



# DAIRS: Service Evaluation Final report

March 2015

## **Bournemouth University Researchers:**

Janet Scammell  
Desiree Tait  
Ashley Spriggs  
Martin Hind  
Caroline Belchamber  
Edwin van Teijlingen

A service evaluation commissioned by the Centre for Implementation Science,  
(Wessex AHSN) on behalf of Dorset CCG

### **Acknowledgements**

The research team at Bournemouth University would like to thank the project funder, the Centre for Implementation Science (Wessex AHSN) on behalf of the Dorset Clinical Commissioning Group. Special thanks go to the Dorset Adult Integrated Respiratory Service (DAIRS) staff in Bournemouth, Poole and Dorchester and in particular service users for their time and participation.

### **Contact for further information:**

If you would like any further information about any aspect of this report, please contact the project lead Dr Janet Scammell via email:

[jscammell@bournemouth.ac.uk](mailto:jscammell@bournemouth.ac.uk)

<b>TABLE OF CONTENTS</b>		<b>Page</b>
1.	EXECUTIVE SUMMARY	4
2.	INTRODUCTION	5
	• Evaluation	5
	• Context	5
3.	EVALUATION METHODS	7
	• Quantitative approach	7
	• Qualitative approach: focus group	7
	• Qualitative approach: interviews	7
	• Analysis	7
	• Ethics	8
4.	FINDINGS	9
	• PREM survey findings	9
	• Findings from qualitative data	10
	• Summary of qualitative findings	11
	• Detailed qualitative findings	12
5.	DISCUSSION	22
	• Service in transition	22
	• Challenges of integrated working	23
	• Service user satisfaction	23
	• Local issues	23
	• Responding to change	24
	• Moving forward	25
	• Strengths and limitations	27
6.	CONCLUSIONS AND RECOMMENDATIONS	28
7.	REFERENCES	29

## 1. EXECUTIVE SUMMARY

This early process evaluation of the newly established Dorset Adult Integrated Respiratory Service (DAIRS) in three localities in Dorset was conducted by Bournemouth University using a mixed-methods approach.

Our evaluation showed staff commitment and enthusiasm for a pan-Dorset approach to respiratory care and a very positive acclaim from service users. Mindful of the fact that DAIRS had been in operation for four months only, the evaluation flags up strengths and issues of concern at the initial stages of service implementation. Discussion of the findings has been linked with current thinking to emerge in the White Paper from NHS Improving Quality around service improvement and change management (Bevan & Fairman, 2014).

Given that DAIRS has been commissioned in the first instance for a period of two years, this early evaluation will be valuable for stakeholders to address the issues raised in a timely manner.

### Recommendations

1. Build upon the high levels of satisfaction to engage service user users more widely in the on-going development of DAIRS.
2. Shared documentation needs to be agreed and implemented as soon as possible, including the DAIRS card.
3. DAIRS should be officially launched with appropriate information for different stakeholders: service users, community staff and non-DAIRS hospital staff.
4. The change process should be actively managed; concerns and challenges expressed by participants should be acknowledged and a supportive environment provided for collaborative problem-solving.
5. Consider selection and use of grass roots 'change champions' across the sites and disciplines to facilitate a more inclusive model of organisational change.
6. Further integration between localities should be explored particularly around staff education, as well as to facilitate on-going peer support.
7. New staff would benefit from being supernumerary for their first month and visiting neighbouring DAIRS localities.
8. Inclusion and exclusion criteria need to be revisited to ensure a shared understanding amongst DAIRS staff, particularly around co-morbidities.
9. Information and service provision concerning emotional support for service users and carers needs to be reviewed.
10. The current Single Point of Access System (SPOA) should be reviewed to improve compliance.
11. Information Technology (IT) systems and possibilities for joint DAIRS systems should be explored.
12. Perceived financial inequities need to be addressed in service planning.
13. Our evaluation provides a base-line for future work, a further more comprehensive evaluation after two years of DAIRS operation is needed to inform future funding and service development. Suggested factors to include:
  - Outcome data
  - Cross-locality service user involvement (avoiding winter peak time), using systematic PREM questionnaire distribution processes.
  - Community staff perspectives.
  - Input from related respiratory services, currently not part of DAIRS.
  - Investigation of impact of a differing skill mix across localities.
  - More detailed service user feedback.
  - Evaluation of staff education (DAIRS and non-DAIRS).

## 2. INTRODUCTION

Chronic Obstructive Pulmonary Disease (COPD), Bronchiectasis, Pulmonary Fibrosis and the management of patients with acute exacerbations are complex and resource intensive. COPD is under diagnosed nationally and the patient experience can be poor with frequent hospital admissions and associated costs. A review of service provision commissioned by Dorset Clinical Commissioning Group *Dorset's Future Desired State Document for COPD, Bronchiectasis and Pulmonary Fibrosis* (Wessex HIEC 2013a) made recommendations for service reconfiguration, resulting in the formation of the Dorset Adult Integrated Respiratory Service (DAIRS). The new service has been commissioned for two years from April 2014 with the service going live from 1<sup>st</sup> September 2014.

The Centre for Implementation Science (affiliated to Wessex AHSN) on behalf of the Dorset Clinical Commissioning Group (DCCG), commissioned an interim evaluation of DAIRS after four months of operation, to provide insights into service implementation and to make recommendations for service improvement for year two and further evaluation research.

### Evaluation

The aim of the evaluation is to determine the experience, expectations and views of patients and staff of DAIRS from three localities in Dorset.

The DAIRS evaluation formally commenced 1<sup>st</sup> December 2014; data collection concluded 31<sup>st</sup> January 2015; however Patient Reported Experience Measure (PREM) data from inception of the DAIRS service were also included. Further service user involvement included a focus group and interview as well as individual interviews with DAIRS' staff. Integrated care coordinators were also approached but were unable to participate.

### Context

DAIRS is a new model of care for respiratory services for COPD, Bronchiectasis and Pulmonary Fibrosis across Dorset that involves a specialist respiratory outreach team (Wessex HIEC 2013b). DAIRS replaced three independent hospital-based respiratory specialist teams: Poole Outreach Respiratory Team (PORT), Dorchester Outreach Respiratory Team (DORT) and Respiratory Early Discharge Scheme (REDS). Whilst individually successful in many ways, a new pan-Dorset model was required due to inconsistency of respiratory care provision across the county and the under diagnosis of COPD despite an ageing population and the association with increased chronic disease. The aim of DAIRS is to: improve patient experience and outcomes; integrate a seamless provision of care for patients, ensuring that services work jointly across the health and social care economy; deliver a new and improved model of care with excellent patient-centred communication (Wessex HIEC 2013b). In the former respiratory service configuration, the hospital outreach teams worked in collaboration with community services; a key difference with DAIRS is a strengthening of this approach to provide an integrated service. This strengthened process included a clinical education programme for community nurses and GPs which ran early on in the initial implementation phase. This programme concluded in January 2015.

DAIRS serves three localities with roughly similar overall population sizes (of about a quarter of a million each). DAIRS in each locality had its base in a district general hospital: Mid-Dorset (Poole Hospital); West Dorset (Dorset County Hospital (DCH)); East Dorset (Royal Bournemouth and Christchurch Hospitals (RBCH)). Whilst sharing the same overall aim, each locality-based service is configured differently due to local NHS Trust priorities and related service structures. These differences impact on staff numbers and grades, as well as on specific elements of services that are included or excluded as part of DAIRS in each of the localities.

### **3. EVALUATION METHODS**

The evaluation is based on a mixed-methods approach, which is largely qualitative in nature with a smaller quantitative component (van Teijlingen & Forrest, 2004).

#### **Quantitative approach**

The patient experience was in part assessed through the analysis of the data derived from the PREM survey. Paper copies of completed PREM surveys were sent to Bournemouth University where they were added to an electronic database. The analysis of the PREM used only descriptive statistics; the timeframe for the evaluation and the fact that the service only went live in September 2014 meant the amount of data available for analysis was relatively small.

A range of other quantitative data is being routinely collected since inception of the service (ie. mortality rates, hospital admissions, length of hospital stay); however no sophisticated statistical analysis of this data will be possible until completion of the second year of service operation, thus falling outside the remit of this evaluation.

#### **Qualitative approach: focus group**

The second methodology of this project is focus groups (van Teijlingen & Pitchforth 2006) with respiratory service users (that is patients and carers). One was planned to be located in the urban conurbation of East Dorset and one in a rural location in West Dorset. At the recruitment stage, DCCG warned us that some DAIRS patients (and their carers) were already involved in focus groups for the local Clinical Services Review and may be reluctant to 'get involved'. Further the timing of the evaluation (Dec. 2014 / Jan. 2015) meant that many DAIRS patients may have experienced recent exacerbations of their condition and therefore be reluctant to leave home to attend a group. This information helped explain our difficulty in recruiting out with East Dorset. Consequently we could only organise one focus group. This was audio recorded (with permission) and transcribed anonymously (i.e. all identifiers names / places were removed) (Krueger & Casey, 2000).

#### **Qualitative approach: semi-structured interviews**

The experience and views of the workforce was elicited through face-to-face interviews with staff working in DAIRS. Semi-structured interviews (van Teijlingen & Ireland, 2003) were conducted in each locality. In total 19 interviews were conducted and audio-recorded (with permission). The interviews lasted between 15-40 minutes. In addition one telephone interview was conducted with one patient, too unwell to attend the focus group. All interviews were transcribed anonymously afterwards.

#### **Analysis**

A basic descriptive statistical analysis was performed on the quantitative PREM survey data using SPSS (v 22.0). A thematic content analysis of the qualitative data both from the focus groups and the in-depth interviews was undertaken (Forrest Keenan *et al.* 2005). The qualitative analysis involved initial coding by all interviewers on the team. Following discussion an initial coding framework was generated. This was applied to all interview and focus group transcripts, resulting in ten agreed themes.

**Ethics**

Bournemouth University's ethics committee granted approval. All participants consented to participate, and to maintain confidentiality, no names are recorded in the report.



#### 4. FINDINGS

The findings will be presented in two parts: the quantitative analysis of the PREM data followed by the analysis of the qualitative findings. Where relevant we have highlighted the link between the statistical data and the qualitative findings.

##### PREM survey findings

A total of 318 questionnaires were issued and 75 valid questionnaires were received in the four-month data collection period: 25 from Bournemouth, 35 from Poole and 15 from Dorchester. This equates to an overall response rate of 23.6%. Hoonaker & Carayon (2009) indicate that 52% is the norm for postal surveys, meaning that caution is noted with this low response. The area-based numbers were equally too low to do sub-group analysis. A nurse saw nearly all respondents (92%). As is common in patient satisfaction research in the health field (Avis, 1997), the overwhelming majority of respondents rated their service excellent (83%) or good (16%). Table 1 shows that the pattern of patient satisfaction was equal between nurses as compared with doctors / other health care professionals.

Table 1: Patient rating of DAIRS by provider

Professional seen		Frequency	%
Doctor / other	Excellent	5	83.3
	Good	1	16.7
	Total	6	100.0
Nurse	Excellent	57	82.6
	Good	11	15.9
	Average	1	1.4
	Total	69	100.0

The survey focused on key factors that influence patient satisfaction. The overwhelming majority of feedback indicated high satisfaction with specified aspects of DAIRS (see Table 2). The results for items e, f and g relate to satisfaction with communication between staff and patient and are particularly positive, being scored either 1 (strongly agree) or 2 (agree) from all respondents. The results for items a, b and c whilst still positive (range= 53-56% answering 1: strongly agree), are more mixed, perhaps reflecting an understandable concern about the nature and on-going management of their condition. This was similarly reflected in the qualitative data from service users who had moderate to severe COPD, and expressed concern about '*what else could be done to help*'. Item d was rated the most negatively of all the items with 12% neither agreeing nor disagreeing that their care plan met their emotional support needs and 3% disagreeing that this was the case. Again this was reflected in the focus group data; when asked how the service could be strengthened, several participants wanted more psychological support to cope with their condition.

*Table 2: Patient feedback on aspects of services (Likert-type scale\*) by %*

	1	2	3	4	5
a. I understand my respiratory condition	56	43	1	-	-
b. I understand my care plan	52	43	4	1	-
c. My care plan meets my physical needs	53	39	7	1	-
d. My care plan meets emotional support needs	45	40	12	3	-
e. Treated with dignity & respect	80	20	-	-	-
f. I was able to ask all my questions	72	28	-	-	-
g. My questions fully answered	73	27	-	-	-
h. The provided support will help me self-manage my condition	65	33	1	-	-

\* 1=Strongly agree; 2=Agree; 3=Neither agree nor disagree; 4=Disagree; 5=Strongly disagree.

### Findings from the qualitative data

The qualitative findings are based on the analysis of data from 19 staff interviews; one service user interview and one service user focus group (4 participants). The staff interviews provided a representative sample from the three DAIRS localities. All service user participants had or cared for a patient with a diagnosis of COPD; these findings therefore do not reflect the views of service users with a diagnosis of Bronchiectasis or Pulmonary Fibrosis. Due to recruitment difficulties, a limited number of service users from East and Mid-Dorset localities only were able to participate. Table 3 provides a summary of the participants.

*Table 3: Characteristics of participants by data collection method*

Method	Participants	Number
Interviews	Lead and associate lead nurses in DAIRS	5
	DAIRS nurses	6
	Clerical Managers and Health Care Assistants	2
	Physiotherapists	3
	Medical Staff	3
	Service user (patient)	1
	Focus Group	Service users (patients and carer)

Overall the qualitative data supported the PREM data around patient satisfaction. They also supported some service user concerns about how the service could meet psychological needs particularly as their condition worsened. Focusing on staff, the data revealed an enthusiastic commitment for the aim of DAIRS to work in a more integrated way, particularly with community staff for the benefit of service users and to contribute towards meeting educational needs, as a key way to help fulfil this goal. However, it was also clear that the newly configured respiratory service for Dorset under the DAIRS banner was in the early stages of implementation and the impact of

adapting to different ways of working was challenging, especially for those less involved at a strategic level.

### Summary of qualitative findings

The analysis revealed 10 themes and 27 sub-themes. Key findings have been summarised in Table 4 with sample statements included to illustrate each sub-theme. This is followed by a more detailed presentation of the qualitative findings.

Table 4: Qualitative analysis: Summary of themes, sub-themes & sample findings

Theme	Subthemes	Findings
<b>Knowledge of DAIRS: “What is DAIRS?”</b>	Service–users’ knowledge	Unsure of what the change means to them
	Wider staff knowledge	Unaware of how service had changed
	No launch of the new service	Would benefit from an official launch
<b>Geography</b>	Service coverage	Different challenges for each locality
<b>Service in Transition</b>	Responding to change	Increase in clinical staff numbers
	Evolving service	Positive experience of evolving services
	Inclusion- exclusion criteria	Uncertainty concerning inclusion criteria
	Documentation	Agreed but not implemented
<b>Rapid implementation</b>	New staff	Variations in knowledge / experience
	Systems not ready	New service implemented before fundamental structures were in place
	Evaluation too soon	Unable to measure outcomes yet
<b>Perceived Resistance</b>	GPs & Community staff	Perceived individual resistance
	Non-DAIRS Respiratory nurse specialists	No clear understanding of boundaries and responsibilities
<b>Communication</b>	Medical staff	GPs: Needs development. Consultants: Good
	Service- users	Good
	Single point of access(SPOA)	Lacks the “personal touch”
	Team working	Supportive teams in each locality
	IT systems	Challenging but worth pursuing. Need for more resources
<b>Integration</b>	Within hospital:	Improving collaborative involvement
	Community	Important but potential for improvement
	Between the DAIRS localities	Only occurs at team leader level
<b>Education</b>	DAIRS staff	Supportive & “on-the-job” learning taking place
	Community staff	Supported education to continue
	Anxiety	Felt by less experienced staff with steep learning curve. Less confident in their role.
<b>Financial support</b>	Funding	Inequity in funding across localities
<b>Service-user satisfaction</b>	One-stop shop	Patient self-referral system is essential.
	Anxiety	Anxious and uncertain about the impact of changes for them

### Detailed qualitative findings

This results section provides a detailed summary of the findings in each theme and subtheme. Each theme is described briefly followed by supporting quotes in a boxed format. Quotes are given identifiers to main confidentiality: SU signifies a service user participant and S signifies a DAIRS staff participant. The quotes are illustrative and represent 89.5 % of participants interviewed either individually or as part of a focus group.

#### Theme one: Knowledge of DAIRS: “What is DAIRS?”

The service user evaluation of the respiratory services was very positive, however in the four-month period of operation, both staff and patients expressed confusion about the name and function of the new service.

- **Service-users’ knowledge:**
  - Aware of a name change but not what that meant for them.
  - With no official update available at the time of data collection, their concern was that the service accessibility criteria would change and they may lose support.
- **Wider staff knowledge:**
  - Clinical staff also reflected this trend when they identified that non-DAIRS health care staff accessing the service were unaware of how the service had changed. The lack of information available for both service users and health care staff liaising with the service appears to have led to (a) confusion about how and when to refer patients and (b) anxiety related to changes in practice and support.
- **No Launch:**
  - DAIRS participants have proposed that some of the problems related to the lack of wider staff knowledge of the service could be resolved by providing an official launch.

#### Box 1 Theme 1 - Knowledge of DAIRS: illustrative quotes

##### Service-users’ knowledge:

*Some people worry about what DAIRS is but the only concern that I’ve got is- will DAIRS be available for me when I want it...If I phone up in October after I’ve had a good summer will they say “Well X you’re no longer eligible” (SU2)*

##### Wider staff knowledge:

*...other members of staff working in the hospital ...they don’t know who we are. Just because of this we might not get some referrals, or they might not know what we do ...oxygen ...assessments. (S5)*

##### No Launch:

*This is a new service and from my experience any new service has to be launched and awareness increased across the Trust, across the whole PCT as well (S11)*

## Theme two: Geography

This theme represents the service providers' experiences of coping with the geographical area and the provision of service coverage.

- **Service coverage**
  - DAIRS participants working in rural areas recognise the challenge this poses, particularly in west Dorset.
  - Extra resources required traveling to remote rural locations.
  - DAIRS staff were however able to provide examples of how some challenges have been overcome. This includes the setting up of regular outreach services in rural communities in order to provide local accessible support on a regular basis. This was perceived as a positive innovation.
  - In some locations where services overlap, participants highlighted the potential for cross- service working.

**Box 2 Theme 2 - Geography: illustrative quotes** *Geography is at the heart of the service, we're covering a lot of countryside... (S16)*

*We cover a huge area (no motorways here!), getting round the patch is not easy, it takes a lot of time and limits what we can do. (S13)*

## Theme three: Service in transition

A strong theme that emerged from the data was related to the experience of being involved with a service in transition. The first two sub-themes relate to how the service has begun to change and the potential for development and improvements in services. The second two sub-themes relate to situations that have been identified by staff and service users as barriers to the process of transition.

- **Response to change:**
  - Participants identified that the key change for respiratory services has been the increase in the number of clinical staff. Service users have also recognised an increase in the number of staff available. One service user identified that he / she used to know all the nurses but not anymore; they also said that the service is as good as it has ever been.
- **Evolving service:**
  - Within this sub-theme DAIRS participants identified a number of initiatives that are beginning to evolve as the service expands.
  - These include: improved services for oxygen assessment; the provision of intravenous antibiotic services; follow-up clinics for physiotherapy; and the potential to improve assessment and diagnosis of respiratory patients.
- **Inclusion - exclusion criteria:**
  - DAIRS participants across the county highlighted examples of situations where hospital and community health care staff appear unsure of the criteria for referral to the new service.
  - Service users have also identified that they are concerned that the inclusion criteria may change and they will no longer be able to access a service that they consider as their lifeline.
  - The consensus of opinion extracted from the interview data is that clear inclusion criteria needs to be agreed and made available as a matter of urgency.

- **Documentation:**
  - A similar trend has been identified with regard to the need to implement shared and standardised documentation across the DAIRS localities.
  - Concerns were raised about the lack of published information leaflets and cards available to service users and staff.
  - DAIRS participants expressed that it was difficult to produce an audit trail of interventions and costs without standardized documentation.
  - These recognised challenges have been referred to as barriers to service transition and link strongly to the next theme, rapid implementation.

### **Box 3 Theme 3 - Service in transition: illustrative quotes**

#### **Response to change:**

*We've had to take on a lot more staff... (S2)*

*There are more people you know... now I'm seeing people I don't know. It's as good as it ever was - the service I mean. (SU2)*

#### **Evolving service:**

*I do feel like it is going to be a better service, it's expanding, taking on more roles and developing. (S8)*

*At the moment, because it's still quite new, as the service is evolving my role is evolving with it. (S5)*

*...I'm learning new roles, new services. ...it's just trying to actually provide for all the patients and not forgetting our COPD patients. (S3)*

#### **Inclusion - exclusion criteria:**

*We do get some GPs phoning up and wanting to refer people but because they have not been seen by the thoracic team here - we still can't deal with them. (S4)*

*Once we have the DAIRS inclusion-exclusion criteria (which don't seem to be adhered to at the moment) it's going to make it easier for medical professionals to refer to us and for us to accept appropriate referrals. ... inclusion - exclusion criteria have to be formalised... quickly. (S11)*

*The only thing I want to know is, am I still eligible for DAIRS? (SU2)*

#### **Documentation:**

*I hope they [patients] don't get confused about who they can go and see. ... once the leaflet is out there, then it will help them and the contact card... (S6)*

*I think a lot of people don't know what happening. They are getting told that the paperwork is changing... but we don't know when (S8)*

*I think it's very frustrating, trying to agree the paperwork... We need a degree of standardization but these things can take a long time to agree and resolve. I think this has been a barrier... we have three acute trust providers who work in very different ways trying to find common ground. (S10)*

#### Theme 4: Rapid implementation

This theme has been presented on the basis of staff responses collected during the interviews.

- **New staff:**
  - All localities have increased their staffing levels and have recognised how this has led to variations in staff knowledge and experience across each patch.
- **Systems not ready:**
  - Some DAIRS participants have identified that they have experienced difficulty with undertaking their new role due to a lack of clear documentation and role definition. They feel that they have been “railroaded” into delivering the service quickly and that they have struggled.
- **Too early to evaluate:**
  - Similarly staff have argued that it is too early to evaluate and those members of the team who were involved in setting up similar services have said that they are not expecting to see a change in outcomes until two to three years after the service implementation.

#### Box 4 Theme 4 - Rapid implementation: illustrative quotes

##### New staff:

*We've taken on a lot more staff and I think it's better for patients. (S2)*

*The obvious hiccup are the logistics of getting the new staff in post, but now we've got them in, they all need staff training at the same time. (S7)*

##### Systems not ready:

*I think the staff feel they have been railroaded into delivering the service quickly, we have had an injection of money but the resources are tight and it may be that we will struggle to deliver all of the outcomes required. ...we will get there but it won't be an easy task. (S7)*

*We have made many changes in the last few months. ...we need another six months for it to feel that we are running the services properly. It's all very “beginning”. (S6)*

##### Too early to evaluate:

*I think it's too early to evaluate, we haven't really got off the ground yet. (S7)*

*My role is a very recent development; I have only done 3 clinics. (S19)*

*I don't think we will know any outcome measures by March 2015 (S13)*

#### Theme 5: Resistance

This theme focuses on the teams' experiences of feeling resistance from community matrons and (non-DAIRS) respiratory nurse specialists as DAIRS has developed.

- **Community matrons and GPs:**

The team believe the resistance has occurred at an individual level rather than at an organisational level and have identified two reasons for this situation occurring:

  - The first is historical in that there are some members of the community staff who believe that the DAIRS service should have taken the form of an ‘in-reach’ service rather than ‘out-reach’.



- The second reason focuses on the organisational difficulties encountered when setting up and running education sessions for community staff and GPs.
- **Respiratory Nurse Specialists:**
  - DAIRS staff have also experienced some resistance from respiratory nurse specialists working outside DAIRS involved in discharge planning for patients with COPD and patients diagnosed with Bronchiectasis as there does not yet seem to be a shared understanding of each other's role.

#### Box 5 Theme 5 - Resistance: illustrative quotes

##### Community matrons and GPs:

*We've had some resistance from some members of the primary care team. They feel that the service should have been evolved from primary care not secondary care. It's individual resistance not institutional resistance. (S7)*

*... uptake from the community is not as good as hoped. People are not prepared to take on this sort of integrated role as well as we had hoped... probably a need for more education ...they need to be on board and take responsibility for these patients... (S14)*

##### Respiratory Nurse Specialists:

*I know there's some resistance about what arm of Bronchiectasis we are taking on board as this is the domain of the respiratory nurse specialist. (S11)*

### Theme 6: Communication

This theme focuses on attitudes towards factors that affect communication between DAIRS providers, community services and patients.

- **Medical staff:**
  - Nurses and physiotherapists have described having a good working relationship with the respiratory consultants.
  - The level of rapport between the DAIRS team and GPs is described by staff as an area that needs to be developed.
- **Patients:**
  - DAIRS staff appear reassured that although the service's name and documentation has changed, patients are still encouraged to use the same telephone help line number.
- **SPOA (Single Point of Access):**
  - This system has been established in Trusts for some time; however the DAIRS teams have only recently adopted SPOA. Implementing the system as part of the transition in service appears to have led some staff to question the validity of the service while others see SPOA as a useful tool that offers an audit trail for the referral process.
  - The area of concern regarding its validity focuses on the perceived lack of personal communication associated with SPOA.
- **Team working**
  - Within the DAIRS localities participants highlighted their experiences of working in a good and supportive team. However, cross-locality team working only occurred at consultant, lead and



deputy-lead nurse level. This is explored again in the theme 'integration'.

- **IT systems:**
  - The development and achievement of an IT system that is interactive and compatible with all the DAIRS localities has been recognised as a challenge, but one perceived as worth working towards.
  - The DAIRS participants describe doing the best they can with limited IT resources and recognise that as the administration process increase they will need stronger IT support and extra resources.

#### Box 6 Theme 6 - Communication: illustrative quotes

##### Medical staff:

*There's a lot more linkage between primary care and secondary care, but also us linking in with the consultants a lot more, the specialist consultants. (S18)*

*The fact that the consultant's in the three hospitals get on well together, and these things often do rather rely on those things, and it would be nice if they didn't; if we could foster this way of working, more collaborative way of working ...people feeling less territorial and defensive; then that would be enormously helpful; and it does involve making yourself a little bit vulnerable; but I think you just have to accept that. (S13)*

##### Patients:

*I know for the COPD patients, if they are at home and feel unwell, even if I haven't seen them for a while, they can always phone us and say, "I don't feel well, my breathing is worse, what shall I do?" and we can advise them. (S5)*

##### SPOA:

*Historically we've always enjoyed quiet a good working relationship with the community matrons and we've enable to take informal phone calls, advising informally... But because the process of referral is now formal through the single point of access system that's written and documented in terms of monitoring outcomes... it's now thrown up a little bit of obstacle and people don't want to use it. (S7)*

*Single point of access is been up running for few years but in terms of the respiratory service using them it's absolutely brand new... In fact we've only just nailed down some guidelines on how single point of access will take a DAIRS team referral but the beauty of it is because it's single point it's documented, it's centralised and the same process happens in all sites. (S7)*

##### Team working:

*I think we are a ... a good team we all get on which I think is a big thing (S2)*

*Other than the team leader nobody else has really have any contact with anybody else in any of the other teams. We don't ... we've not met, we've not all gone to one place at one time and say, "oh hi, I am" ... that's not happened. (S7)*

##### IT systems:

*Definitely IT wise. We do share information but we're doing it by fax and it's still very antiquated. (S1)*

*It would be so much better if there were combined clinical notes for the whole of the NHS.*

(S13)

**Theme 7: Integration**

The findings related to this theme highlight the amount of progress made towards the integration of DAIRS -

- **Within hospital:**
  - Staff participants responses related to integration within the hospital settings were generally positive. The team identified that the consultants in the various localities were offering more support with the new system than they were able to do previously.
  - Specifically interdisciplinary involvement with referrals and multidisciplinary team meetings were reported.
  - There are increasing opportunities to collaborate with some of the in-hospital respiratory specialist teams.
  - Some participants highlighted that although there was some integration between different parts of the wider hospital based respiratory service; there was a need to integrate the DAIRS more effectively with the respiratory nurse specialists working outside DAIRS in order to provide a more seamless service.
- **The community**
  - All DAIRS participants recognised the importance of improving integration with the community teams and some were able to provide examples of good integration, while other participants identified that some community matrons were reluctant to integrate. One participant identified that this was not about encroaching on the role of the community matron but rather working more closely and collaboratively.
- **Between the DAIRS localities:**
  - The findings revealed that DAIRS participants do not perceive the three localities as being integrated, apart from the team leaders, no one has met or been introduced.
  - There is a perception that the three sites have very different philosophies and styles of management.
  - Participants described feeling protective of their own areas.
  - There was also the question of who was overall the strategic lead for the service

**Box 7 Theme 7 - Integration: illustrative quotes****Within hospital:**

*I think what's different from before is we have far more support from the consultants than what we did before, just from a point of easier access. We, also, can refer them into an MDT if we need to. We're quite close to the TB nurse, to the respiratory physiologist, the respiratory physiotherapists and we're much more closely linked now. (S1)*

*...in theory the DAIRS is about adult integration respiratory services but in this hospital the respiratory service, the respiratory nurses are a bit of a separate limb, even though we are going to incorporate Bronchiectasis and Pulmonary Fibrosis. (S11)*

**Community:**

*I don't think integration is there yet. I think we've always been fairly integrated, we've never seen ourselves as a secondary care service, and we've always spent roughly 50% of our time out in patients' homes. (S10)*

*We are lucky with community matrons; there are only a couple that are a bit awkward. Generally we have a massively a good rapport with them and we speak to them. I would say there's probably not a day gone by where I haven't phoned their office. GP wise, I haven't had much involvement only other than one patient the other day and they have been okay. Generally the GPs are quiet good, so if they phone up and ask questions, they accept what we say. (S12)*

**Between sites:**

*...nobody else has really have any contact with anybody else in any of the other teams.(S4)*

*I think all the philosophy across all three sites is very different, yeah, and the way we run it. (S14)*

*I would say we were maybe a little bit more protective of our areas maybe... (S1)*

### **Theme 8: Education**

This theme focuses on the DAIRS participants' experiences of learning and developing their roles.

- **DAIRS staff:**
  - The level of clinical experience and expertise in the three localities was varied and included a number of staff that have recently been appointed to their posts and are unfamiliar with their roles.
  - Participants across the service described having increasing amounts to learn about specific respiratory conditions.
  - They describe the learning experience as a combination of 'on-the-job' learning and seeking opportunities to attend relevant courses and study days.
  - Some participants have described looking for opportunities to network with similar centres around the UK.
  - Some participants expressed a desire for more 'in service-training' in order to limit the time they are away from providing the respiratory service.
  - Participants have recognised that there is funding to support education.
- **Community staff:**
  - A strong message that has emerged from the data is the importance of continuing with structured education programmes for community staff and care home staff. Participants describe the advantages of this approach as (a) the improvement of the quality and standardisation care for service-users and (b) the promotion of a more integrated service.
- **Anxiety**
  - Some DAIRS participants have described experiencing anxiety as a result of "being thrown in" to providing a service that they have limited experience in. This finding is consistent with data that identified differences in the levels of experience and expertise between the three localities.

**Box 8 Theme 8 - Education: illustrative quotes****DAIRS staff:**

*It's a learning process for all of us, because there is so much to learn, obviously with the interstitial lung disease we're going to be taking on, we haven't been on a course yet. (S2)*

*We've had to go through a huge amount of change with everybody having to learn an awful lot. We are all involved with kind of outside training as well as in-service training. Lots of people have been making links with other hospitals to go out and see their departments. (S18)*

*I've been very lucky; in my first four months my brain has nearly exploded with education and information. But that was really good, I said, I will be honest with you if I don't know something, and they've sorted it. (S16)*

*So we can't all be off for the training because nobody will be here to do the jobs. So we are learning as we go. (S3)*

**Community staff:**

*We have developed a three day educational programme for community practice nurses and community matron and those practitioners in the community; to increase their skills in the management of COPD; in the management of Bronchiectasis and interstitial lung disease. ... We had some very good feedback ... I feel very positive about the whole thing. (S13)*

**Anxiety:**

*We've been sort of thrown in and we're taking over a service that we haven't got that much experience in, and I say that I know, particularly with the pulmonary fibrosis patients there aren't really any courses that we can do for that, so, we are just going to try... but that's a bit scary, you know, actually looking confident and being comfortable with patients when you, you feel if you haven't got enough knowledge. (S2)*

*I do feel overwhelmed sometimes, which I find difficult. And then there are other times where it's all going really well and absolutely loving it and... I think that's the nature of this type of job, really. (S1)*

**Theme 9: Financial support**

This theme focuses on DAIRS participants' perceptions of funding.

- **Funding:**
  - Some participants described feeling concerned about how the funding for the service had been allocated. These concerns seem to stem from a perception that different Trusts have different funding contracts. This may be considered as a barrier to future integration.

No quotes are provided, as those available would breach confidentiality.

**Theme 10: Service-user satisfaction**

This theme presents the findings from DAIRS participants and service-users about how they experience service-user satisfaction.

- **One-stop-shop:**
  - Participants from service providers and users have stressed the importance of the patient self-referral system. They describe this as essential for providing a safe and effective service.
  - Both groups of participants have also identified the importance of continuity of care and service users have provided examples of nurses who "have always been there" for them during difficult times.

- **Anxiety:**
  - Some service-users have described feeling anxious about the changes to the respiratory service and are concerned that they may no longer be eligible for the service.
  - Service-users describe the benefits of being able to talk to someone who knows and understands what it's like to feel breathless and frightened.
  - Both service providers and users have identified that more structured psychological support for managing their respiratory condition would be beneficial.

**Box 9 Theme 10 - Service–user satisfaction: illustrative quotes**

**One-stop-shop:**

*We love the fact that they [service-user] can just pick the phone up for self-referral, they absolutely love that...again I think a little bit more time to prep so that the patients know exactly what pathway is might have been helpful, I appreciate that. (S7)*

*I think what's nice for a patient is it's a little bit more of a one- stop- shop, as it were, whereas before a patient could have asthma, COPD, Bronchiectasis and need oxygen, they'd have to be in touch with four different people for that, whereas now they only have to contact one service, and I think that's a lot easier for them. (S1)*

*...they go beyond what is expected, without a doubt, you know, I'm not creeping, but they've always been brilliant. ... in my times of difficulties and problems, they've always been there for me, when I lost my wife, years ago, the next morning on the doorstep there they were, you know, because they were obviously worried about my situation. (SU1)*

**Anxiety:**

*I think, it was particularly the asthma patients that come into the clinics, some of them were quite anxious and I think and were, very apprehensive about the changes... (S2)*

*...the only thing I think is missing from DAIRS is something to do with stress or anxiety and I suffer terribly with stress and anxiety, I think they could have somebody attached to that. (SU2)*

*Sometimes you are a bit out of puff; you just want someone just to talk you through because I'm on my own. You do get a bit frightened. (SU5)*

## 5. DISCUSSION

The findings attest to a largely satisfied DAIRS service user group supported by committed and motivated staff. However unsurprisingly so early into the implementation of the new service, they also highlight the practical and psychological issues that participants have experienced as part of the transition from the old to the new service. One central issue dominates the findings: the impact of change on both service users and providers. From this four further issues merit further discussion (see Figure 1).

*Figure 1: Diagram representing key issues from the findings*



### **Service in transition**

A central issue within the data was that staff and service users were experiencing a service in transition. Whilst the potential for development and improvement was apparent, it was clear that some barriers were perceived as a result of the rapid implementation of the new service before all structures were in place [recommendations 2 and 3]. This left some DAIRS staff slightly confused about processes [recommendations 8 and 10], but of more concern, staff from the wider health community in the hospitals and the community were unsure, particularly about the boundaries of the service and how these linked with related service provision [recommendation 3]. The findings indicated that the most collaboration between sites occurred at the highest level – consultants and lead nurses, whereas perhaps the identification of grass roots ‘change champions’ [recommendation 5] across the sites and disciplines might facilitate a more inclusive model of organisational change (Rivas et al. 2010; Hendy & Barlow, 2012).

### **Challenges of integrated working**

The data indicated that staff participants understood and valued the goal of integrated working with community staff but could see this was a 'work in progress'. Whilst some DAIRS staff perceived resistance to the new approach, the evaluation did not include community staff views [recommendation 13] and so this cannot be confirmed nor has data on the impact of the education programmes been collected due to the timeframe of the evaluation. Whilst these challenges were expected, those associated with integration with related services within the hospital were less anticipated and this seems to have added some stress to the implementation of DAIRS [recommendation 4]. This was made even more problematic by the use of different, non-integrated IT systems [recommendation 11]. Hayes et al (2014) writing about improving healthcare quality identify similar issues, arguing that in trying to make a new service work the staff involved can feel pressured to 'work harder'. They argue however that 'working smarter, not harder is the real key to success and that this can be realised by engaging all levels of staff in the design and development of the service in order to ensure commitment through genuine involvement and understanding [recommendation 3 and 4]. For example the benefits of integrating between localities seemed largely unconsidered by the participants with the exception of the medical consultants who had been working together for some time and consequently this resource was largely unexploited [recommendation 6]. Whilst a useful communication and support network seemed to be developing between the lead nurses, further inter-locality working seemed to be an obvious area of potential benefit, not least for staff orientation and on-going education [recommendation 6 and 7].

### **Service user satisfaction**

It was clear from the data that a major driver for staff was service user satisfaction and from the patients perspective it is pleasing to note that this was largely achieved. Service users really valued the idea of a 'one stop shop' and took great comfort from the self-referral idea. Nonetheless there were some anxieties around failing to meet the criteria to remain 'on the books' for DAIRS, particularly if they went into remission or became so unwell that it was deemed that DAIRS had no more to offer [recommendation 9]. Nonetheless service users were extremely complimentary about staff and how they 'were always there for them' and therefore relied on them in particular for emotional support.

The patients seem to have had a positive experience with the pre-DAIRS service, but due to the lack of an official launch with supporting information [recommendation 3], they were unaware of the changes; when presented with this information there was some anxiety that 'normal service' (and their access to it) would be maintained. Hayes et al (2014) recommends that in managing change, patient-centred strategies need to be used which involve co-designing the service with service users as this is most likely to result in a better fit with patients expectations, needs and abilities [recommendation 1].

### **Local issues**

For organisational and historical reasons, each locality whilst under the DAIRS banner was also unique in a number of ways. Each had challenges associated with for example; geography, Trust funding structures and clinic space. There was some cross-locality working particularly in the East and Mid localities whilst in the West the service was rapidly trying to expand into previously uncovered areas. Because

DAIRS was housed in hospital Trusts, at the periphery different services, were included or excluded from DAIRS: pulmonary rehabilitation is a good example. Service users from two localities in the focus group were perplexed as to why this differed. Such confusion is also likely to extend to community staff especially those who work across DAIRS boundaries [recommendation 2, 8 and 10]. Lockett et al. (2012) argue that service improvement is highly dependent upon effective relationship building with ALL stakeholders, those peripheral to the service as well as at the centre. Everyone associated with DAIRS needs to know what it includes and excludes at a local level; this could be addressed through a high profile launch with supportive leaflets designed for different stakeholder audiences [recommendation 3].

### **Key issues: Responding to change**

Having considered some themes to emerge from the findings, one overarching issue merits further attention: DAIRS is clearly a service in the early stage of change. Change for service improvement is very challenging, no more so in large organisations such as the NHS. The findings identify practical and psychological issues that participants have experienced as part of the transition from the old to the new service [recommendations 2, 3, 4, 6, 10, 11]. These can be summarised as key drivers and barriers to change (see Table 5).

*Table 5: Drivers and barriers for change emerging from the data*

<b>Drivers that have supported change</b>	<b>Barriers to implementing the change</b>
Increase in the number of new staff	A lack of knowledge and understanding of DAIRS by patients and wider service users
Oxygen assessment	No official launch of the service
Intravenous antibiotic services.	Lack of implemented inclusion and exclusion criteria
Follow-up clinics for physiotherapy	Lack of implemented DAIRS official documentation e.g. patient ID cards
Potential to improve assessment and diagnosis of respiratory patients	Rapid implementation
Strong medical support from consultants.	Perceived resistance from community services
Feeling well supported within local teams	Challenge of integrating DAIRS with other in-hospital respiratory services
Educational support for the DAIRS teams	The perceived need for IT resources
Educational support for community staff	Perceived differences in funding
Positive service-user satisfaction	

The qualitative findings represent the participants' personal and emotional responses to service improvement after four months into the change process. According to Kelley & Connor (1979) the emotions of participants fluctuate between highs and lows as they progress through the change process. This concept has been adapted by Barker (2010) and Pearson et al. (2007) and is described as an emotional cycle of change. They propose that the process usually begins with a high, as the perceived benefits of the change are anticipated. However, as the participants begin to recognise the full implications of moving from a position of safe and established practice towards new territory, feelings of uncertainty, doubt and anxiety begin to



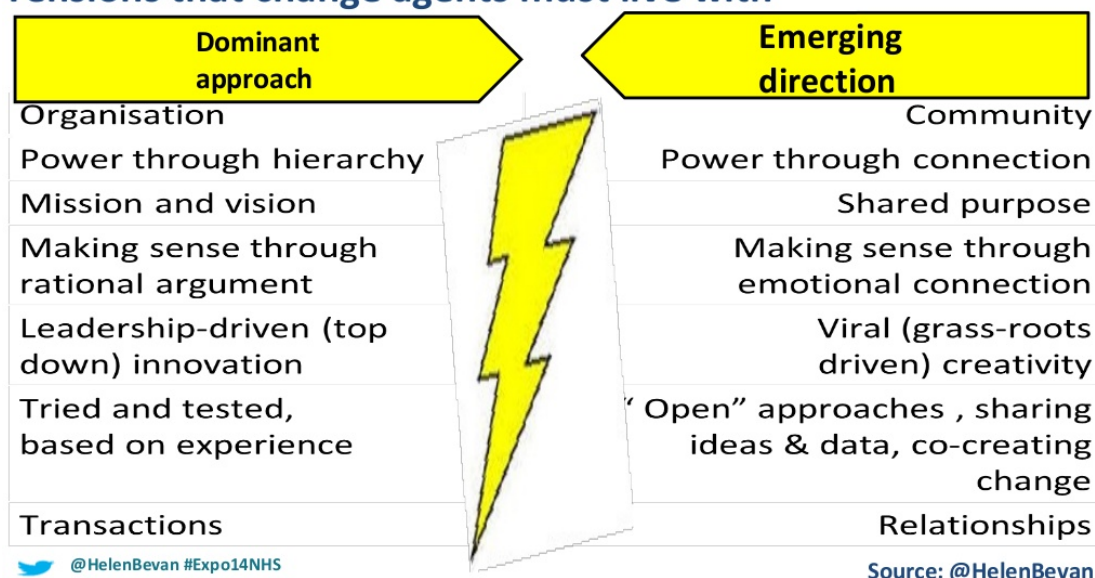
emerge. The latter is clearly illustrated in the themes identified in our evaluation: service in transition; rapid implementation; and perceived resistance. This process can be considered to be a healthy response to change and according to the NHS Institute for Innovation and Improvement (2010), participants need to feel discomfort in order to recognise, learn and respond positively to change. Providing support and respect for individual concerns is important at this stage as this encourages participants to avoid high levels of anxiety and facilitates movement towards what Kelley & Connor (1979) describe as hopeful realism.

## Moving forward

Bevan & Fairman (2014) in their White Paper produced for the NHS Improving Quality body for England, argue that to achieve transformational change, leadership is essential, but advocate change leadership not based on authority but rather mobilising everyone using and providing services to become change leaders by connecting ideas and knowledge. A collective leadership style is recommended by the Kings Fund (2014) to shift power to front-line staff and service users for change to be sustained and transformative. This requires a move from the traditional dominant model of leadership often accepted as the usual way of working to what Bevan & Fairman (2014) term the emerging direction for successful leadership for service change and improvement in the NHS (see figure 2).

Figure 2: Dominant and emerging leadership approaches.

## Tensions that change agents must live with



Source: Bevan, H. and Fairman (2014: p17)

The new era of thinking and practice in change and transformation: A CALL TO ACTION FOR LEADERS OF HEALTH AND CARE

Given the findings from this evaluation, these ideas may be valuable to the DAIRS team as they move forward into the next stage of project implementation. The White paper argues that the dominant approach to leadership, which relies on positional authority, is prominent in the NHS but fails to capitalise on the power for change

through connection and ability to influence throughout the system through networks. This reflects the emerging direction in leadership and starts with a clear purpose, shared cross-organisationally with all stakeholders.

*Recommendations:*

1. *Build upon the high levels of satisfaction to engage service user users more widely in the on-going development of DAIRS.*
2. *Shared documentation needs to be agreed and implemented as soon as possible, including the DAIRS card.*
4. *The change process should be actively managed; concerns and challenges expressed by participants should be acknowledged and a supportive environment provided for collaborative problem-solving.*

Bevan & Fairman (2014) write that traditional planning logic underpinned by data has been the mainstay of change management in the NHS in the past. Whilst these remain vitally important, they are not the whole story: It is argued that change agents need to make an emotional connection with those affected by the change. This starts with making clear the values underpinning the new approach and drawing upon people's desire to take action to makes these a reality of the new service. This means telling but also listening to ideas from the grass roots to create novel approaches to change. Creating systems for a meaningful dialogue with those using the service (staff, patients, carers) enables change agents to respond to the lived experience of the service, thereby strengthening stakeholder buy-in.

*Recommendations:*

3. *DAIRS should be officially launched with appropriate information for different stakeholders: service users, community staff and non-DAIRS hospital staff.*
5. *Consider selection and use of grass roots 'change champions' across the sites and disciplines to facilitate a more inclusive model of organisational change.*
6. *Further integration between localities should be explored particularly around staff education, as well as to facilitate on-going peer support.*

Finally Bevan & Fairman (2014) argue whilst change is often enacted through transactions such as performance agreements and incentive systems amongst others, increasingly successful change in an emergent approach can be measured by the quality of relationships, their foundations and commitment towards the common cause of delivering a particular approach.

*Recommendations:*

7. *New staff would benefit from being supernumerary for their first month and visiting neighbouring DAIRS localities.*
9. *Information and service provision concerning emotional support for service users and carers need to be reviewed.*
11. *Information Technology (IT) systems and possibilities for joint DAIRS systems should be explored.*

**Strengths and limitations of the evaluation**

The aim of this evaluation was to determine the experience, expectations and views of patients and staff of DAIRS from three localities in Dorset. It was undertaken at a time when the service was being newly implemented and the objective was to highlight strengths and areas for development as the commissioned service moves into its second year of operation.

In judging the outcome, it is important to acknowledge key strengths as well as some limitations.

**Strengths**

- Independent investigation of the early stages of service change in order to inform subsequent service development.
- High quality evaluation carried out at short notice by an experienced team comprising relevant of health professional and academic disciplines.
- High levels of patient satisfaction were apparent throughout the data.

**Limitations**

- Although the areas were similar in population size, the way DAIRS was set up, staffed and implemented varied for a variety of historical, clinical and wider local health services reasons.
- Service user involvement was far more limited than planned due to service-users feeling too unwell to travel and their existing involvement in other service evaluation initiatives. Only service-users from east and mid Dorset were represented.
- The sampling strategy focussed on the development of the service from the perspective of DAIRS teams and did not include an evaluation of experiences of other health care professionals in hospital or community settings.
- The sampling strategy focused on DAIRS staff and excluded health care practitioners from related hospital services.
- COPD patients were represented but not service users with Bronchiectasis and Pulmonary Fibrosis.
- The timing of the study coincided with the busiest period of service delivery with an impact on staff and service user participation.
- Some staff in all localities were very new at the time of data collection.
- It was not possible to include meaningful data from a range of outcome measures due to the limited time that the service had been live.
- The overall response rate from the PREM was low.

## 6. CONCLUSIONS

The aim of the evaluation was to determine the experience, expectations and views of patients and staff of DAIRS from three localities in Dorset with a view to inform planning and implementation of the service as it moves into its second year. The evaluation has revealed wide-spread staff commitment and enthusiasm for a pan-Dorset approach to respiratory care provision as well as an overwhelmingly positive acclaim for the staff and service from service users.

It is, however, early days and the service staff and processes are relatively newly established and not yet embedded, as all concerned are adapting to change. The value of this very early evaluation of DAIRS is that it has been possible to flag up strengths and issues of concern at the initial stages of implementation in order for issues to be addressed in a timely manner.

### Recommendations

1. Build upon the high levels of satisfaction to engage service user users more widely in the on-going development of DAIRS.
2. Shared documentation needs to be agreed and implemented as soon as possible, including the DAIRS card.
3. DAIRS should be officially launched with appropriate information for different stakeholders: service users, community staff and non-DAIRS hospital staff.
4. The change process should be actively managed; concerns and challenges expressed by participants should be acknowledged and a supportive environment provided for collaborative problem-solving.
5. Consider selection and use of grass roots 'change champions' across the sites and disciplines to facilitate a more inclusive model of organisational change.
6. Further integration between localities should be explored particularly around staff education, as well as to facilitate on-going peer support.
7. New staff would benefit from being supernumerary for their first month and visiting neighbouring DAIRS localities.
8. Inclusion and exclusion criteria need to be revisited to ensure a shared understanding amongst DAIRS staff, particularly around co-morbidities.
9. Information and service provision concerning emotional support for service users and carers needs to be reviewed.
10. The current Single Point of Access System (SPOA) should be reviewed to improve compliance.
11. Information Technology (IT) systems and possibilities for joint DAIRS systems should be explored.
12. Perceived financial inequities need to be addressed in service planning.
13. Our evaluation provides a base-line for future work, a further more comprehensive evaluation after two years of DAIRS operation is needed to inform future funding and service development. Suggested factors to include:
  - Outcome data
  - Cross-locality service user involvement (avoiding winter peak time), using systematic PREM questionnaire distribution processes.
  - Community staff perspectives.
  - Input from related respiratory services, currently not part of DAIRS.
  - Investigation of impact of a differing skill mix across localities.
  - More detailed service user feedback.
  - Evaluation of staff education (DAIRS and non-DAIRS).

## 7. REFERENCES

Avis, M., 1997. Incorporating patients' voices in the audit process. *Qual Health Care*, 6, 86-91.

Barker, J., 2010. *Evidence-based practice for nurses*. London: Sage Publications.

Bevan, H. and Fairman, S., 2014. *The new era of thinking and practice in change and transformation: a call to action for leaders of health and care*. NHS Improving Quality. Available from: <http://www.nhs.uk/resource-search/publications/white-paper.aspx> [Accessed March 2015]

Forrest Keenan, K., van Teijlingen, E.R. and Pitchforth, E., 2005. The analysis of qualitative research data in family planning & reproductive health care. *J Fam Plan Reprod Health Care*, 31, 40-43.

Hayes, C., Batalden, P. and Goldmann, D., 2014. A 'work smarter, not harder' approach to improving healthcare quality. *BMJ Qual Saf*; 0,1–3. Available from: <http://qualitysafety.bmj.com/content/early/2015/01/09/bmjqs-2014-003673.full> [Accessed March 2015]

Hendy, J. and Barlow, J., 2012. The role of the organizational champion in achieving health system change. *Social Science & Medicine* 74, 348-355.

Hoonaker, P. and Carayon P., 2009. Questionnaire Survey Nonresponse: A Comparison of Postal Mail and Internet Surveys. *Journal of Human-Computer Interaction* 25 (5), 348-373.

Kelley, D. and Connor, D., 1979. The emotional cycle of change. In: Jones, J. and Pfeiffer, J., eds. *The annual handbook of group facilitators*. LaJolla, CA: University Associates, 117-122.

King's Fund., 2014. *Developing collective leadership for healthcare*. London: The King's Fund. Available from: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/developing-collective-leadership-kingsfund-may14.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf) [Accessed March 2015]

Krueger, R.A. and Casey, M. A., 2000. *Focus Groups: A Practical Guide for Applied Research*. 2<sup>nd</sup> edn. Newbury Park, Sage.

Lockett, A., Currie, G., Waring, J., Finn, R. and Martin, G., 2012. The role of institutional entrepreneurs in reforming healthcare. *Social Science & Medicine* 74, 356-363

NHS Institute for Innovation and Improvement., 2010. *The handbook of quality and service improvement tools*. Coventry: NHS Institute for Innovation and Improvement

Pearson, A., Field, J. and Jordan, Z., 2007. *Evidence based clinical practice in nursing and health care: assimilating research, experience and expertise*. Oxford: Blackwell Publishing

Rivas, C., Abbott, S., Taylor, S., Clarke, A., Roberts, C., Stone, R. and Griffiths, C., 2010. Collaborative working within UK NHS secondary care and across sectors for COPD and the impact of peer review: qualitative findings from the UK National COPD Resources and Outcomes Project. *International Journal of Integrated Care*, 10, 1-13.

van Teijlingen, E.R. and Forrest, K., 2004. The range of qualitative research methods in family planning & reproductive health, *J Fam Plan Reprod Health Care* 30, 171-73.

van Teijlingen E.R. and Ireland, J., 2003. Research interviews in midwifery *RCM Midwives* 6 (6), 260-63.

van Teijlingen, E. and Pitchforth, E., 2006. Focus Group Research in Family Planning & Reproductive Health Care, *J Fam Plan Reprod Health Care* 32, 30-32.

Wessex HIEC Partnership., 2013a. *Dorset Clinical Commissioning Group : Dorset's Future Desired State Document*. NHS: Southampton University. Available from: [http://www.impressresp.com/index.php?option=com\\_docman&task=doc\\_view&gid=89&Itemid=70](http://www.impressresp.com/index.php?option=com_docman&task=doc_view&gid=89&Itemid=70) [Accessed January 2015].

Wessex HIEC Partnership., 2013b. *Dorset Clinical Commissioning Group: Admission Avoidance and Early Supported Discharge for Respiratory Services: Review Report of Dorset's current service provision for COPD; Bronchiectasis; Pulmonary Fibrosis*. NHS: University of Southampton. Available from: [http://www.impressresp.com/index.php?option=com\\_docman&task=doc\\_view&gid=88&Itemid=70](http://www.impressresp.com/index.php?option=com_docman&task=doc_view&gid=88&Itemid=70) [Accessed January 2015]