Negotiating evidence; the Researcher-in-Residence model

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Increasing the impact of evaluation

<table>
<thead>
<tr>
<th>Problem</th>
<th>Nature of evidence</th>
<th>Nature of decision process</th>
<th>Solution</th>
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</thead>
<tbody>
<tr>
<td>Knowledge transfer</td>
<td>A product</td>
<td>One-off event</td>
<td>Improved dissemination of evidence to users (‘Push’) or demand for evidence from users (‘Pull’)</td>
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<tr>
<td>Knowledge production</td>
<td>A process</td>
<td>Iterative social process</td>
<td>Work together to define, refine, generate and implement evidence (‘Co-creation’)</td>
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Adapted from Canadian Health Services Research Foundation, 2003
The challenge

There is a significant gap between the articulation of a process for knowledge mobilisation (models, theories and frameworks) and the translation of these accounts into workable, practicable and properly resourced strategies’

Davies et al., 2015
Origins of the in-residence model

Barnsley FC
Poet-in-residence

All England Tennis Club
Artist-in-residence

British Library
Innovator-in-residence
Defining features of the in-residence model

1. The researcher is a core member of an operational team

2. They are explicit about their expert contribution to the team:
   - the evidence base
   - theories of change
   - evaluation, both formal and informal
   - use of data

3. There is a strong emphasis on influencing through negotiation and compromise
Examples of the model being used by UCLPartners

**Anthropologist-in-residence at UCLH**
*developing a clinical leadership strategy*

**Social Scientist in-Residence in Essex care homes**
*helping to reduce safety incidents in care homes using improvement science methods*
Examples of the model being used by UCLPartners

Operational researcher-in-residence at Great Ormond Street Hospital
*improving flow through operating theatres*

Political scientist-in-residence in Newham general practice
*supporting the development of new network models of general practice*
Examples of the model being used by UCLPartners

Health Services Researcher-in-Residence at Whittington Health
advising on the development of a quality improvement programme

Health Services Researcher-in-Residence in Islington community services
helping to redesign sexual health services in North London
Social Scientist and Policy Analyst-in-Residence in the Waltham Forest and East London (WEL) Integrated Care Pioneer Programme
Evaluating the WEL IC programme: expectations and expertise

Stakeholder expectations
• “...the executive group want a more embedded and process oriented evaluation...focuses less on whether the programme ‘works’ and more on how to use research evidence to optimise effectiveness of the programme...”

Researcher expertise
• Social scientist with expertise in interpretive policy analysis, linguistics and critical discourse analysis
Researcher-in-Residence activities

1. Mobilise established knowledge

- HSR literature describing effectiveness of integrated care programmes and barriers/facilitators to implementation
- Other literature as required e.g. care plans, MDTs etc.
Evaluation activities

2. Collaboratively design and carry out a qualitative, participative and formative evaluation of the WEL IC programme
Research design

- 3 year evaluation (Sep ‘14 – Sep ‘17)
- Qualitative, formative and process oriented evaluation using the Researcher-in-Residence model
- Multiple embedded case study design
- Iterative and evolving evaluation
Data generation
(Feb ’15 – June ‘16)

- Interviews
  - Phase 1 (stocktake) n = 75
  - Phase 2 (GPs / social care) n = 55
  - Phase 3 (strategic / mngt) n = 20
- Participant observations (240 hours)
- Documentary analysis
Analysis and dissemination

- Thematic analysis + concepts from Critical Discourse Analysis
- Interpretive discussion sessions with stakeholders after initial analysis
- Further analysis + recommendations
- Sharing, presenting and discussing findings and recommendations at key forums and events
Research findings: key themes

- Disconnect between strategy and delivery – the realities of operational and relational issues often overlooked at strategic level
- Greater focus on governance and structures than operational delivery
- Poor continuity of leadership
- Inadequate patient and public involvement
- Crowded policy context makes implementation difficult
What we are learning (1)

• Letting go of control (power?) can be very difficult for a researcher!

“The training of researchers makes it hard for them to relinquish control and embrace community diagnosis and local knowledge……They are taught to consider themselves and the knowledge they have learnt as superior….Training instils in researchers notions of ‘objectivity’ and of the ‘purity’ of science which numbs them to the political realities of life in the real world”

Cornwall and Jewkes, 1995

• Not everyone wants to be engaged:

‘local people may be highly sceptical as to whether it is worth investing their time and energy in the project, particularly if it seems to offer little in terms of direct benefit.’

Cornwall and Jewkes, 1995
What we are learning (2)

- The model seems attractive to many commissioners and providers
- Some academics like the idea – particularly early career researchers - but many have concerns
- There is tension between being useful and academic success
- The current service environment is a challenging one in which to build relationships – takes time
- Balancing engagement and objectivity is hard – risk of capture
- There are ethical challenges – handling sensitive conversations, gaining ethics approval
- Beware scale, agree boundaries
- Not easy to make the business model work in the university sector
- The required skill-set of participatory researchers is becoming clear – requires a high level of emotional intelligence
INFLUENCING
The power to sway or affect emotions, opinions or behaviours by informing, persuading or negotiating.

- Self awareness
- Patience
- Empathy
- Comfort with conflict
- Facilitation

Brent and Dent, 2010
Cialdini, 2014
Kopelman, 2014