enabling these participants to realise that fun is an important element of work, it de-stresses and promotes a culture of openness and honesty resulting in a happier environment to work in.

Acknowledging that other people have a valid point of view and also have the patient's best interest at heart has enabled the participants to view things from other perspectives and also respect other people's opinion. Taking into account the responses from the research it is evident that additional benefits have been gained from attending either the post graduate course on social innovation, the NHS leadership course or training days extending beyond just working on the actual innovative project.

### *5.4 Theme 6 – The Development of the Real Me & the Impact of Learning*

This next set of sub themes relates to the time when the participants moved on from their respective course and were actively advancing their project. How the course broadened the participants' knowledge and skills base first in a practical sense, then enabling them to better conceptualise their project's needs, and how they managed significant others with whom they had to work, had all been part of their learning. Themes identified ranged from quite straightforward new knowledge, better planning, taking a strategic view and using the confidence gained with the new knowledge to be bolder in their actions. The theme of confidence, which was discussed in the previous chapter, can be seen here too but is underpinning other factors as opposed to being an actual theme itself. The themes related to the impact of learning were:

- Skills gained – finance, business plans, negotiating

- Working strategically
- Seizing opportunities
- Not frightened of failure

#### 5.4.1 Skills in finance, business plans, negotiating

Many of the participants stated that prior to attending their course on innovation their knowledge of finance and writing business plans was limited or non-existent. Many were unsure of whom to seek financial assistance from and had been under the impression that their finance department was rather unapproachable. With hindsight, they realised that writing a technically sound and convincing business plan was essential before a financial department would consider a new initiative

Negotiating and seeking funding for projects was a completely new experience for the majority of the participants. They described themselves as being so wrapped up and single minded while focussing on the need for the change in practice and the hoped for outcome for their patients, that they had not realised the importance of producing a plan of action before they could implement their idea. This they later acknowledged to be in part due to their practice of working alone and not sharing with colleagues. This resulted in disappointment for some, with two participants commenting that their inexperience had held them back. One of the Specialist Nurses said:

*“Through my inexperience the outcomes for my project were not fully established and I had not put measures in place to implement the change”*(participant 7)

However, she did learn from this experience and represented her business plan with clear expected outcomes, costings of the service and expected savings. She realised that what was required was a clear rationale and a solution. She had set up a support service for families of children who were suffering from a rare cancer and she wanted to connect families nationally. Initially she introduced the idea by presenting the quantitative data, but she had not worked through the solution and how this support would be met. When it was first rejected she was disillusioned, but then went on to seek advice from outside of the NHS. In search of technical help, she made contact and negotiated with a dating agency and using their format she

applied the same concept to connecting families who had a child with NF1 (rare childhood cancer). This concept has now spread into Europe and families are using this network as a means of support, thus saving time visiting hospital and releasing time for the consultants and specialist teams to concentrate on new patients.

Another participant stated that her idea of reviewing District Nurses' caseloads was initially rejected because she was unable to articulate what the purpose of her project was. She said:

*"If I had clearer aims and objectives .....an audit tool and evaluation of project it would demonstrate the success of such a project and also involve patient feedback"*  
(participant 1)

However, having the project rejected did not dissuade her from her goal. She improved her business plan and presented clear aims and objectives. Although it took two years to get funding for the project, with some stakeholders losing interest along the way, it is now up and running. She claimed that even though she was very disappointed when it was originally rejected, she has learnt from this setback and as a result she has now been approached by the Trust to lead this project throughout her Trust.

A further example is that of one of the Learning Disability Nurses who said that she was disappointed with herself when she realised that she had not really understood the financial incentives that drive organisations to either accept or reject an idea. She was developing a care pathway for patients who had repeat admissions which may have been due to reasons such as falls, chest infections, urinary tract infections, etc. She said:

*"I didn't really understand that money was an incentive for the organisation – if I had understood this I would have focussed on just one specific reason for admission and this would have been less daunting and manageable"*(participant 19)

Later, knowing what was required of her she condensed her business plan, focussing only on patients who were admitted to hospital with a urinary tract infection and at the time of the interview she was waiting for a response from the trust.

#### 5.4.2 Working strategically

While the development of a business plan was acknowledged as key, taking a strategic view was just as important. Without exception, all of the participants commented that when they thought of their idea they were focussing on their individual area of work. Whilst they were confident that their ideas would improve the service provision for patients/clients they worked with, they had not necessarily thought beyond this to the rest of the service.

One of the Specialist Nurses said:

*“My project has now been recognised by NICE (National Institute of Clinical Excellence) as a demonstration of good practice. It has been published and presented widely and is replicated in many areas”* (participant 8)

She was looking at care for patients with a neurological condition and identified where there was duplication of service which was distressing for the patient and an ineffective use of resources. She identified the skill mix and expertise required and represented her plan to the Trust. As the Trust was employing a number of the agencies who had the responsibility of visiting these patients it has led to a significant saving by reducing the number of unnecessary visits to these patients. The patient is happier as there is more continuity of care and the Trust can demonstrate cost savings of £300K per annum.

Not all of the projects have had such a national profile, but many of the participants have commented that they now look to see how their idea can be implemented further afield than their ‘patch’.

#### 5.4.3 Seizing opportunities – finding new courage

Throughout the interviews the participants repeatedly spoke about the realisation of the importance of networking with other professional and patient groups. To have an informed audience to bounce ideas off they said had been invaluable. Yet it was not just the networking that was important, but the opportunity this, at times, gave them to seize new opportunities. Communicating with like-minded people inevitably meant that there could be some synergy in their thinking. This was reported by many participants and the experience of two District Nurses provides an illustration. They

were both working in the Community caring for patients who had lymphedema. On identifying a gap in their patients' care, they decided to put their ideas, energy and joint expertise together into developing a social enterprise in order to develop a lymphedema service for all patients, not just cancer patients, who have lymphedema. They left the community trust they were working in and set up their own social enterprise whereby they were commissioned by the clinical commissioning group (CCG) to provide a lymphedema service. They provide a service across their region and they have since also commenced yoga for patients suffering with lymphedema. This has seen an increase in patient's well-being and is also being commissioned by the CCG. These clinicians are both now highly successful entrepreneurs and would not have taken this leap of faith if they had not had the confidence that their educational programmes had instilled into them.

*"Whilst on my course I learnt that if I want change to happen then I have to make it happen and grab every opportunity that comes my way"* (participant 12)

Another example of seizing opportunities that required some courage is the example of a Specialist Nurse whose Chief Executive Officer (CEO) was visiting her clinical practice area. When leaving to visit another practice she offered to drive the CEO there. Whilst in the car she seized the opportunity to share her idea with the CEO and they met the following morning and the specialist nurse presented her project idea to her and she was given the funding for the project. This project which was mentioned previously, was addressing duplication of services to patients with a neurological condition.

#### 5.4.4 Not frightened of failure

A key theme that was mentioned by many of the participants referred to the importance of learning from mistakes. Learning to cope with failure was seen as a major learning curve for many of the participants. Prior to commencing their relevant programmes many said that if an idea was rejected or was unsuccessful they would have given up. They would not have persevered and may have become disillusioned. The education programmes they attended inspired them to carry on and improve their original idea. Numerous comments were made about coping, or not, with failure.

A District Nurse who, in her own words, always worked within the rules and never did anything that had not been done before said:

*“Now I am not afraid to try new things and to turn negative into positive”* (participant 5)

Another participant who has had numerous setbacks in her career, commented:

*‘Since being on the course I now feel alright about failing, previously if my idea was rejected or failed I would have put it to one side and start from scratch with another idea’* (participant 2)

A Community Matron said:

*“It doesn’t matter how out of sync your ideas are – go for it, explore it, test it. It doesn’t matter if it fails. Failure is not a problem ....Yes out of three ideas one might work, but if that one works it is worth it, and so it’s very much about embracing failure”* (participant 20)

One of the Specialist Nurses (participant 10) claimed that: *“Failure has served me well”* because she learned from it.

These comments have highlighted how embracing failure has enabled the participants to move forward and learn from failure. They see this as a learning opportunity and therefore are more inclined to pursue an activity and wait for the outcome. If it fails they will ask themselves ‘why’ and ‘how can I do it differently next time’. This is a major advancement in the way many of the participants now practice.

### *5.5 Summary of ‘the real me’ & the impact of learning*

The impact of learning is multi-faceted as can be seen from the range of themes above. One does take a key place however, that of rejecting the solo worker image as their only, or preferred, way of working and involving others in their ideas and plans. Importantly, their learning and the opportunity to put their new knowledge into action has strengthened their inner self and positively impacted on their personal lives. Within their working environment many reported that they now think strategically, seizing opportunities and learning from any setbacks along the way. Key to all the themes that surfaced from the interviews can be seen a spirit of



personal determination that underpins the attitude of the majority of the participants and is reinforced by a comment made by a health visitor: '*Watch and wait*'.

The next chapter presents four case studies, two deemed to be successful and two which failed to materialise. The aim is to bring to life the work of these community healthcare professionals and to illustrate how many of the themes outlined above manifested themselves in real life.

## **Chapter 6**                      **Innovation in Action**

The last chapter identified key themes seen through the participants' working lives as a result of undertaking training and, most importantly, through putting their learning into action. This chapter first provides an overview of all of the projects that the participants were involved in which are set out as a table (Appendix 1). It provides details of those projects that were successful and those that were not. It details the approximate cost of each project when first set up and the anticipated, or actual outcome, in terms of service improvement and money saved.

### *6.1 Summary of the chart information*

The chart (Appendix 1) shows the wide range of diverse projects undertaken. They address the perceived needs in the patient experience across the lifespan, those with chronic illness and those vulnerable to addictive behaviours. When looking at the outcomes of these initiatives what is immediately noticeable is the substantial amount of money saved. Even the more modest ones generated a saving of at least double their start-up cost while several tripled or quadrupled the outlay making substantial, sustainable annual savings for their organisations. This is without considering the clinical and social benefits to the patients. In broad terms, these savings were most often achieved by reducing the need for hospital admission as a result of better care in the community. Timely intervention saved many hundreds of pounds annually. Some projects aimed to improve access to care and so delay or prevent the onset of complications. Others offered a better level of care and a few focused on raising awareness of types of medical conditions or behaviours. It is noteworthy and may be worthy of further investigation at another time, that the initiatives which focused on processes that were already in existence in some format, and offered a better version of an existing service tended to succeed, while those which tried to introduce new ideas or services *extra* to what was in existence, often fared less well from a point of view of initial funding or management support. These observations are offered by way of context only, this research does not aim to evaluate the projects but it is helpful to get a picture of the real world circumstances the participants worked within and the goals that drove them.

## *6.2 Four Case Studies - two successful ones and two which did not meet their original goals*

Two successful and two unsuccessful projects undertaken by these respondents will be looked at in depth. It will explore each project's aims, structure, process and any other factors that played a role in its success or failure. It is approximately two years at the time of writing since the original interviews took place and all four participants were contacted to ask how the projects had progressing. The names of the participants have changed to maintain anonymity.

### *6.3 Case One: Patient Support Network (successful initiative)*

The first project to look at is one that was developed by a Specialist Nurse (Freya) she worked with children who had been diagnosed with Neurofibromatosis Type 1 (NF1). It is a rare genetic condition which predisposes patients to the development of nerve tumours. It has a range of manifestations: tumours on eye nerves, rare nerve sheath cancers, bones which when broken are difficult to heal, benign tumours which can cause an altered appearance and learning difficulties such as autism. It affects 1 in 4560 people in the United Kingdom (Evans et al 2010), with approximately 11,267 individuals with NF1 in England today (Ferner 2010).

This condition has well-being implications beyond the medical. People with NF1 also report feelings of isolation and frequently ask their health professionals to help them "meet somebody like me". Korf & Rubenstein (2005) acknowledge that keeping a record of all the medical visits, tests results and clinical decisions can be difficult and frequently results in fragmented care, making continuity of care and implementing support groups difficult. This is recognised as being a potential problem and therefore the project developed has been as a response to requests by attendees at an NF1 public and patient involvement day. Many people with this condition do not know anybody else with NF1 and report feelings of isolation. They wanted to meet somebody with similar manifestations of the condition who shared similar experiences as themselves. They asked to meet others affected by NF1 to provide support at diagnosis, give advice on treatment centres and treatment options, share experiences of navigating the school education system and be a "listening ear."

As this request for peer support appears to be echoed in NF1 clinics across the country on a regular basis this was supporting evidence to proceed with developing a support network for patients and their families. The nationally commissioned complex NF1 service constantly encounters people who have accessed treatments late, have very little understanding on the management and implications of their condition, thereby demonstrating the need for increased education and support. In particular to provide help early on in the individual's journey with this condition.

### 6.3.1 Setting up a patient networking project

To alleviate this need, an "introductory service" was established which encouraged people affected by NF1 to send in details of how they are personally affected. It was developed in three stages and this is one of the reasons that the project was so successful as the Specialist Nurse who developed it wanted to test the hypothesis that people with NF1 want to meet others and share experiences and also to trial the use of the internet as a means of facilitating a support network. In doing this she was also raising awareness of NF1 amongst people not known to the Nationally Commissioned service. She identified an already well used and respected website which is the UK's biggest parenting website offering local information, expert parenting advice and friendly support. It was piloted on this national parenting website the week following the first international NF1 day in May, 2015 when NF1 awareness was at its highest and parents were encouraged to post their experiences of living with NF1. Those accessing the website were encouraged to ask questions to a panel of professionals in two online clinics. The answers could be viewed on line by all members of the parenting organisation as a means of creating an increased understanding of this condition, this site continues to host a NF1 awareness week. It acts as a platform that has raised the awareness of NF1 and in doing so stigma associated with this condition is reduced as people now have some understanding of the condition of NF1.

Responses from participants who accessed the online clinics clearly demonstrated that this initiative was a success and some of the comments made by users of the on line service are demonstrated below:

*“Hi, I also have neurofibromatosis type 1. I am so glad this has been posted on here as I have never met anyone else apart from my father (now passed away) who has this condition.”*

*“----I feel we really need advice on how to broach the disorder in an age appropriate and loving way that we can develop and expand as he gets older .... Help!”*

*“.....I just wanted to say hello to any other families with NF1”*

These few testimonials are just some of the responses which have all shown that the online network has been a supportive tool for families of NF1 sufferers.

Due to the success of the pilot, it appeared that a web-based approach was an appropriate medium through which to offer support to such a diverse population as the hypotheses proved that people do want to meet others affected by this condition. The access to the on-line clinics also proved that there is a gap in the market for effective on line professional support and the internet was a valid medium for facilitating this.

The second stage of the project was then implemented. A support network was set up which was referred to as the National Friends 1<sup>st</sup> (NF1) support network which facilitated the introduction of people with similar manifestations of NF1. To take this to the next stage the project lead contacted an online dating website to discuss how to set up a similar service for children and families with NF1. Having sought advice and spoken to the IT department within her Trust a national support network website was developed to enable people to register their details and request an introduction to somebody with a similar aspect of the condition enabling the computer to make appropriate “matchings”. It had password protected areas, so people could meet online in a safe, secure and private area within the website. It then matched people with similar aspects of the condition and facilitated the introduction. The network could also be accessed by post, telephone and website to ensure equitable access.

For this project to succeed a business case had to be presented to her Trust where she presented the cost of this service to be delivered over a period of 12 months. Freya calculated the cost based on the table below and kept the cost to a minimum in the hope of getting funded for the project:

Table 8

A band 7 nurse for 6 hours per week	£6,500
A band 3 clerical assistant for 16 hours per week	£7,500
Professional & legal advice	£1,000
Marketing & Administrative support	£2,500
Building & Managing a website	£2,500
<b>Total</b>	<b>£20,000</b>

Throughout the development of this project a national renowned NF1 Consultant was a constant source of support. Additional financial support was provided by a national charity and therefore with the agreement of the Trust and the national charity the NF1 support network was implemented and this second stage of the project has continued. It has spread beyond the UK as Freya was invited to speak at a conference in Europe about the internet support service for NF1 patients and families. This initiative was welcomed by European NF1 health providers and this service has now extended to Europe so patients and families are able to communicate with other NF1 sufferers across the UK and Europe also.

The third stage of the project was to find further financial support to develop hand held electronic records. The Department of Health (2012) recognises that one of the biggest challenges facing the National Health Service (NHS) is the increasing prevalence of long term conditions, and they observed that a lack of coordination of care is a major issue for both patients and professionals (Ayling, 2012). Korf & Rubenstein (2005) acknowledged that keeping a record of all the medical visits, test results and clinical decisions can be difficult and they recommended that the coordination of care for people with NF1 is for the patient or a nominated family member to keep all the records in one place, so that they can be taken to each appointment with every professional involved in their care, which would mean that the consulting doctor had all of the up to date information available. To do this a reliable technological system seemed the most likely aid. Freya visited a company that has developed an electronic patient record system facilitating the gathering of information into one secure password protected web-based location. It allows face to face discussions with patients via a secure online video link which is already built into the NHS secure network. Information can be shared with clinicians via any internet-connected computer or hand-held device. This enables those patients and families who live far from specialist centres to be afforded the same opportunities as

those who lived near the specialist clinics. This was funded for a year trial period by the Trust where Freya was employed. Unfortunately the funding for the hand held systems has not yet been approved as the Trust and the NF1 organisation are unable to find a sponsor who will support this. The costings were calculated at approximately £72,000 so it is an investment that will require a secure benefactor.

This project was regarded by her managers as innovative and forward thinking, they recognised Freya's ability to draw parallels with other systems beyond the NHS that could be amended and developed to promote communication via the support network system. The success of this project was due in a major part to her application of her learning, for example the importance of careful planning, having a clear vision of what she wanted to achieve, and provided evidence supporting her observations. Alongside this it was essential to have the ongoing support from senior clinicians who had the vision and belief in the Specialist Nurse to enable the project to be developed and to succeed.

#### *6.4 Case Two: End of Life Care - Learning Disabilities & Families (successful initiative)*

The second successful project to be discussed is the development of a bereavement service which focusses on improving the care that people with learning disabilities receive at the end of their lives. The hypothesis that people with learning disabilities are less likely than non-disabled people to be given a choice or to be able to communicate their wishes in relation to end of life care was the driving force for this project. Yet the Department of Health (2008) has recommended that effective end of life care must be delivered in such a way as to ensure that an individual has a 'good death'. This may mean being pain free, dying in familiar surroundings or being in the company of people they know and love. This is particularly significant for people with a learning disability as unfamiliar surroundings frequently cause them more distress. However, the majority of deaths usually take place in hospitals although statistically this is the least preferred place of death (Gomes et al, 2011). Celia had been inspired by a quote made by the famous Dame Cicely Saunders, founder of the modern hospice movement. *'How people die remains in the memory of those who live on'*. She wanted to promote this philosophy across her Trust so that all patients and families at the end of their life would benefit from a positive end of life

experience. With this desire to improve the end of life care for her client group Celia met with the Chief Executive to discuss this. It had not been easy to arrange a meeting with the CEO, but Celia's resilience enabled her to find ways to cross boundaries and management structures, eventually meeting with the CEO to present her project.

The National End of Life Care Programme (2011) recommends that deaths should be in a person's usual place of residence. The project lead for this programme (Celia) attempted to find out how many people with learning disability had died in hospital, but the hospital notes and death certificates did not code their learning disability making it difficult to give accurate numbers. Nevertheless she did acquire information which stated that in her borough there was an average of 1%-2% of deaths of people with a learning disability. This translated to approximately 62 deaths per year, of which 60% died in hospital, 20% in care homes and 20% in their own homes (National End of Life Care Intelligence Network, 2012). It was interesting to note that the local hospice had not reported on people with learning disability being admitted or dying in the hospice. This she thought, indicated that there may be inequitable access to hospice care for people with a learning disability.

#### 6.4.1 Stages of Development for End of Life Care in Learning Disability Sector

The success of this project was due to the planned stages of development. The development and implementation of the project was devised into five sections. Firstly, Celia carried out scoping exercises and gathered data to support the need for such a service presenting a sound rationale for implementing this. Having acquired this information regarding place of death, Celia went on to interview learning disability staff employed by the trust and the local council. Without exception all staff interviewed claimed that they did not engage with planning end of life care and subsequently access to specialist palliative care services was often patchy and poor. Learning disability staff commented that they were unfamiliar and uncomfortable with providing end of life care, but having been questioned about this many said that they would benefit from additional training in this area of practice.

Secondly, the project lead recognised that there was a significant gap in training for this group of nurses so in order to address this deficit of knowledge she contacted



the Macmillan Nursing service. In collaboration with the Macmillan Nursing service a training programme was developed to educate learning disability nurses and allied health professionals in end of life care for adults with learning disabilities. This was a two-pronged training programme as the Macmillan nursing service required an increased awareness of the needs of people with a learning disability and they required training in communicating with this group of people, alongside this the Macmillan staff delivered training in end of life care to the learning disability staff.

The third part of this project fell in line with the Department of Health's (2009) vision to promote the development of care pathways, so a detailed care pathway was designed clearly mapping out the support that can be offered by learning disability services to people with a learning disability. This care pathway began from the point of advancing disease up to the death of a patient and followed with bereavement support. An advance care planning booklet – *'My Future Plan'* was also developed which facilitated end of life care discussions between staff and patients and families.

The fourth part of this project involved Celia setting up an End of Life Care task and finish group in the Learning Disability Service. The terms of reference of this group included the development of a consistent approach to quality end of life care support across the Adult Learning Disability Directorate.

Due to the success of the additional training in end of life care to learning disability staff the fifth part of the project resulted in Celia completing a scoping exercise of care homes with learning disability registration with a view to extending the learning disability awareness and end of life care to the staff in the care homes.

The business model presented to the Trust required an identification of the requirements to deliver this project for 12 months. It involved End of Life care trainers, workshops on enhanced communication skills training for 6 nurses, communication development worker, a band 5 nurse one day per week, end of life spiritual care training for 2 nurses, marketing and printing. The costings for the project totalled £10,500 which was fully funded by the Trust. The table below outlines the details of the project:

Table 9

A band 5 nurse 1 day per week for 20 weeks	£4,000
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Communication Development Worker	£190
Conference Room Hire	£300.
End of Life Care Trainers	£600.
Refreshments	£200.
Enhanced communication skills training for 6 nurses	£2,874
End of life spiritual care training for 2 nurses	£300.
Printing design & printing – <i>My Future Plan</i>	£2,036
<b>Total</b>	<b>£10,500</b>

Having calculated that this could potentially save up to £68,000 per year by preventing admissions and hospital deaths per year the Trust were willing to fund this for an initial period of 12 months. This project has proved successful so the Trust are willing to support this project beyond the twelve months and is now embedded in the Trust vision. Celia now sits on a steering group within her trust board with a task to roll out an end of life vision for the whole trust.

Not only had Celia identified an inequity of service for people with learning disabilities she has now highlighted this plight so that it is part of the Trust mandate meaning that people with a learning disability will no longer be invisible. The success of this project has been confirmed by staff who have undergone the training and some of their comments are noted below:

*“I am far more comfortable supporting people to start talking about death and dying”*

*“I have gained so much awareness of the needs of people with a learning disability and I can use these additional skills in every aspect of my work and personal life”*

In the last financial year, two training sessions with GPs in the area have been funded by a company commissioned to do GP training. In January 2017 a local hospice funded a training day for professionals in palliative care and for professionals working in learning disabilities. Celia co-delivered the training with a palliative care educator. As recently as February 2017 a second hospice funded a training event for Celia to train district nurses, hospice staff & care home staff regarding excellence in End of Life care for people with Learning disabilities. The beneficial outcomes to the local trust has seen that far fewer patients with learning disabilities are being admitted to hospital as they are being cared for in their own homes or care homes by palliative care staff, district nurses and care home staff who have developed communication skills in working with this client group. Actual cost benefits have not yet been calculated, but the initial business case projected £68,000

could be saved in 12 months, an assumption therefore is that significant savings have actually been made as the project continues to be supported by the trust. Celia's learning around a need for sound planning and seeking cooperation with others was operationalised and delivered success.

Both projects mentioned have been led by inspiring and visionary practitioners, whilst the NF1 project had ongoing support from the onset, the End of Life project did not initially have support as Celia was unable to bring it to the attention of influential people within the Trust. Nevertheless, once she had used tactics to get her voice heard she eventually gained support from senior management in her trust and the project is ongoing and is now an ongoing agenda on the Trust agenda, so should Freya leave this particular Trust it is gratifying to know that her legacy will live on.

The next two projects discussed unfortunately were not as successful as the practitioners had hoped. As mentioned in the introduction to this chapter, it is interesting that these are both products rather than a service improvement.

#### *6.5 Case Three: The development of an alcohol consumption awareness game for the over 65s (unsuccessful initiative)*

This project was a game board that had been developed for the over 65year population. It was developed by a District Nurse (Evelyn) who was working as a Public Health practitioner and had observed first-hand the way alcohol consumption for some patients crept up on them without their apparent concern or even awareness. She could also see the impact of alcohol dependence both socially and medically. Her aim was to provide a way of informing her patient group of the signs of dependence with the aim of their reducing their alcohol intake. The game provided a light hearted and fun way of highlighting the issues of alcohol consumption in older people and was not developed as a blame tool, but rather a tool that raised awareness of the potential dangers of drinking in the over 65 year age group. Evelyn had compiled a business case outlining the cost of alcohol related admissions to hospital for this age group. Her research had calculated that every minute alcohol related problems cost the UK economy £48,000. Every hour more than 100 people are admitted to hospital in England and Wales with an alcohol related accident or condition and every day 40 people die as a result of alcohol in

England and Wales (IAS, 2015). The percentage of men and women drinking more than the weekly recommended limits has risen by 60% in men and 100% in women (IAS, 2015). Evelyn carried out a scoping exercise with Community Pharmacists, Road Safety Partnership and Drug & Alcohol Services and it affirmed a gap in an alcohol awareness method for older people in her geographical region. Her role as a Public Health practitioner gave her access to day clubs, warden controlled accommodation and other communities where older people meet. She felt confident that she had enough representation of this older population to engage this group in a brief intervention which 'sowed the seed' for them to alter or improve their lifestyles in relation to healthy living. Evelyn's aim was to reduce the actual and potential harm caused by alcohol misuse to individuals and communities whilst ensuring that alcohol could still be enjoyed safely and responsibly. According to the Royal College of Psychiatrists (2011) every single pound spent on treatment in the public sector saves £5. According to a regional public health observatory report (2008) if providing alcohol treatment to the 10% of the UK population who are problem drinkers it could reduce costs between £109million and £156million a year (PHO, 2008). The data did not differentiate between the various age groups so it proved difficult to specify how many of these were over 65years.

Evelyn's business plan was presented to her Trust and they agreed to fund her £1500 towards the development of the board game.

The prototype game and poster materials cost £260.00. However, Evelyn had not calculated the cost of staff time of those who had incorporated the game into their busy workload and the plan outlined a projected spend of £650. She had also not incorporated the cost of future orders for the game to be used in other Public Health services across her locality. In addition, there was no costing for training other health professionals to use this game as a public health tool. Overall there had been no forward thinking and the business plan was not thought through in a logical format and planned expenditure was not part of the business plan. The funding only enabled the development of one game and one person to deliver it which does not demonstrate sensible business acumen. Even-though Evelyn was very enthusiastic and the game was extremely innovative and fun this was not enough for the project to be successful. The costings totalled £900 which was within the budget of £1,500, this left a surplus of £600. Unfortunately this was not enough to develop additional

games to be utilised across the various sectors, so sadly this business venture did not succeed. Evelyn continues to use the one game originally supplied and uses it when she is delivering a public health awareness session to health professionals.

She was regretful that future planning had not been part of the business plan because those that had used the game found it very useful and some of the comments are made below:

*“Information this way sticks, remember old brains need reminding .....*”

*“Start and stopping places need to be larger for old eyes, but it was very informative”*

In Evelyn’s own words she felt that she was *“in a small boat in a huge unknown sea, rudderless and without direction”*. This really sums up why this project did not succeed - there was no clear direction. Enthusiasm and creativity was not enough without a solid business case to support it.

Evelyn became very disillusioned, in her words, ‘with the patronising attitude that her ‘game’ received from her immediate Line Manager and subsequent senior clinicians’ so she has now gone freelance. She has not gained further funding for the game, however she has adapted the game and has developed it as a question and answer quiz which she presents at her local age concern groups.

#### *6.6 Case Four – The development of sexual health promotion material (unsuccessful initiative)*

The project was seeking funding for the implementation of a series of quizzes for adolescents as a way of promoting sexual health promotion. This was being developed alongside the development of a book which had used the same technique of questions and answers relating to sexual health. The project was two pronged, firstly the piloting of a series of quizzes and secondly the support for publishing a book based on the findings from the quizzes. It was anticipated that the quizzes would take place in schools and public health and sexual health clinics in the South of England. This concept began when Jeannie in her role as a School Nurse met a young girl from a local grammar school who had in the past three months experienced unprotected sex with many different men, all of them casual and unknown to her. She had been diagnosed with chlamydia, gonorrhoea and genital

warts, all of which had successfully been treated. She later developed genital herpes and the genital warts returned. This still did not result in her changing her sexual behaviour. She was aware of the implications of sexually transmitted diseases, but she didn't like using protection, so she intended to continue having unprotected sex. The fact that this was a young intelligent girl who had this attitude left Jeannie struggling how to get the message of safe sex across to all the young people in her local schools.

Jeannie decided that she would develop a sex challenge quiz as it combined fun with learning in a non-threatening way which she hoped would create a competitive spirit to excite and engage young people. Jeannie felt that this approach would bring a fresh approach to sexual health learning. The hypothesis for addressing this situation was also supported by the Health protection Agency (2012) who claim that there is evidence of considerable inequality in the distribution of sexually transmitted infections (STIs) and efforts were needed to continue to focus on high risk groups in adults and should also be intensified in those parts of the country with the highest rates of STIs.

Acknowledging that local clubs attracted teenagers and young adults Jeannie developed the quizzes to target a 14-24yr old audience and the logo used for the intended book was graphic in the hope of gaining immediate interest from this group. As more groups participated the objective was to measurably improve the sexual health profiles in those particular areas that had participated.

The business case Jeannie developed was looking for £36,000 to pilot the project for the development of the games and discussions with publishers, which when scaled up would aim to produce a saving of £330,000 per annum or £1 million in 3 years in the Southern region where Jeannie worked. This could be done by reducing the amount of STIs by 10% and human immunodeficiency virus (HIV) by 1% as STIs diagnosed amongst young people in the area where Jeannie worked were 50% higher than any other region in England.

The cost of treating 25,000 cases of STIs in her region is £3.3m per annum which is based on the tariff of £132.00 per case. If there was a 10% reduction in treating STIs this would equate to a saving of £330,000 per year as mentioned above. The £36,000 was required to develop, pilot and evaluate the competitions.

This project did not go beyond the stage of being a 'good idea', despite the clear statistical saving that could have been gained. When the business case was presented only three commissioners attended the presentation and they claimed that they did not have enough unallocated underspend to support the business plan. Some of the commissioners did not like the language used in the quiz questions and did not feel it was appropriate to be used in schools. If the language used was going to be transferred into the book they would not allow the book to be part of any school health promotion campaign.

This is an innovative approach to delivering public health and sexual health awareness but Jeannie needed a stronger rationale for using this technique to get the message across. To put this project into action a sample of questions and text from the book should have been sent to managers to gain some idea of how it would have been accepted. Consideration of using 'more acceptable' phrases might have gained some approval from the commissioners. However, this was Jeannie's point exactly, she felt that the usual health promotion messages on the topic of sexual health has always been delivered in 'acceptable language' which is not necessarily the language used by many young people who are participating in unsafe sexual habits, hence using this radical approach as a means of capturing attention. The business plan was also too busy. Jeannie should have just focussed on introducing the quiz to see how this could be used effectively and then produce another business case for the development of a book which would have had clear statistical evidence of why it would have been successful (providing the quizzes had taken place).

Jeannie has since become a social entrepreneur and has published her book abroad where she has gained support from a government initiative in a country where HIV is rife. She no longer works as a School Nurse but spends her time working with young sexually active people and attends sexual health clinics, 'drop in clinics' where she can meet young people and she continues to promote sexual health awareness.

Even though the quiz/book projects were not successful under the auspices of the NHS, they are still being utilised in ways that public health messages can be received by the relevant groups.

## *6.7 Summary*

These four examples, whether successful or not, clearly demonstrated the passion that the individual project leads feel for their particular topics. Passion, however, would not seem to be enough, an ability to apply learning from their course would seem to be an essential requisite if innovations are to be supported.

## **Chapter 7                      Discussion**

### *7.1 Discussion of key findings*

This chapter will discuss the key findings of the study which examined the personal and professional development of a group of community healthcare professionals,



who, after training in social innovation, instigated and managed their own innovative community healthcare initiatives. Here I will outline the key findings before going on to discuss some of the threads that draw them together and how they can inform recommendations for prospective innovators, their managers and creators of training courses in social innovation for health professionals. As discussed in an earlier chapter, given the paucity of material on the personal characteristics and experiences of healthcare innovators, industry, the arts and education were searched to look for similar studies, and some provided helpful contexts for the findings here.

Through gaining new knowledge about innovation the participants were better informed. This impacted on their professional capacity to work differently and more creatively in their clinical areas in their attempt to improve service delivery.

This study identified and surfaced several characteristics and attitudes that played a significant part in each individual journey mentioned in this study. The key qualities emerging are: having a '*can do*' attitude, *perseverance* and *resilience*, recognising the *need to involve others* and *work differently*, having *self-belief* in their clinical knowledge and *confidence* to make changes, *not being frightened of failure* and learning from it. Personal characteristics also surfaced, with some having an innate confidence from the outset of their project and training and gaining an even deeper understanding of themselves and their strengths, also actively working in an innovative way served to enhance their confidence further. Hence, *self-efficacy* and *confidence* in their specialist subject area was evident and a key theme. Other participants only recognised or developed their confidence when they had the chance to demonstrate to themselves and others that the improvement in their clinical practice showed that they were working more effectively, combined with evidence of an increased patient satisfaction.

## *7.2 Exploration of skills required to set up an innovative project*

The first set of findings related to the start of the participant's journey and to the first research objective: ***To explore and identify the personal qualities, knowledge***

***and skills required of health care professionals when setting up and managing a health and social innovation project.***

*Emerging Themes:*

7.2.1 Better is possible – a perceived need to raise standards of health care delivery above and beyond current practice / Swimming against the stream – challenges faced when setting out ideas for improvement

At the very start of the process which resulted in their becoming effectively a ‘social innovator’ most participants had little idea what the term meant and had not consciously aspired to become one. Their starting place was personal and local, frequently as a result of observing poor, but not necessarily bad or dangerous, healthcare. In different locations this comprised of: *wasted resources* and the *delivery of suboptimal care*. Their concerns often centred around practical issues such as *ineffective time and resource management*, the *inequitable delivery of good clinical care*, *poor communication of patient risk*, *a lack of specialist services* and *difficulty in maintaining excellence in clinical practice*. Most significantly, however, was a factor not visible to the naked eye - a lack of imagination from managers to identify a need for improvement within their organisation. It often took a complaint or crisis to alert managers to the situation, these research participants however sensed disquiet and unease and were keen to avert any concerns through better practice.

Commentators in other fields such as the arts, (Beefink et al, 2012), industry (Miller & Le Breton-Miller, 2017, Laforet et al, 2006 ), education (Sarasvathy,2001) ) as well as those in healthcare (Adams et al, 2006, Pekkarinen, 2010) acknowledge that even once a problem has been recognised, applying innovation to an established current practice can bring challenges. The findings from this study report that only a portion of the NHS organisations possessed the capability, or desire, to invest in new practices if there was no pressing need. Adams et al (2006) and Cormican & O’Sullivan (cited in Patterson et al, 2004) claimed that when innovation is applied it is often disjointed, frequently with opposing pressures and so only achieved in part. This was not reflected in this study where an innovation was accepted, a project was either implemented or not, there did not seem to be any middle ground.

Sarasvathy's (2001) principles for effectuation, suggest that to create solutions resources must be available and Sarasvathy's concept of 'effectual reasoning' begins with a given set of means and allows goals to emerge fortuitously over time from the various ideas and diverse aspirations of the founders and the people they interact with. These ideas can be witnessed in this study, the participants had to make changes, initially with existing resources, and make good use of their imagination and that of those around them who were supportive. However, some projects did require additional resources such as the befriending service project (project 25, Appendix 1). This required a hired bus to take older people to and from a befriending service at a local community hall as a means of reducing social exclusion. Unfortunately a bus was not provided so this service was unable to proceed. Knock backs such as this were frequently experienced by the participants, nevertheless this did not prevent them from trying other tactics and so *resilience and perseverance* also became a key theme throughout this study.

These findings are reflected in the work of Beefink et al (2012) and Laforet et al's (2006) studies focussed on the creative industries and small manufacturing firms where innovation is central to the ever changing demands of creative businesses and small organisations and they discovered that self-efficacy was crucial to survive the challenges in these areas, and found to be an important predictor of performance. This suggests that one's belief in one's own ability to succeed plays a major part in how individuals approach tasks and challenges as well as a measure of their likelihood to succeed. This echoes the findings here, of participants who developed their creative skills to solve elements of suboptimal service provision within their Trusts. It could be argued that these participants had an innovative cognitive style (Shalley et al, 2004, cited in Beefink et al, 2012) revealing their creative orientation to problem solving, promoting individual performance as well as organisational innovation and effectiveness (Sung et al 2009: 941).

Miller & Le Breton-Miller (2017), in their exploration of sources of entrepreneurial courage and imagination, reveal several characteristics that resonate here. For example seizing opportunities and the willingness to take risks in pursuit of a belief was a key finding. However, Miller & Le Breton-Miller (2017) report that the outcomes in their studies were not always clear in the minds of their subjects at the

onset, whereas in this study all participants had clear ideas of the desired outcomes. This may be the reason why at least two thirds of the projects were successful.

An industry based study by Sullivan and Ford (2013) suggested that individuals require courage to take a risk, even if the outcomes are not known in advance, a view also supported by Miller & Le Breton-Miller (2017). Despite seeing a need for this change some individuals remained afraid to take a risk. The participants of this current study had similar concerns when their Managers were frequently unprepared to take a risk even in the light of limited service provision which could impact on ineffective care. Whilst the NHS and the Department of Health's regulatory bodies have published documents showing how their approach to regulation supports innovation (DH, 2017) incorporating the topic of innovation in its policies, it often fails to manage innovation and innovative people well. This strategic message (encourage innovation) is targeted at all community health services, but according to Teece (2007, cited in Miller & Le Breton-Miller, 2017) even this strategy is not static, it changed and often left one time willing participants confused as to what they could do. Participants in this study were frequently presented with such dilemmas (strategy shift or change of department goals) which added to their frustration.

Pekkarinen et al's (2010) study looked at how public sector in Finland dealt with innovation and highlights some of the challenges which are similar to those experienced by the participants of this study. Minimising the amount of non-productive time, decreasing the costs and providing faster treatment and improved value for their client group, and breaking down 'silos' and encouraging cross-departmental co-operation, are all areas which, it is claimed, can be influenced by innovation. Interestingly Pekkarinen et al (2010: 521) have also claimed that the organisational culture in the public sector is characterised by hierarchy and bureaucracy which can stifle creativity and is also supported by the findings of this study. Moreover, and encouraging is the opinion of Pekkarinen et al (2010) that often these clashes frequently pave the way for innovation. Several of these participants found this to be true.

7.2.2 Can't do it alone – recognition of the need for further training and support, Early involvement of others – No man (or woman) is an island, Seeking support

Findings from this study acknowledged the advantages in seeking out the influential people in an organisation who could not only support an innovation but also persuade others to follow, supported by Bandura's (1997) thoughts on learning from others. Many of the influential people required further persuasion, but through being grounded in the agentic perspective, social-cognitive theory suggests that the participants' self-efficacy and belief in their innovation and evidence of sustainability was sufficient to make things happen. Brooks et al's (2011) study which looked at innovation in mental health services highlighted the importance of the local context as a means of ensuring that the innovation is sustainable. Similar findings were found in this study recognising those that were sustainable had brought their colleagues along with them.

Fitzgerald (2003) looked at how credible evidence of a need for change and proposed benefits influenced innovation in primary healthcare settings and how inter-organisational collaboration and multi-professional involvement impacted positively on diffusion of innovation. The findings signified the importance of sharing information and open debate with other professionals prior to adopting a new process. The participants of this study did not always work this way, there was not always evidence of their seeking open debate with their colleagues or informed others, they relied rather on presenting evidence to support their business case, frequently focussing on their specific discipline only. Of importance to these participants are the lessons learnt from Fitzgerald's (2003) study. They show that working in 'silo' is not the most productive way to promote innovation. O'Leary (2011) when discussing innovations in healthcare concurs with this and commented that in order to drive up the quality of care we can all learn from each other. The findings from this study also agreed with this as many of the interviewees commented on the support and knowledge they had gained from listening to, and sharing their experiences with fellow students, but several could do more to work cooperatively and to make that a goal.

DeGraff et al (2002; 140) writes about incubating creativity, promoting motivation, increasing employee satisfaction and developing a strong sense of community. The success of this approach depends on having supportive management to enable those incubators of creativity to have autonomy to develop their ideas. McLean (2005) reports the importance of having management support to progress an idea,

as numerous excellent ideas never see the light of day. Therefore it is imperative that managers are made aware of new initiatives from the onset if support is going to be forthcoming. Findings of this study support this view and one of the participants of this study suggested:

*“Get ‘buy in’ early on. Find an influential person in the organisation that can support and fight your corner”*

Opportunities for innovative ideas are often stifled by competing demands and unfamiliarity of the concept; frequent competing demands and poor communication across teams and organisations prevents the progression of an idea (Cooper, 2010). To bring an idea from concept to market, it should be recognised for its potential; it must receive funding in an environment of scarce or at least competing resources; and it must overcome potential obstacles such as technology challenges, competitive pressures, and a variety of other obstacles. For example, Baghi (2015) carried out a case study in Shanghai on the application of mobile healthcare and his findings showed greater patient engagement and compliance as patients were able to monitor their conditions. This could be compared to the specialist nurse here who developed the on-line support system for NF1 sufferers which gave patients, and families, greater autonomy and ownership of their condition, or the community matron who developed the virtual ward, directing care to the appropriate professional, preventing duplication of services.

### 7.2.3 Change of Perspective in recognising alternative ways of approaching clinical practice and working differently across the sector

The community work-force are pivotal to changes occurring within the NHS relating to the second objective of the study: ***To identify the difficulties encountered within individuals themselves and the external factors within their organisations that have impacted on the development of their project.*** Many of the changes are outlined in the ‘*The Five Year Forward View*’ (DH, 2014) which plans to meet the challenges of people living longer, frequently with long term conditions and being cared for in their homes or community setting. The Kings Fund (2014) report that community services make up a large part of the NHS service provision from chronic disease management, rehabilitation, health visiting and

midwifery services. It is essential therefore that professionals work together in an integrated way. This causes challenges but reinforces the importance of bringing people on side at an early stage in the change process. Herold & Fedor (2008) also highlight that even if people are supportive of the change from the beginning they must realise that the acquisition of new routines and adapting to these changes may take some time as these are frequently overlooked. Many of the participants of this study were only supported for a set period of time, eg. 3 months, 6 months, 12 months which could lead to difficulties around sustainability. It was therefore essential for them to address the time line in their business case.

Heathfield (2016) commented from a human resource perspective and advised that plans need to be put in place at the onset of a potential change so that teams have a responsibility in building and developing the change and have some ownership of the change. The findings from this study support this view, whereby early involvement had been successful, as in the case of the community matron with her virtual ward project (participant 9) and with others recognising that they should have had buy in earlier, evidenced in the occupational therapist interview (participant 2). This will require focussing on the benefits of the change, cost of service provision, patient experience and outcomes both quantitative and qualitative (Gosselin et al, 2015) and thereby providing a solution and an enhancement of the care provision.

It is virtually impossible for managers currently working within the NHS to be dismissive of innovation as The International Council of Nurses (ICN) commented that if progression was to be made in health services across the world then innovation was fundamental (Joseph, 2015) and this was reinforced again in 2010 when the Prime Minister's Commission on the Future of Nursing and Midwifery in England pledged to promote innovation, stressing that innovation in nursing would become a way of life introducing a cultural change which would affect all levels of nursing (Cooper, 2010). The Kings Fund (2016) also recognises that this will place pressures on the NHS which can only be achieved with the involvement, engagement and commitment of NHS staff. It requires changing cultures both within and across organisations. The participants of this study were constantly trying to change the cultures of their organisations with the aim of driving their innovations forward, but even so they found support erratic.

Even-though many managers may not have the vision they have a responsibility to support their staff in promoting innovation and creativity as this had become a government mandate. In 2009 the NHS produced a survey report on NHS Innovation and Improvement which claimed that there was a 'hunger' for widening knowledge of innovation, but the NHS also said that there was room for improvement through better cross-team integration and communication (NHS, 2007). These views have also been supported by Fitzgerald (2003). The success of any innovation depends on responses from early adopters, realising that individuals will adopt at various stages, so the implementation of an idea may take longer than anticipated.

In a study by Nelson et al (2010) it was the external forms of social support that were associated with the adoption of an innovation. This is relevant to the NHS who frequently rely on external support, whether in the form of external staffing agencies, transport, voluntary services or charity support. However, this was not the case in this study – the staff relied on internal support almost exclusively. The innovations were based on clinical expertise with some administration support only, adding to the value of this research as few external services were required to implement their innovations. Yet unlike commercial companies where they try to introduce new innovations to the market as soon as possible (Dervojeda, K., Schretlen, J., 2013), adopting an innovation in the NHS does not automatically involve their customers (patients). Frequently an innovation is introduced and patients are informed without being an active participant in the change. Once again, this was not evident in this study. Where appropriate, such as the prostate cancer support telephone follow up service (participant 3) and the heart failure service (participant 1), patients were actively involved in the changes recommended to their service provision.

An inductive approach was used in Haggman's study (2009) looking at how innovations began and what were the deciding supportive factors that enabled them to survive. He found that it was essential to recognise a 'champion' of the innovation so that management could be educated in the background of the innovation and the relevance and potential benefits of the planned change would be transparent. This view was supported by Sloan (1875, cited in Miller, Le Breton-Miller, 2017) who said:



*“There has to be this pioneer, the individual who has the courage, the ambition to overcome the obstacles that always develop when one tries to do something worthwhile, especially when it is new and different.” —Alfred P. Sloan (From Miller & Le Breton-Miller 2017.)*

An essential skill of managers taking a new initiative forward and changing a service requires faith, confidence and an ability to respond to challenges. They have a duty to mobilize employee’s knowledge and encourage innovation at the same time as maintaining quality. Malloch (2013: 60) reports that leaders within health care organisations are being held responsible for inappropriate variations in care and suboptimal care which could be a reason for not wanting to make changes. However, the participants of this study were not letting this attitude interfere with their projects and continued to proceed with presenting their ideas.

However, in order to alleviate such accusations, solutions to any suboptimal care should be addressed. Yet the pace of implementing a change to improve care, no matter how small, can be slow. Ryan (2017) suggests that on occasions change is not recognised, but gradually change is implemented and individuals begin to react positively to changes quite slowly. Berwick (2003) found in his study outlining that mastering the generation of good changes is not the same as mastering the *use* of good changes a view also supported by Simpson (2009) who recognises that organisations will need time to prepare for change and must consider staff resources, staff training, financial implications and patient satisfaction which can be very challenging. In presenting their business plans to management the participants of the study were able to take account of potential changes and where appropriate included this into their plans for change.

Change is incremental and requires fine tuning and monitoring as it is implemented, reviewing the outcome and perceived benefits on a regular basis (Kaya et al, 2015). Managers who are early adopters frequently have the management skills to support an innovation but do not always have the initial vision, demonstrating they are not risk averse. They work strategically so are influential in gaining support from others who may fall in the early majority category range. Roberts & Machon (2015) recommend that for managers who are supporting change and innovation it is essential that they change themselves first. However, even managers who are early

adopters do not always find working with innovators easy as they challenge current practice, but managers should recognise that these innovators are '*diamonds in the rough*' (Roberts & Machon, 2015) and may need to look beyond the individual and consider the innovation that is being presented.

The challenges also encouraged the participants to work differently and so generating change in the workplace. Ovretvreit et al (2012) reviewed twelve organisation and management innovations in Swedish healthcare. The findings showed that the clinicians and not the managers played a significant part in getting innovations implemented. They also found that the internal local context of the organisation was more important than external factors. These findings are not dissimilar to the results of this current study. Interestingly Ovretvreit went on to suggest that innovations may not always be original, but they may be new to the organisation which is when organisations must consider working differently; also suggesting that to work differently frequently leads to quality improvement which was also evident in this study. The specialist nurse who worked with the district nurse to improve services to patients with a neurological condition (participant 23) and the dietitian (participant 10) who identified patients requiring supplement drinks are just two examples of improving quality of care through working differently. One of the challenges that Ovretvreit et al's (2012) study discovered were the various interpretations of the innovation which links to the findings of this study as it was frequently reported that managers did not understand why change needed to happen, often interpreting change as a request for more resources which was not the case.

In the current climate of transformation of community services it is the ideal time to look to new ways of working, engaging stakeholders and other health professionals as changes are made, rather than forcing changes unfairly without consultation. Working through this transformation will require determination, belief, accurate business planning, realistic anticipated outcomes, cost effectiveness and clear communication. Despite this MacFadyen (2015: 4) reiterates that the 'bottom-line principle' of any new idea is the responsibility of the individual and suggests that this may not be easy as they may have to fight for their belief as it may be the only way that change will happen. Linking to this study, the perseverance of the participants displayed resilience to deal with these challenges.

*7.3 To look at the impact of education and training on the progress of the participants was the third objective of the study. The educational input had developed in all participants, insights and skills which enabled them to carry out an innovation in their clinical area.*

Carr & Clarke's (2010) study demonstrated that nurses struggle with tensions as they aim to improve clinical practice. Approaching their work with a new fountain of knowledge enabling them to work differently they are frequently met with barriers such as entrenched ways of working. These barriers were also experienced by the participants of this study who were frequently confronted with phrases such as "*we have always done it this way, so why change now*". Statements such as this were challenged by the participants with one of the participants in the study saying: "*Just because something has always been done like this it doesn't mean that this is the best way*".

It became apparent to all, that to succeed in their endeavour to improve their patients' care they needed to work with others and that their skills and knowledge base required development. The most frequently reported gap in their knowledge was financial management: budgeting and fundraising and how to present a business plan. They looked to formal education to meet these needs but the learning experience gave them so much more. Korukcu & Kukulu (2010) who carried out a study on innovation in nursing education discovered that a number of innovations were being utilised in nurse education resulting in nurses being taught in non-traditional ways, such as using technology, simulation and action learning sets, some of these methods were used by the participants of this study. As mature learners the use of action learning sets supported their experiential learning giving them the ability to draw on their experiences using their new knowledge to form the basis of their discussions. While learning the business skills they were exposed to other ideas and learning experiences such as how to understand white board economics and carry out costing exercises.

Cooley's (2008) study looked at nurses' motivations for studying post-registration nursing programmes and the impact this had on their personal lives. The findings revealed that the reasons were to assist their professional development and to keep up to date with new treatments. They also wanted to gain skills in doing things differently which resonated with the participants of this study. An important finding

from Cooley's study was the positive aspect of working with multi-disciplinary teams which did not necessarily rate high in this study, but did resonate with not working alone.

Stanley (2003) reviewed the lived experience of part-time post registration students who were similar to the participants of this study. An increased confidence was discovered which met with the findings of this study, but additionally Stanley (2003) discovered some of her participants had found the studying stressful and had impacted on their personal life. This was contrary to the findings here as stress was not mentioned at all and the personal development had flowed over into their personal life enhancing their personal development. The demands of their course developed their level of perseverance and raised the motivation to new heights. It made their dreams a possibility.

#### *7.4 The real me – finding a professional home, Increased confidence, Personal development*

A finding that was raised by almost every subject and, it could be argued is the single most important one, was the strengthening of the 'self', the discovery of the 'real me' as a result of being in a group of likeminded people. This new manifestation of the 'self' came about through being accepted by others – no longer being the 'difficult' colleague – and by working through the many stages of getting their project off the ground. The struggle had made them stronger. This new self-belief was for some transferred to their personal lives in a positive and sustainable way.

Bandura & Locke (2003) recognised that individuals function at different levels which affect their personal efficacy, stressing that the level of self-efficacy shown by an individual frequently linked to individual perseverance in trying to solve problems. This was evident in this research as many of the participants thrived on trying to solve, what for many would be, unsolvable problems. One such example is the specialist nurse (participant 6) who set up leg ulcer clinics in both areas of her borough delivering an equitable service across her Trust a seemingly simple approach, but it was met with strong opposition.

The individual characteristics of those involved in this research were crucial as to whether a project was successfully implemented or not. One of the key

characteristics found in this study was that of self-efficacy as already mentioned, and research carried out by Amo (2006), Ziyae et al (2015), Mobaraki et al (2012), Beeftink et al (2012), Tierney & Farmer (2011), Ng & Lucianetti (2015), Kumar & Uz Kurt (2010), Bandura & Locke (2003) have consistently shown that self-efficacy contributes to attitude, motivation and overall performance.

Sarasvathy (2001) argues that all entrepreneurs begin with three categories of means: (1) Who they are – their traits, tastes and abilities; (2) What they know – their education, training, expertise, and experience; and, (3) Whom they know – their social and professional networks. The findings of the current study also highlight that the personal traits of the professionals are key to their success, education is important and developing professional networks were key to the success of several projects. And as Sarasvathy (2001) says '*Using these means the entrepreneurs begin to imagine and implement possible effects that can be created with them. Most often, they start very small with the means that are closest at hand, and move almost directly into action without elaborate planning.*' Our healthcare innovators started with what they had at hand, funds, existing policies, the limited support of colleagues but used them to create a new way of working.

These survival tactics fall in line with Robinson's (2014) traits for a successful entrepreneur, whilst these are not research based the participants of this study displayed these seven traits: tenacity, passion, tolerance of ambiguity, vision, self-belief, flexibility and rule breaking. Paterson et al's (2009) review of characteristics and behaviours of individuals support these views but have also added that 'Intelligence is a necessary but not sufficient condition for innovation' claiming that cognitive ability alone does not account for much of the variance observed in individual innovative performance, and that domain specific knowledge is a key resource for innovation in organisations. This was apparent in all of the projects that were presented; each individual had a vested interest in the project because their whole self was emerged in their specific innovation due to their intense knowledge of the subject. Sung & Choi (2009) also identified five personality factors in support of innovation, these being; extraversion, agreeableness, conscientiousness, emotional stability, openness to experience. Other than extraversion the participants of this study would fall in line with these characteristics also. Reflecting on one interview

the participant said that she felt that she did not have to have an extrovert personality to be a successful innovator.

The majority of the participants in this study identified a resilience which was driven by their increased confidence and self-belief. As such there are many factors that contribute to the use of resilience in the workplace and for those practitioners working in the field of community health there is a greater need for resilience now more than ever. Cusack et al's (2016) study which looked at factors in nursing workplaces that promote psychological resilience identified that environment as well as self-efficacy, coping and mindfulness were important factors in promoting resilience. This is particularly pertinent to the community health professionals who frequently work in non-purpose built community buildings and also patient's private homes. This adds to the significance of their coping abilities and resilience as they are often working in sub-optimal environments.

A study by Cope et al (2016) claim that nurses are survivors and transformers of their own reality which is why resilient nurses are the ones that remain in the workforce despite the adversity. This is exemplified in the data gathered from the participants of this study who developed their resilience as the belief in their innovation grew. Even though some of the participants of the study did not remain in their place of work, they all transferred to an environment where they were able to utilise their resilience to develop their innovation, supporting Cusack et al's (2016) work on the relevance of having a supportive environment.

A report carried out by the Royal College of Nursing in 2016 found that nurses are under more pressure now than ever before, often resulting in burn out, a view supported by The Kings Fund (2015) claiming that the UK suffers from the highest burn out in Europe amongst NHS staff. These indicators have also been seen by Turner et al, (2015) and Rushton et al (2017). Therefore, to be able to work effectively amidst the chaos, changing landscape and demands of the workforce, resilience is recognised as a beneficial attribute enabling healthcare professionals to flourish and thrive amid challenging work environments (Hunter & Warren, 2013).

Masten's (2001:228) research on resilience in children looks at the systemic nature of resilience, for example the risks, assets and protective factors and suggests that: "resilience refers to a class of phenomena characterized by good outcomes in spite

of serious threats to adaptation or development". Similar research on adults is scarce even though organisations offer training on resilience as a means of one could argue that this does not deal with the issue of stress within organisations. This is an area that could be researched further. Nevertheless this concept is transferable to the participants of this study who were constantly threatened with negative views from managers and colleagues but had positive outcomes nevertheless.

Whilst there is considerable overlap between resilience and other psychological constructs (Cusack et al, 2016), with most definitions based around two core concepts: adversity and positive adaptation. Although resilience has been a major construct in positive psychology (Winnie et al, 2011: 610) frequently strengthening the capacity of an individual to respond to stressors in a way that balance and harmony is maintained (Pines et al, 2012) and is a necessary quality for surviving negative effects of workforce challenge and stress (Tusaie & Dyer, 2004). As such there are many factors that contribute to the use of resilience in the workplace and individuals react to difficult times in a variety of ways, some becoming overcome with stress but others strengthening their determination and energy resulting in a resilient approach which gives individuals the strength to break cycles of hostility and negativity frequently displayed by managers (Jones, 2012). Having an optimistic attitude and being able to contextualise and visualise the anticipated outcomes of a project is an additional benefit in following a project through from idea to implementation which corroborates the actions shown by the participants of this study.

The ability to cognitively process thoughts and ideas is instrumental in fuelling resilience which frequently results in the formal solution-focused therapy approach (Walsh, 2010). This model originated in family therapy and has since proceeded to be used in organisational change, incorporating strength-based values. It was not apparent that participants were consciously using a specific model, but the fact they began with the solution relates to Walsh's theory through the utilisation of their individual strengths.

The personal development experienced by the participants of this study was grounded by their inner confidence which gradually developed as they progressed through the programmes they studied, but also as they were able to see their

innovations becoming a reality. Research carried out by Gardner et al (2008) on nurse practitioners in Australia and New Zealand suggest that confidence increased as knowledge and competence improved. Gardner et al's (2008) study collaborates the numerous findings of this study: working well with others, being creative, taking risks, open communication, being a knowledgeable doer, self-efficacy in managing unfamiliar situations and having a vision. Gardner's (2008) work also supports the notion that education and training are a significant factor in nurses' confidence. Even though Gardner et al's (2008) study was not looking at innovation the traits found in their participants were similar to those found in this study. Gerrish et al (2011) also looked at the role of the advanced practice nurse and concurs that knowledge is power, instilling confidence in nurses.

### *7.5 Recommendations*

The fourth objective: ***To inform potential innovators about what they can expect to encounter as they develop an idea and wish to develop their own project,*** will be met when the following recommendation are met.

The findings of this study established that providing the participants with relevant skills to formulate a business plan with sufficient detail to present to a business board suggests that these are skills that all health professionals should aspire to. Therefore it is recommended that innovation should be a subject covered within all health professional curricula, particularly post registration programmes. As a result of carrying out this research and discovering that the participants of the study were making a significant difference to community service provision, the researcher was influential in changing the Specialist Community Public Health Nursing and Specialist Community District Nursing programmes which are delivered at the researcher's university. These programmes now have a module which looks specifically at innovation in the community providing students with an introduction to economics to enable them to prepare business cases demonstrating clear costings, savings for the organisation and expected outcomes and benefits for patients. Commissioners will be invited to speak to students outlining what their expectations of business proposals are and established innovative practitioners will also be invited to speak to students to discuss how they achieved the support of their organisation in making



changes. The importance of sustainability and engaging key influential people in the organisation are essential skills to develop, additional topics such as developing personal resilience, dealing with failure, swallowing pride and taking advice from others and listening to others within the workplace are all be essential elements of the module. The overall aim of the module is to produce practitioners who are more entrepreneurial and business savvy than previous community health professionals. Community health professionals will be expected to present business cases in a factual way identifying clear anticipated outcomes and potential savings to the organisations whilst putting aside any emotional factors if they want their business case to be viewed seriously. They have to understand that taking an innovation forward will require tenacity and viewing their role as one of immense importance in getting changes implemented in their workplaces. In times of transformation of community services health professionals must contemplate working differently demonstrating an increase in shared working, utilising the expertise of others and reducing silo working to provide high quality care.

The researcher is a member of a national body of community health educators and the findings of this study and the introduction of the module on innovation will be shared with this national group as a means of influencing future curriculum developments across the country. All members of this group provide post qualifying community health programmes and in introducing this module to future community health professionals it will enhance practice knowledge and result in a strengthened national community workforce. The community workforce has previously been seen as a Cinderella service compared to secondary care provision. However if there was a national drive to enhance the skill set of community practitioners demonstrating that they are business minded and can promote innovation within community services it is anticipated that local organisations across the country will see an increase in efficiency and patient satisfaction and the government may give community services the recognition it deserves.

The findings of the research stress the importance of not only having the right environment but having the support of the organisation to support an innovation. A poorly structured organisation without the ability to support staff will frequently result

in failure. The research discovered that some managers were prepared to take on the ideas of others but had not always recognised the suggestions as a potential innovation. If Managers were given the tools to recognise an innovation and a skill set to provide a platform for innovators to be listened to it would improve the possibilities of innovations being driven forward. The tools to promote innovation could take the form in various guises:

- A handbook identifying key characteristics of innovative people - The overall aim of the handbook for managers is to have a resource that will give the managers skills in supporting innovative practitioners.
- Suggestions to enable staff to have 'thinking time' to experiment with new ideas
- Space and opportunities for staff to discuss evidence based practice and share best practice with like-minded people
- Carry out a meaningful appraisal with employees enabling them to speak openly about new ideas and initiatives
- Provide opportunities for employees to attend an education/training in innovation giving the employees the tools to promote and implement their innovation
- Develop study days for managers as a 'taster' to prepare them for working with innovator practitioners.

A Community Health Care Trust has asked for the findings of this study to be presented to senior managers in their organisation. This is an ideal opportunity to disseminate the results and engage local health providers and commissioners to work with their front line staff in providing evidence based innovative practice to patients in their region. The presentation and a list of key factors in recognising innovation will be provided. Work will commence on developing the handbook for managers with the aim of having a finished professional product by Spring 2018.

Finally, the contribution to practice knowledge will be enhanced through publication of this study. The researcher initially aims to publish the findings in peer reviewed journals such as the Journal of Nursing Management, Journal of Community Health and Health and Social Care in the Community journal and also the British Journal of

Educational Psychology. These journals are targeted at managers, educationalists and community health professionals and will address the skills required to be an innovator, but most importantly, will stress how enabling innovation to occur has opened up opportunities for the participants identifying 'the real self'. The discovery of the 'real me' was the most profound finding of this study and this should be shared with others, increasing understanding of the complex learning and development that innovative practitioners experience.

### *7.6 Limitations of the study*

**A wider sample:** The sample was guided by the opportunity to include individuals who had undertaken formal education in innovation or had presented their own social care projects at conferences, two factors are noteworthy: 1) the imbalance between the genders (more women than men) and 2) the limited ethnic diversity among the sample. It would be worthwhile investigating both issues. Are there in reality as many men working as innovators within the NHS as women but pursue their goals without feeling the need for structured education? Likewise, are there as many healthcare professionals from a diverse ethnic pool working innovatively but again do not seek out training or are there barriers to some individuals considering undertaking a plan to improve clinical practice in their area. These biases, may well have influenced the responses reported here, this research is therefore, only a snapshot of a growing phenomenon which must involve a broad range of staff profiles.

**A longer study:** The researcher was in contact with participants for just two years which is a relatively short period of time considering the complexity of setting up a new project and seeing an impact, let alone get any idea of the sustainability of the projects. Revisiting these same projects and their innovators at the five year point would be instructive.

**Theory:** This study is a straightforward, descriptive, inductive study which has not been informed by any theoretical perspective from the disciplines of management or psychology. As so little was known about the topic this was considered a legitimate place to start, letting the participants tell their story without any externally imposed

framework. However, given the complex and personal nature of the themes that emerged, it may be of value if any future study worked within an established psychological framework to give a deeper understanding of the lives of these innovators.

### *7.7 Conclusion*

This study has produced some important findings in relation to the personal and professional journey of healthcare social innovators and has provided information for others taking the same road in future. This is the first time that the process of innovation has been researched from the perspective of the health professional. It became clear during the interviews that behind each innovative project there was a dedicated, indeed passionate, person who cared very much about the quality of service their patients and clients received. It was their observations of suboptimal care in their professional area that ignited their interest: money being wasted, time misused, poor use of existing resources, poor communication of risk to patients were all observed in various forms. A secondary, but important motivator was the apparent lack of concern by many colleagues and managers responsible. It was the lack of attention given to patients and sometimes their families, to deliver care that was excellent not just adequate that slowly pressured the innovators to take action which may have been due a lack of vision, or even ambition. Nevertheless this could not be ignored and the participants of the study felt the need to intervene.

Some interviewees had been in a state of limbo for many months, frustrated at a lack of encouragement from their managers before they discovered and signed on to their particular course promoting challenging the status quo and supporting innovative practice. Many reported feeling like the 'difficult' colleague and that their idea for improving practice was seen as criticism of current work and colleagues. However, once in the company of like-minded individuals in the safety of the classroom they blossomed and talked of becoming the 'real me' for the first time at work. The combination of their learning and the practical experience of setting up a project led to some significant developments. Their readiness to identify a solution rather than focussing on the problem was an essential element to the success of their projects.

Many barriers and challenges were presented along the way, but the experience of failure gave them an added incentive to try harder; being knocked back developed an inner resilience that they had not readily acknowledged or been aware of previously.

Much has been written about the operationalising of a project, but no literature has been sourced on the impact of the learning experience on the individual. As such this study is a contribution towards research in this field and questions whether education on social innovation has improved clinical practice and enhanced the personal and professional development of individuals. The study has shown that in instances unlearning traditional practices and learning new ways of working has improved patient outcomes. Acknowledging that frequently innovation begins at the face of delivery and not necessarily from managers was significant, however it was essential that gaining support from the organisation was key in enabling an innovation to move forward. The ability to take advantage of opportunities and the passion, resilience, competence, confidence and clinical expertise were seen to be essential drivers in providing creative and innovative solutions to delivering a quality, effective service provision to patients in the community. Their learning was considerable and spanned their professional and personal lives. It should not to be forgotten that the outcome of their work was, in many cases, a significant improvement of the quality of care delivered to the patients.

## **Chapter 8**                      **Reflection**

### *8.1 The researcher's personal journey*

This is my personal journey through the Professional Doctorate programme and my evolution from being a novice researcher to becoming a competent researcher. It

has been challenging and enjoyable in equal measure – it has defined me as a person and as a professional. It has made me look at research in a whole new way – taking account of the bigger picture and how my research can influence the future of community health professionals through the inclusion of innovation in programmes that I deliver to community health students. It has demonstrated to me that I can perform research at doctoral level as previously I was like many students – the word research filled me with dread. I now have a much deeper understanding of the various research approaches that can be used for social science research.

I sometimes thought that the pressure of working on the professional doctorate programme and working full time in a highly pressurised job at another University would break me. My working life is very stressful and the past five years have presented me with many exasperating challenges at work. Whilst this was difficult, it was also the catalyst that made me continue with my studies.

I began my Professional Doctorate whilst in my final year of the MA in Leadership and Management so from the commencement of the programme I was juggling academic studies with work. I was a student on the first cohort to enrol onto the Professional Doctorate at Westminster University. The first year I studied a reflective module and a professional practice module so I was fairly comfortable with both of these topics. As a qualified nurse reflection is a practice that is encouraged throughout all aspects of our work and as I had only just completed my MA in Leadership and Management I was also relatively confident with the content of the professional practice module.

## *8.2. Year One*

During the first year we were asked to think about our topic for the research project. Since qualifying as a nurse my main interest has been in care of the older person and during my years working as a District Nurse I had become increasingly concerned with the number of staff, both qualified and unqualified, that were visiting vulnerable people in their homes so my initial focus was to look at the quality of service provision for older people in their own homes. I presented my research idea to the research teaching team and they suggested that it might be difficult for me to gain ethical approval to speak to either patients or carers as I was no longer working

as a practitioner and did not have direct access to patients. This threw me slightly so I had to go back to the beginning to look for another research topic that would interest me. At the time I felt very disillusioned and considered whether I should discontinue the course; if I couldn't research an area that I was interested in what was the point in carrying on? However, my resilience and determination to never give up kept me going. I reflected on this incident and how I had felt, and using Gibbs Reflective Cycle (1988) I asked myself if I had to present my research topic again, what would I do. I would take the advice of the teaching team and look at another topic where I could still research an element of quality of care and service provision. I also needed to consider how I could do this so that I would be able to gain ethical approval from both universities.

### *8.3 Year Two*

The second year of the programme concentrated on research and the various research methodologies. It was during this period that I began to recognise and understand the various research methods that I could potentially use. So I spent about six months looking at how I could still carry out a meaningful piece of research that would be able to influence care in the community. I was fortunate that at that time I was recruiting for an exciting programme on social innovation. As the social innovation course evolved and students were coming back to the classroom with ideas and ways of improving the service that was being delivered to patients in the community I had a light bulb moment. I could use students on this programme as the core participants of the study and I would still be able to use my findings to influence care in the community. I spoke to my supervisors about this idea and the view was that this would be suitable for my research. This interruption had delayed my progression but it had been worth it as I was now looking at care in the community across the cross sectorial service provision in the community. Once the ethics had been approved from both universities I was able to commence the data collection. Reflecting on this period of deciding which theoretical research approach to use once again delayed the actual commencement of data collection. As the methods chapter (chapter 3) has suggested, I had contemplated using a number of different research approaches and I think that it was during this period that my greatest learning took place. Recognising that grounded theory, which is commonly

used in health research, would not be appropriate for the length of time that I had to gain the data opened my eyes to how time consuming this approach would be and how it would benefit a longitudinal study. Why then couldn't I use a narrative analysis approach as I wanted to understand the journey that the participants had travelled during their studies? This wouldn't work as I required an element of structure to my interview questions. Surely an ethnographic research approach would be suitable as I had been a District Nurse so I could have 'insider' knowledge to many of the responses. I realised I could not use this approach as I was not observing the participants in practice. Prior to studying for the Professional Doctorate I would not have appreciated the subtle differences between these approaches. Deciding on thematic analysis has once again opened my eyes to an approach to research that, in my opinion, enables the researcher to gently direct questions, but at the same time allows the participants to share their experiences and tell their story in a format that then enabled codes and themes to be identified.

#### *8.4 Professional Development*

What have I done with this learning now? I have taught on a research module which I would never have dreamed I would be confident in my knowledge to do so. I have supported colleagues who have wanted to carry out research and have shared my knowledge with them. I realise that when I previously sat on the ethics committee at my university I did not have enough knowledge of the different research approaches that could have impacted on the ethics of an application. I am going to apply to sit on the ethics panel once again as I am sure that I will have an increased ability to offer constructive comments in relation to the research approaches presented.

As I mentioned at the onset of this reflection I have not only grown professionally but also personally. Professionally as I have progressed with the data collection, literature review, data analysis and the writing up of my findings I have become less stressed about the end result. I have learnt so much along my research journey that I am able to take constructive criticism, comments and suggestions from supervisors without feeling a failure. I am in awe of their expertise in research and would aspire to being able to support students in the same way at some stage.



### *8.5 Personal Development*

From a personal point of view, life has thrown many personal challenges my way during this past six years. Even though I have been immersed in reading articles and collecting data these challenges have highlighted what is important in life to me, which is why at times I have had to put my studies for the professional doctorate aside to deal with what I see as my priorities. This has assisted me in 'keeping sane' throughout this period of my life. Recognising that I have had to do more 'juggling' than I have ever had to do before has enabled me to compartmentalise sections of my life with the aim of trying to achieve a work life balance. I am not saying that this has been easy, but my motto in life is that this is not going to beat me but it is not going to make me ill either – from a nursing background I have the philosophy that there is never an educational emergency so I refuse to be a casualty of one through stress. I think I have achieved this over the past six years. However, even though I have said that I have maintained my work life balance there is always a section of my brain that says 'why aren't you working on your professional doctorate?' I am looking forward to no longer hearing that voice in my head.

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### Appendix 1 Details of Projects

Overview of projects research participants initiated **1 - 17** were deemed to be successful projects, **18 - 26** did not succeed as planned.

	Aim of Project	Project	Financial Expenditure	Anticipated cost savings	Outcomes	Progress
1	To reduce emergency admissions for patients diagnosed with heart failure	Heart Failure Self-Management Programme	£7,550 – Develop self - assessment toolkit and additional hours for band 6 nurse	£14,270 over a 6 week period for 36 patients with heart failure	Reduction of hospital admissions and bed days. Patients could monitor their quality of life and take	First 6 week period successful additional costs submitted to carry out an evaluation of programme

					ownership of their actions	
2	Reduce hospital admissions due to falls	Falls Prevention Service	£20,000 – to employ a band 4 falls prevention champion and minimal marketing costs	£115,000 saving if 15 referrals per week are prevented over six months.	Reduction of hospital admissions and community team referrals	6 month pilot successful – plans to employ an additional band 4
3	To provide a cheaper alternative to hospital appointment follow-up	Nurse-led telephone follow up for men with prostate cancer	£35,000 – to employ a part time band 6 community nurse & admin costs	£82,600 if 800 patients are telephoned per year (each hospital visit costs £147.00)	Improved patient satisfaction - they are able to fit telephone consultations around their work/personal life	Successful – after 3 years a full evaluation of this service to be carried out
4	To provide 3 x weekly clinics for mobile patients with venous leg ulcers	Nurse-led venous leg ulcer clinic in General Practice	£35,000 – 1 community nurse band 6 and one band 4 for 15 hours over 6months	£102,500 saving over a 6 month period estimated on 2 visits per patient per week	Improved patient & staff satisfaction due to faster healing rates & reduced social isolation	Successful – have now employed a community nurse lead for the clinics Commission services to a wider audience
5	To develop a pathway to identify Learning Disability patients at high risk and for carers to track early warning signs in order to access health care sooner	Reducing Avoidable Hospital Admissions Pathway through inter-professional working	£12,000 to develop pathway	£19,000 per year	Prevention of hospital admissions, reducing anxiety in this client group	Successful – application to employ a discreet fixed term ‘Reducing Hospital Admissions’ nursing role
6	Reduce the inequality of leg ulcer care across a geographical region	Silver Standard Leg Ulcer Service	£15,000 – 4hr x 52 weeks for band 6 time + £7,800 dressings	£375,000 per year by reducing chronic leg wounds by 50%	Reduction of chronic leg ulcers	Successful after 1year.
7	To provide training and tools required to facilitate quality end of life care for adults with learning disabilities	End of Life Care awareness training for care home staff and learning disability awareness training for Macmillan staff	£10,500 – training, printing, Band 5 x 1 day per week for 20 weeks	£68,000 per year by reducing current hospital admission by half	Raised profile of end of life care for people with learning disabilities and 50% of staff have had training, reducing hospital admissions and improved end of life care for patients and families	This project is now on the Trust annual agenda and will continue for the foreseeable future
8	To improve the quality of nursing care to all patients requiring care from District Nursing teams, through the use of a standardised caseload management tool.	Development of a pro-active caseload management tool	£11,550. For 3 month pilot Band 6 project lead, administrative support, Training & Development materials	£90,000 per District Nursing team over a 3 month period by preventing 2 hospital admissions per month	District Nurse time is freed up to visit more patients by reducing caseload	The District Nurse profile within Trust has been raised and she is now taking on more projects. This caseload tool is now used to inform commissioning, workforce planning
9	To keep patients with long term conditions at home through extending out of hours community health services	Virtual Ward out of hours service	£15,000 to pilot the programme for 3 months – £7,200 Band 5 community nurse and £3,200 Band 3 health care assistant	Estimated saving of £48,000 for 1 night stay for 10 patients per month over 3 months. Reduced hospital admissions, particularly for patients with long term conditions.	Access to service 24 hours per day resulting in improved quality of life & continuity of care.	Virtual Ward has been commissioned and is ongoing.
10	Financial saving from a reduction in oral nutritional supplement prescribing	Reduction of inappropriate prescriptions for oral nutritional supplements	£51,000 to employ a prescribing support dietitian and part time dietetic assistant for an initial 12 month period	Anticipated to save £150,000 by reducing prescription for oral nutritional supplements.	Improve the quality of care delivered to patients by ensuring that malnutrition is identified and managed appropriately.	Savings have been made and a dietetic assistant is still employed

11	Raise awareness of NF1	To improve the lives of NF1 patients and families	£20,000 for Band 7 nurse and administrative support	Reduction of hospital emergency admissions due to additional available expert support	Improved quality of life for patients and families of NF1 sufferers	NF1 support network continues
12	Prevent long waiting lists for patients requiring lymphedema provision	Develop a lymphedema service for patients within a general practice region	Set up social enterprise with colleague	Creating a value for local people whilst utilising expert skills	On- site service provision reducing time spent on hospital outpatient clinics	Ongoing successful lymphedema service provision for local people
13	As above		Set up social enterprise			
14	To improve service provision for communities in a rural region	Identify duplication of services, develop a training schedule for community & primary care nurses	Joint training sessions for District Nurses and General Practice Nurses	Prevent duplication of service provision	Seamless care provided for patients, promoting continuity of care and increased patient satisfaction	Work is continuing with Clinical Commissioning Groups & Trust
15	Promote infection control in the workplace and reduce hospital admissions	Develop a training programme for care home staff	Time to develop poster outlining key facts relating to infection related conditions and time to deliver training to care home staff	To enhance care home staff knowledge of risks associated with infection related conditions	A 70% reduction of infection related admissions to hospital	Posters are displayed in care homes outlining key risks associated with infection related conditions
16	To assess vulnerable patients in the community predicting those at risk of adverse outcomes	Develop a prediction tool to assess vulnerable at risk patients	Time to introduce this tool to all District Nurses at monthly meetings	Individualised care pathways benefitting individual patients	Carers, health professional & patients benefitting as a result of early identification of risk	Steering group set up to support this project
17	Improve the physical activity levels of females	Develop a community cardiac rehabilitation women's walking group	Plan cardiac education into District Nurse & General Practice Nurse visits & clinics for female patients	Improved well-being of female participants	The women's quality of life improved and blood pressure was maintained at optimal level	The project is ongoing
18	To encourage young people to learn about and test their comprehension of a broad range of contraception and sexual health topics.	Games/Quizzes to decipher the knowledge and understanding of public health issues related to sexual health practices	£36,000 to develop quiz and publish findings in the format of a book on sexual health	Anticipated saving of £330,000 per year through reduction in unplanned pregnancies and reduction in sexually transmitted diseases	No improved health outcomes to report	Was unable to seek funding for the project
19	To reduce the number of patients being admitted inappropriately from between 50-70 per day down to 20-25 per day	Accident & Emergency Health Visitor Service	£46,750 – whole time equivalent full time HV band 6 + administrative costs	£144,000 anticipated saving of 100 patients per month	Reduction of 100 admissions per month	Pilot service explored but not implemented - HV since left and set up a Social Enterprise
20	To reduce the actual and potential harm caused by alcohol misuse to individuals and communities	Produce a game linking to the Public Health work plan for Healthy Ageing	£1500 – time to develop game, health professionals time facilitating the game and producing ongoing games had not been factored into the costing	Prevention of alcohol related admission of older people to A&E had not been calculated	Those that used the game did say that it raised their awareness to the dangers of excess alcohol, but no statistical evidence available	This project did not proceed as future planning had not been accounted for in the original costing

21	To increase capacity and delivery, cut agency spend by 50% within Health Visiting teams	Development of a transformational leadership programme that incorporates coaching, supervision, goal setting & motivation mapping	£10,000 to deliver over a 9 month period	£182,000 approximately over 9 months	Greater autonomy for Health Visitors, increased morale and increased job satisfaction and productivity within Health Visiting teams, reduced agency staff	Unable to obtain funding from Trust or various charities to support this transformational programme. The Health Visitor has since left and has set up her own company
22	To provide an equitable maternity service for all pregnant women in a rural area and to enhance staff skills and knowledge to provide continuity of care	Implementation of local scanning procedures and purchase a birthing pool	£35,000 Train 2 midwife sonographers, purchase relevant stationery. Purchase & install birthing pool Staff training to lead unit and backfill for staff	Improved choice for pregnant mothers and an increase in local maternity services	Anticipated outcomes were to reduce travelling time for expectant mothers, care closer to home and provide greater choice of method of delivery	Unable to obtain funding to purchase equipment. Midwife has now left this post and taken another position where she has more autonomy
23	Reduce unplanned admissions for patients suffering with multiple sclerosis	Unplanned Admissions	£15,000 to backfill band 6 for 1 day per week	Anticipated reduction of 100 admissions to hospital per year saving approx. £146,000	Increased patient choice, care closer to home	Unable to supply funding beyond pilot stage. Participant has now left this employment
24	Improve mental health services for outpatient clinics	Develop a weekly mental health drop in clinic	Band 6 nurse to facilitate sessions for 3 hours per week	Reduction of A&E visits	Improved quality of life for patients through ongoing care in the community	Trust provider changed so project not taken forward as business case not produced in detail to support this
25	Prevent social exclusion	Arrange a bus befriending service for the older socially excluded	Bus hire and hire of venue for group meetings	Reduction of hospital admissions caused by depression and mental health conditions	Improved well-being of patients	Interest in project from the mental health services, but no funding to support bus service
26	Promote family support for patients with mental health conditions	Reduce hospital admissions	Provide training for mental health practitioners and support workers	Anticipated cost saving would be reduced hospital admissions and inappropriate emergency call outs	Ongoing family support, continuity of care	This project did not continue due to changes of commissioned services

## Appendix 2 Information Sheet for Participants of the Study

**Title of Study:** *A qualitative study of UK community health practitioners' perceptions of their personal and professional development after training for and practicing as health and social innovators*

I would like to invite you to participate in this research study. You are not obliged to participate and if you choose not to take part you will not be disadvantaged. Before you decide to take part, it is important for you to understand why the research is being carried out and what your participation will involve.



**What is the project about?** Innovation is not a new concept and this study aims to determine the expectations of students undertaking a programme where this is actively promoted and encouraged. A number of students will be interviewed before and after completing the programme. It will also determine the impact of such a programme on students and their practice, exploring whether such a programme facilitates theory to practice knowledge transfer and if this impacts on the quality of care given to service users by having social innovators as part of the community health workforce. This research will also be looking at community practitioners who have not had any formal training on innovation but who have been successful in setting up an innovative project in their work place.

**Selection Process:** You have been invited to participate as you have expressed an interest in innovation either through partaking in a programme on social innovation or by being an innovative community practitioner. For those of you who have attended a social innovation educational programme I would like to find out your views about the programme and how this has impacted on your clinical practice. For other participants I would like to find out what have been the drivers to enable those of you who have not had formal training on innovation but have been successful in implementing an innovative project in your clinical practice.

**Who is involved in the research study?** The study will be led by a member of staff from Buckinghamshire New University who is undertaking a Professional Doctorate at the University of Westminster. The staff member has a special interest in utilising innovation to enhance clinical practice

**Do I have to take part?** No, participation is entirely voluntary. If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form agreeing to take part. Should you decide not to partake in the study you do not have to give a reason. If you decide to withdraw during the study, any of the information you have provided can also be withdrawn if you request this.

**What is involved?** If you agree to take part you will be amongst other participants who have agreed to take part in this study. I will arrange to meet with you at an agreed time prior to commencement of your period of study. If you are participating in focus group interviews it will last between 1-2 hours and there will be a number of key questions that I would like to ask you. The interview will be audio taped, subject to your permission to allow all of your responses to be captured accurately. If you are having a telephone interview it is anticipated that it will last between 10 – 30mins. The telephone interview will also be recorded for accuracy. Individual face –to- face individual interviews will last no longer than 60 minutes.

**What happens to the information?** All of the information is confidential and your information will be coded not using names so it will be totally anonymous. The information will be downloaded onto the researcher's personal computer, which is password protected and the data will only be accessible to the researcher.

**What will happen to the results of the project?** The results will be collated and presented as part of the researcher's final thesis. Some data will be used in publications and conference presentations, but these will be anonymous, unless permission to name individual projects has been given by any of the participants. A copy of the final report can be sent to you if you request this.

**Thank you for taking the time to read this information sheet.**

### *Appendix 3*

### *Consent Form for Participants*

*Please state yes or no*

I have read and understood the project information sheet.....

I have been given the opportunity to ask questions about the project.....

I agree to take part in the project. Taking part in the project will include being interviewed on an individual basis or as part of a focus group and will involve the focus group discussion being audio taped  
.....

I understand that my taking part is voluntary; I can withdraw from the study at any time and I will not be asked questions about why I no longer want to take part.....

I understand my personal details such as phone number, email or address will not be revealed to people outside of this project. ....

I understand that my words may be quoted in publications, reports, web pages, and other research outputs but my name will not be used .....

I agree for the data to be held by the Key Researcher for the period of time that the study is being carried out and understand that it will be destroyed once the final thesis has been written up.....

I understand that no other researcher will have access to the data. ....

On this basis I am happy to participate in the research study looking at the impact of innovation on the quality and effectiveness of service delivery in a clinical community setting.

Name of Participant ..... Signature..... Date.....

Name of Researcher...Agnes Fanning..... Signature.....*Agnes Fanning* ..... Date.....

If you have any queries or concerns, please contact: [

Agnes Fanning

Buckinghamshire New University,

Queen Alexandra Road,

High Wycombe,

HP11 2JZ

[Agnes.fanning@bucks.ac.uk](mailto:Agnes.fanning@bucks.ac.uk)

01494 522141 ext. 5765

One copy to be kept by the participant, one to be kept by the researcher

*Adapted from the UKDA Model consent form*

## Appendix 4

## Questions for participants

*Question 1:* Why did you enrol onto the programme?

*Question 2:* Did you have any expectations from the programme you studied?

*Question 3:* What skill set did you bring to the programme?

*Question 4:* Having been on the programme has it changed your practice?

*Question 5:* Do you feel the programme has enhanced your practice?

*Question 6:* Has your organisation noticed any change in the way you work?

*Question 7:* If you learnt one key thing from the programme you attended what would it be?

*Question 8:* Looking back on Day 1 do you feel you are working in a different way than before the programme?

*Question 9:* What made you want to look differently at how you, or others in your organisation were delivering care? Was there a problem in the way they were working?

*Question 10:* What impact did that level/style of care have on the client group?

*Appendix 5*

*Additional Questions*

*Question 11:* Are there any areas of disappointment for you in how your project is progressing/has been able to develop?

*Question 12:* What would you do differently (if anything) if you could start your project again?

*Question 13:* What advice would you give to anyone who is planning to introduce innovation into their organisation or profession?

*Question 14:* Thinking of your current project, how has working in a different way changed the service provided? If it has, In particular, how are these three key areas impacted:

- The impact on the quality of care delivered to your client group?
- Any difference in the service delivery process?
- Evidence of value for money for your organisation
- Any other observations you may have about the impact

*Appendix 6*                      *Consent Form for Transcriber*

*Please state Agree or Do Not Agree*

I have read and understood the project information sheet .....

I have been given the opportunity to ask questions about the project.....

I agree to take part in the project as a transcriber for the project. The project will include interviews on an individual basis or as part of a focus group and will involve the focus group discussion being audio taped .....

Transcripts will be sent to the transcriber at intervals agreed between the transcriber and the researcher .....

All information remains confidential and must not be shared with anyone other than the researcher .....

I agree for the data to be held by the Key Researcher for the period of time that the study is being carried out and understand that it will be destroyed once the final thesis has been written up.....

I agree to destroy all transcriptions once they have been sent to the researcher and the content has been confirmed by the participant and the researcher .....

I understand that no other researcher will have access to the data. ....

On this basis I am happy to participate in the research study looking at the impact of innovation on the quality and effectiveness of service delivery in a clinical community setting.

Name of Transcriber ..... Signature..... Date.....

Name of Researcher...Agnes Fanning..... Signature.....*Agnes Fanning* ..... Date.....

If you have any queries or concerns, please contact: [

Agnes Fanning

Buckinghamshire New University,

Queen Alexandra Road,

High Wycombe,

HP11 2JZ

[Agnes.fanning@bucks.ac.uk](mailto:Agnes.fanning@bucks.ac.uk)

01494 522141 ext. 5765

One copy to be kept by the transcriber, one to be kept by the researcher

Appendix 7 Ethics Approval from Bucks New University



22<sup>nd</sup> April, 2013

Mrs Agnes Fanning  
Primary Care & Public Health,  
Buckinghamshire New University,  
Queen Alexandra Road,  
High Wycombe, HP11 2JZ

Dear Agnes,

I am writing to confirm that Ethical approval was granted by the Society & Health Ethics committee of Buckinghamshire New University on 26<sup>th</sup> February 2013 for your project titled:

“A qualitative investigation of the impact of a Social Innovation educational programme on Community Health Professionals and their client group”

I hope that your research project goes well.

Yours sincerely,

*Mel Nakisa*

Dr. M. Nakisa  
Secretary to the Ethics Committee  
Research Unit  
Academic Quality Directorate



<b>Ethics Committee-database</b>									
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Comments			Date Closed		Final Outcome				
Approved by Chair's Action			29-Jul-13		Approved				
Application No	Date Received	Surname	Forename	Level	School/Faculty		Supervisor (Where applicable)		
12-13-28		Fanning	Agnes	PhD Student	Life Sciences		Patricia Maitland		
Project Title		Course (student)	Date of Meeting	Outcome	Discussion	Conditions	Amendments Deadline	Comments	Date Closed
<i>A qualitative investigation of the impact of a social innovation programme on community health professionals and their client group</i>		Mphil/Phd	26-Jun-13	Resubmit		Yes		Approved by Chair's Action	29-Jul-13