Supplementary material 3 Detailed descriptive case accounts

Table of Contents

[Introduction 2](#_Toc43533252)

[Bridgetown 2](#_Toc43533253)

[Background 2](#_Toc43533254)

[The embedded researcher 3](#_Toc43533255)

[Rationale and specification 5](#_Toc43533256)

[Relationships 6](#_Toc43533257)

[Embedded activities 11](#_Toc43533258)

[Achievements and challenges 12](#_Toc43533259)

[Coxheath 14](#_Toc43533260)

[Background 14](#_Toc43533261)

[The embedded researcher 16](#_Toc43533262)

[Rationale and specification 17](#_Toc43533263)

[Relationships 19](#_Toc43533264)

[Embedded activities 21](#_Toc43533265)

[Achievements and challenges 23](#_Toc43533266)

[Porter 27](#_Toc43533267)

[Background 27](#_Toc43533268)

[Rationale, specification and relationships 28](#_Toc43533269)

[Embedded activities 39](#_Toc43533270)

[Achievements and challenges 41](#_Toc43533271)

[Evansville 42](#_Toc43533272)

[Background 42](#_Toc43533273)

[The embedded researcher(s) 43](#_Toc43533274)

[Rationale and specification 45](#_Toc43533275)

[Relationships 45](#_Toc43533276)

[Embedded activities 48](#_Toc43533277)

[Achievements and challenges 51](#_Toc43533278)

# Introduction

*Chapter 4* provides the initial descriptive analysis of each of the cases, and *Chapter 5* outlines the cross-case analysis. This appendix provides a more detailed case-by-case descriptive analysis with fuller data transcripts to augment the necessarily abbreviated account in *Chapter 4*.

# Bridgetown

## Background

The antecedents of this embedded initiative were extensive and predated the period of data collection by at least 2 years (hence the time scale of the initiative documented as 2+ years); however, the initiative itself was relatively new, suggesting that some initiatives may have a long developmental period in which relationships, expectations and governance arrangements between partners are clarified. In this case, we were informed that an early incarnation or forerunner of the embedded researcher role had been introduce in the trust to support research capacity development for front-line clinicians. This role was held by Jill, a physiotherapist within the trust who became involved with research through completing a masters and PhD. After completing her PhD, Jill went on to complete further research training aimed at supporting front-line clinical staff in research. She was then offered a personal position split 50/50 between the trust and local university with the purpose of supporting her clinicians to undertake the research apprentice scheme and, in turn, build research capacity in the trust.

When Jill then moved to a full-time academic position, there was a 2-year hiatus with limited support for research support for front-line clinicians. It seemed, however, that this pause allowed for strategic planning around the re-appointment of a split embedded researcher role, especially how it might not only support capacity development, but also facilitate broader culture change, the implementation of evidence-based interventions and closer strategic alignment with organisational priorities. As such, the revised initiative had a more strategic outlook and focus.

**Gillian, AHP director (NHS), Bridgetown:** When Jill moved… we took the opportunity to sit down and say what was it we wanted and… we still needed, a research lead. [Anna] is a bridge for us in terms of that link with universities. But she's also focused on getting the infrastructure and generally their interest and their capability and capacity for research… also that work is around being able to use access and evidence to inform practice… people being confident to use research and understand research…

**Hannah, AHP practice and education lead (NHS), Bridgetown:** People have really engaged… because they know Anna and they understand the drive and the purpose behind it… There's a definite link between clinical practice and her role. Also the embedding of it gives her a voice in that leadership table in [place] that’s not only about what's happening here influencing her research priorities but it's her knowledge and her understanding, her viewpoint is influencing our policy development, leadership planning, erm, governance activity because she's getting heavily involved in that side as well because she brings her research knowledge and skills to those conversations.

**Interviewer:** Would it be fair to say you're almost striving for a change in culture?

**Hannah:** Yes absolutely…

## The embedded researcher

By professional background, Anna was an occupational therapist but knew while completing her degree that she was interested in what she describes as a clinical academic career. In line with these aims, Anna then undertook her PhD (moving away from her OT background and working with organisational and management literature, in particular, professional decision-making theory). She then spent much of her time post-PhD in various roles initially outside of the NHS and in the voluntary sector. Anna experienced a degree of frustration while in a permanent lecturing post where there was little focus on building her research portfolio. As a result, she came back to research in healthcare and worked on a variety of research projects. In sharing her experiences of previous roles, Anna offered insight into her ‘unique’ skill set and her overarching interests:

**Anna, embedded researcher, Bridgetown:** I was someone with quite a unique skill set which was about being able to um, focus on knowledge and, bringing people from completely different disciplines and backgrounds together… It was about supporting [specialist nurses] within the research environment and kind of being the translator if you like in between… Then [the NHS] got in touch with me… we’re setting up this job [the current embedded researcher role] and would we be interested. And so… as a second year OT student, thinking I want to do a PhD and I want a clinical academic role, err so that would have been… 2007, to then getting my first clinical academic role in 2013… That it was quite a long time in the making.

… I was excited about it… being able to fulfil that dual responsibility and to be much more embedded in the NHS… but I was definitely filled with a bit of um, uncertainty about it, I was quite happy where I was, I had moved myself into much more of a social science environment… I kind of sit in the boundary between the two and that’s where I quite like to be… I saw it as such a great opportunity to do what I was good at, which was to kind of move between research and practice.

Anna now described herself as a clinical academic with specialist interest in implementation science and knowledge translation:

**Anna, embedded researcher, Bridgetown:** I am interested in knowledge and how it’s used… in terms of my own programme of research and the grants that I’ll be going for… I have absolutely no desire to be leading a grant that is about um, evaluating a particular intervention, or leading a grant that is about um, systems, whereas, I’d be much more interested in understanding healthcare, err [name] health professions or wider, how they think about practice, the knowledge that they use.

## Rationale and specification

The Bridgetown initiative was configured primarily in terms of the appointed embedded researcher, Anna, rather than as a specific project or portfolio of activities. Anna’s role was split 50/50 between the local NHS trust and the university, with the employment contract held with the university and the NHS ‘buying back’ Anna’s time. The particular specification for Anna’s role was as the lead for research for allied health profession, with this combined with a more traditional university research fellow post.

Formal line management of the embedded research position was through university departmental hierarchies; although there was also a degree of accountability and responsibility to the director of allied health professions within the NHS trust. Although part of Anna’s role was still to grow research capability and capacity, it was configured in ways that were different from the earlier incumbent, in so much that Anna did not directly supervise individuals or research teams, but instead pointed them towards building connections and networks related to their service-improvement research. That is, the people and teams she supported were typically carrying out research whose primary purpose was to address service-facing issues or improve patient experience. As outlined below, her work involved guiding people to find and utilise research design and management support.

The current role was also different in being configured to provide research expertise and evidence into the NHS organisation’s strategic-level decision-making processes, especially in building the profile of AHP research from the top down, in addition to her direct work with front-line staff. The initiative also sought to generate new academic knowledge through Anna’s own research.

The text below is taken from the original job advert and offers further insight into the aims of the role:

We are seeking an experienced researcher for this exciting and innovative clinical academic role. The role is jointly funded by the School of Nursing and Health Sciences at the, and the Allied Health Professions (AHP) Directorate. The purpose of the role is a) to provide leadership to AHPs in NHS location for the development of research capacity and capability across the Allied Health Professions b) to support the development of a programme of implementation research that focuses on the generation and translation of evidence into Allied Health Professions (AHP) practice, to improve health outcomes relevant to populations served by these professions.

In line with the broad specification outlined above, the embedded researcher’s role related to research, strategy involvement, leadership, responsibilities and collaboration. In terms of research, for example, there seemed to be a dual focus on supporting research, research translation and implementation for AHPs, and also on developing an independent programme of research. In terms of strategic leadership, the role was anticipated to involve advice and influence, as well as supporting cultural change and capacity development.

In other ways, the role was framed as having particular expectations for networking, communication and managing people. In other words, the role was specified as both focused (on research capacity, implementation and strategic influence) but also relative broad (in terms of general project management activities).

## Relationships

When considering the relationships involved in Anna’s embedded role, it is important to recognise that she had only been in post for a relatively short amount of time (commencing late 2018). Much of Anna’s initial work focused on identifying important networks and then building the associated relationships.

**Anna, embedded researcher, Bridgetown:** … to try and understand the research culture first and spend the first year… trying to get to know the different AHP professions and their research priorities and their wealth of skills and ability, and what people are good at and what people need support with and then I would use that to inform what my strategy and my plan would be for the coming year… They were really good with that because I think the director really got a sense that it takes time to both understand the research culture but also to become embedded within it so people knew who I am and I’d developed a bit of kind of credibility or an approachability over the first year.

Anna worked with a variety of clinical and academic colleagues – she acknowledged particularly important people and groups to her role in the completed identification tool (*Figure SM4.1*). During the various interviews with Anna, we spoke about these individuals (and groups) to understand the nature of each relationships, and how it had evolved. We also discussed the types of activities and interactions that took place between her and them, and that would (or would not) occur without her involvement.

Anna had some contact with front-line clinical colleagues: these relationships usually took the form of research methods training and also one-to-one mentorship or supportive relationships (examples of which are offered later in this section). Some of these clinicians, such as prospective PhD students, also had formal ties with the university. Anna also had formal relationships in the academic institution through her line management as noted previously.

A group that was key to Anna’s role in the NHS was the AHP director and lead team, including administrative staff – they were her closest working group within the NHS organisation. The extract below describes the nature of these relationships:

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

**Bridgetown: Anna**

Research dean/reader

NHS organisation

AHPs

AHP directorate and admin

Patients

Wider university collaborators outside school

AHP director

Friends – with work-related knowledge/informal/
personal relationships/
colleagues

AHP leads for each locality + AHP governance group

Figure SM4.1: Embedded researcher key partners, Bridgetown – Anna

Nursing and health sciences school

**Anna, embedded researcher, Bridgetown:** AHP director is, I guess she’s my line manager in the NHS really. I mean she’s not my line manager because I’m line managed in the university and I’ve got an honorary NHS contract but she is my, for all intents and purposes, is my boss in the NHS… So I meet with her every maybe 3 or 4 months and I’ll provide an update on all of the stuff that I’ve done, so I’ll do like a report, erm, that describes what I’ve been doing and then what I’m thinking about my next steps will be… I mean it’s not micromanaged at all, I mean I hardly see her. I’ll see her at some meetings, so say like the AHP leads meetings that happen every 6 weeks, or we’ve got AHP governance meetings, so I will see her at those but in terms of her actual input into my role and what I do, that’s really just when I meet with her every 3 or 4 months.

Anna was also building relationships with other AHP leads who ‘sat under’ the AHP director. Anna was the AHP lead for research. There was also a different lead for education, mental health, child and adolescent health in addition to others. Anna’s relationship with each varied according to the degree to which their work crossed over; this was often influenced by, in part, colleagues’ preconceptions about what research was (and therefore, what Anna did).

Although these relationships, due to the length of Anna’s employment, were ‘new’, they had already started to grow. She shared a particularly poignant example of a maturing and evolving relationship which had largely changed as others’ perceptions changed (as they got to know Anna). This example also introduced other issues surrounding Anna’s capacity, competing expectations and the purpose of her role:

**Anna, embedded researcher, Bridgetown:** We've got this governance priority… one of the groups is quality and effectiveness… So when I started, that group were kind of I guess, floundering a little bit. So it’s led by an OT and a physio. They are both very senior, they're both service managers… They knew that research was one of the standards that they were supposed to be looking after, but they didn't have a clue at all. So I got paired up, put with them, as a critical strength, they were calling it.

And I think… well at first I think they were very intimidated, they were a bit concerned about me turning up speaking about it, but then we just had a look at kind of defining well, what do we mean by research, and how is that different from quality improvement? How do we make sure that you've written your standards in a clear way, that’s about people using research evidence, or the fact that... and also that we're doing research, at best as the option comes up.

… As I start to work with them, they move a bit closer [on her interpretation of the quadrants of the identification tool].

… I think they were quite anxious about reviewing it at first… they're the people that were probably the earliest to give me like feedback, because they said then, you're just a normal person… I don't know what they were expecting. If they thought I was, I don't know, be like stern or talking in a completely different language to them, or... there was a lot of our meetings were kind of starting and ended with general chitchat about their daughter's wedding, or weight loss or you know, just general chitchat… I think that helped, after the first few times. The first few meetings they just seemed really anxious, waiting for whatever piece of wisdom was going to come out of my mouth. I think they thought I was going to come in, tell them they were doing it all wrong.

… It's not nice going into a room where people feel that... you get the sense that people feel intimidated or worried. But I mean, it didn’t last long, I think once they realised I was a lot nicer, then that was all right.

… I think almost she was scared of me at first. But that has completely gone away, and I think now she's... she expects me to do too much. She'll be like, oh well, you know, someone in my service has got an idea, then why can't Anna just come in and do it, why can't Anna just come in and do that piece of research?

[She] moved from her being very resistant, to now almost expect[ing] things from me, not realising that you know… I've also got 12 professions to cover over how many geographical miles, so I can't come in and just do literature searches for everyone that needs one, you know… It's almost like I became a bit too accessible if you like.

## Embedded activities

Anna had been in post a year. She and the wider supportive team had made a conscious effort for Anna to spend this time mapping out the current (NHS) organisational research landscape and culture. This process involved establishing and building key relationships and networks, as well as making herself (and her role) known to front-line and managerial colleagues. Anna described this as laying the foundations of the work to come. Therefore, examples of co-creation and co-production were arguably more subtle at this stage in the initiative.

Despite this, examples of the transition and translation of knowledge between worlds – namely clinical and academic – were plentiful. Anna described her extensive experiences of translating academic knowledge to practice and, in doing so, increasing the accessibility of this knowledge to the practice audience.

**Anna, embedded researcher, Bridgetown:** Part of it is about breaking down the barrier… I’m quite cavalier with the research papers, I also start the session by being ‘They’re boring, they’re badly written and they’re really crap to read… they’re not my bedtime reading,’ and then kind of say these are yours to use and read as you want. You know, you don’t have to read it line-by-line from the start, look for what it is that they’re telling you and their findings and their discussion.

… I never get them to start with a research paper, we look at an advert or a newspaper article and I get them to come up with all the things that would give them confidence in whether something was trustworthy or not… you know, who published it, who the author was, is there any funding behind it. So, to try and make that point that critical appraisal was not some special skill, it’s just what you’re doing all the time.

… It is actually breaking down that boundary between the university between research and practice, and part of that I think is highlighting the difference… so that practitioners understand that research will work into different agendas often, but also highlighting the similarities.’

During observations, it was recorded how Anna placed a strong emphasis on her role in mentorship and signposting for front-line clinicians – her work here was translational. For example, in meetings with clinical staff seeking advice on their research projects, Anna constantly offered to make introductions and connections via email with other individuals or groups. This was more complex than networking as Anna seemed to act as a conduit between numerous groups and stakeholders, thereby bridging the space between multiple organisations and individuals, working across well-established barriers and making new connections for collaboration.

A tangible and explicit example of Anna’s role in the co-production and co-creation of new knowledge (rather than the brokering and translation of existing knowledge), could be seen during a recent event she had led on the theme ‘How do we make research useful for practice?’ and its follow-up webinar to disseminate methodology and findings from the event. The motivations and aim of the event were driven by Anna who sought to co-design new ways of presenting research knowledge for healthcare practitioners. She explained a desire to ‘change the conversation’ around research and research impact, and said: ‘We should be asking, not how can we get research into practice, but what knowledge is useful in practice?’ Anna saw that more needed to be done to make academic knowledge useful and accessible to clinicians – she explained that we should ‘think about usefulness as a marker of quality, move away from linear approaches’, ‘academic knowledge [is often] being pushed onto clinicians (and blaming clinicians when it isn’t taken up)’. She argued that, instead, we should ‘challenge our assumptions about what is valid’. To fulfil these aims, Anna brought together a wide range of AHPs, academics and creative individuals from different ‘worlds’ at the co-production workshop. The event was successful in generating multiple ideas for protypes of knowledge products, many of which were successfully taken up in practice.

## Achievements and challenges

Despite Anna’s short time in post, there was already a strong sense of initiative ‘success’, particularly from an NHS perspective. The interpretation of this success was largely through positive feedback relating to Anna’s role from ‘shop floor’ clinical staff. The following quote reflects that: Anna’s role in translating and brokering academic knowledge between academia and practice is seen as fundamental, and her success as the ability to overcome these barriers:

**Hannah, AHP lead for education (NHS), Bridgetown:** People have told me that it feels more approachable having an HP research lead that doesn’t feel so scary or so daunting… Having that link person has made research more accessible to people as a topic… [Staff] often describe research as scary, too big, beyond them and [Anna has] broken down those barriers by showing people how they can either use existing research and evidence or actually create research and evidence themselves to… form the evidence basis out there. So it's about managing to do it in a way that feels doable and feels manageable for people.

Although the initiative was seen to be making progress in changing research culture, there was also a sense from Anna that there was much still to be done: she often shared experiences of how inaccessible she felt research was to practitioners – for example, research papers being ‘pushed onto practice’ rather than trying to ‘create something that’s useful and accessible’. The extract below, from observation of a mentorship and guidance meeting between Anna, Jill and a current physio PhD student, offers insight into the perceptions Anna felt were present:

**Observational data, November 2019, Bridgetown:** An established fear of research from clinical colleagues (she feels staff lack the confidence around research education and language) she feels she must adapt her language, accordingly, using encouraging research terminology, she sees her role is to make research less intimidating. Anna talks about her priorities for the future in line with these challenges - she sees the importance of physical research leadership, staff skill and education, organisational motivation and infrastructure to support a new research strategy…

Other challenges of the initiative and Anna’s role in particular related to competing expectations: firstly, the expectations surrounding her role – for example, that she was a research lead and not a researcher. This also related to broader expectations around her own capacity and capability; there was no doubt that, at times, Anna faced the challenge of two sets of expectations and agendas (academic and clinical), and meeting both was unsurprisingly difficult. The data below offers her experience of this:

**Interviewer:** Between the research world and the NHS world, what’s your experience of that boundary, if there is one?

**Anna, embedded researcher, Bridgetown:** Yeah, I would say that there is definitely a boundary there because I think they’ve both got completely different priorities, so with these people in the NHS world my career as a research and the research that I do is seen as distal and actually had no bearing on their day to day work. They don’t really understand or get it, and there’s a culture [that] research has been an optional extra that certain people do but it’s not part of core service delivery; and then in the school here and the wider university their priorities are still grant applications and REF [the Research Excellence Framework], and all of these things that matter and drives things here.

# Coxheath

## Background

The Coxheath initiative was informally established in 2011, but its development and formalisation were in many ways shaped by the extensive career history and international reputation of the embedded researcher. In other words, the embedded initiative was based on and configured around the given individual, rather than a particular organisation or service issue; although shared priorities for NHS and university leaders were important in sanctioning the role. More information about Jane, the embedded researcher, is given below; but it is noteworthy that long before taking up a formal embedded researcher role, Jane had actively worked across the university–NHS interface to promote nursing research and leadership. This included documenting many of the key professional texts and resources on nursing research and influencing future generations of clinical academics in nursing.

Based on this track record and her established connections within and across her employing university and the local NHS trust, Jane was initially offered a joint appointment between the university and NHS trust to promote nursing education and research in order to support wider strategic pressures around recruitment and retention of nurses. The trust’s director of nursing and quality and chief operating officer, Clare, was especially influential in creating this role, which she described as a strategic fit between Jane’s longstanding commitment to nursing empowerment through research and leadership and the needs of the NHS organisation to address lines of power that inhibited change:

**Clare, NHS trust director of nursing and quality and chief operating officer (retired), Coxheath:** I’ve always had quite an interest in education and research as well as actually how, how we can use some of those things to improve what we do, in practice and, and operationally.

… I needed to do quite a lot of work on empowering, particularly the nursing staff, and also the R&D strategy for the organisation was heavily sort of medically led really and there wasn’t a lot of research-active nurses… recruitment and retention was a particular challenge for us and so what was really important was that we got the right sort of culture to attract people… Jane helped me think through… How do we empower people? How do we develop a career framework for people? And also how do we enable people that wanted to, to [become] much more research-aware and research-active?

… We did a co-design piece of work, which enabled staff to articulate the competencies at different levels of practice, and we were able to articulate much more of a career path for those people. I was there… 9 years… I think I worked with [Jane] on some of that for at least 3 or 4 years… I can’t remember exactly when we appointed her into the role and but over the course of time.

Jane was appointed to the post of professor of practice development, research and innovation, with the purpose of building capacity and capability and increasing credibility for nursing research and leadership. As we show below, this role evolved over time to take on a broader range of activities beyond nursing, in line with the strategic priorities of the NHS organisation, together with the evolving expertise of the appointed embedded researcher around transformational leadership, co-production/co-creation and practice development. These were captured, for example, in the trust’s research strategy document:

**Trust ‘Our Research’ agenda documentation:** The most valuable asset in the health service is its staff. The trust is passionate about developing and training its staff and therefore in collaboration with the [name, research centre] it has developed a research programme that centres on staff development and training. Areas that it is investigating healthcare practice change that is collaborative, inclusive and participative; the development of effective workplace cultures that are person-centred, informed by the best evidence; practice expertise, individual and team effectiveness; and the use of the workplace as the main resource for scholarly learning, development and inquiry.

## The embedded researcher

From 2011, Jane initially worked on short-term contracts with the university and as a research fellow in the NHS organisation. In 2012 she was made an honorary professor in the university and associate director in the trust. In 2015, she gained her chair. Jane’s background in nursing was extensive – throughout her long career, she had been involved in various levels of national and international nursing research. She had led on the setting up of various research centres and education programmes. Jane brought this extensive experience to the initiative as a practitioner, clinical educator, a practice-based researcher and programme director for undergraduate and postgraduate programmes. She had a global academic reputation. Her trust research profile recognises some of these achievements:

Jane has an international reputation for the development of effective workplace cultures in healthcare linked to the provision of quality services…Jane has extensive experience as a practitioner, clinical educator, practice developer, practice-based researcher and programme director for both undergraduate and post-graduate programmes in nursing.

Jane’s motivations, expectations and aspirations for the embedded role echoed her past experiences in their focus on co-creation: she aimed to influence change.

**Jane, embedded researcher, Coxheath:** That’s the nature of our work, to co-create inclusively and participatively… for the same values of delivering person-centred safe and effective care… and growing workplaces where people can flourish. So that’s what drives [me], if you like.

The extracts below offer further insight:

**Jane, embedded researcher, Coxheath:** Probably two key motivations, one is… I’m passionate about growing a workplace culture where everyone can grow and flourish, I think that’s really vital, and… the second one is about being person-centred and being person-centred with each and with our patients and staff and modelling those values… [Its] about recognising the person, and the patient, recognising their choices as an individual and using those principles with each staff member as well… It’s part really of the wellbeing agenda, health and wellbeing, because we know [that if] we’ve got health and wellbeing for staff, then we will have quality for patients basically.

… We’re doing all this work with the front-line teams, the leadership programme… We’ve got the skills, and know-how to develop the cultures and I can’t understand why it’s so invisible to the executive team… There’s no infrastructure to embed it, and there’s no infrastructure because there’s no sign-up from the executive team, and the executive teams themselves don’t have the shared values… I try and help the organisation to recognise what they’ve got to do to support our front-line teams, but basically the key motivator… is the front-line teams at microsystems level. That’s where care is provided in experience, that’s where we must put in our support and effort.

## Rationale and specification

As noted, the initiative was largely configured around the appointment of a particular individual to work across the NHS and university interface, based on her track record and commitment to supporting nursing research and leadership.

Jane had a joint contract; her main contract was with the university and she had an honorary contract with the trust. The contract with the university was for a 5-year fixed term; the contract with the trust was indefinite. She had an assigned workspace in both settings. Jane reported to senior colleagues within both organisations. The organisational chart in *Figure SM4.2* (taken from the job specification) details this structure.

Information also extracted from the job description and person specification for Jane’s role offers extensive insight into her key areas of work and how this work was structured. Jane was closely involved with those staff in both organisations accountable for and working within practice/staff development, and used her research to offer influence, management, guidance and networking opportunities:

Research centre director

Executive director of operations, NHS trust

Joint clinical chair in practice development, research & innovation

Figure SM4.2: Coxheath structure

The post holder will contribute to the achievement of the related practice development and research and evaluation aims of the trust’s and the Faculty’s strategic plans, by the development, management and monitoring of major practice development, practice centred research and or consultancy activities across these partner organisations. The post-holder will be expected to create a vibrant practice development and practice centred research community and to lead a network of trust and university staff to develop the trust’s practice development and evidence based knowledge and innovation activities in a systematic and scholarly manner ensuring that there is a clear link between academic research/evaluation to clinical practice and service development… The key principles and criteria that underpin an appointment are three-fold in that the post holder will be accountable and responsible for:

1. Maintaining a strategic focus through co-production and aligning priorities with all agendas in relation to practice development, practice research and innovation across trust and university
2. Focusing on transformation, integration, growing capacity and capability
3. Integrating quality, effectiveness, research, inquiry and innovation.

## Relationships

*Figure SM4.3* offers insight into the people and groups who Jane perceived as influential to her role. We completed this figure together during interview and then spoke through the rationale for her choices. These groups included a wide range of clinicians, managers and academics, from various national and international institutions, organisations and charities. The relationships Jane had grown also included various levels of seniority: from the front-line clinical staff which whom she worked closely, often offering one-to-one mentorship and guidance (for example, to PhD students), through to CEOs and similar.

The nature of these relationships differed but, as noted, Jane’s interactions included the dissemination of guidance, advice, support, networking, liaising, influencing and managing. In completing the tool, Jane identified certain individuals and groups as important, in line with the following criteria:

* Being able to work with them, to deliver on strategic intentions, visions, or policy directives
* Shared values.

Many relationships had developed over many years – Jane had known some senior management, directors and leaders for the duration of her nursing career of more than 40 years. These relationships had evolved over time.

One particular example was her relationship with Clare. Jane and Clare first met when they worked together as clinical nurses in the same speciality; later, Clare took a director role and appointed Jane into her embedded role. Now, Jane was working with Clare in a research/advisory capacity in the charity sector. This relationship had evolved over more than 30 years:

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

**Coxheath: Jane**

Undergraduate and postgraduate students

Those with integrated roles,
clinical colleagues/clinical leadership participants
and facilitators/non-medical consultant practitioners

Practice development director

Research and
innovation
director

Chief nurse (director of quality)

Various national charities

HEE colleagues
and patient safety collaborators

Local, regional and national HEE and patient safety

PhD supervisors and students,
HR colleagues (clinical)

Figure SM4.3: Embedded researcher key partners, Coxheath – Jane

Senior
 lecturers,
 programme
 directors,
 both postgraduate
 and undergraduate

**Clare, NHS trust director of nursing and quality and chief operating officer, Coxheath:** I was in the NHS for 35 years, probably the last 15 in executive director-type roles and I’ve had a mixture of director of nursing roles and chief operating officer roles in NHS acute environments… I’ve sort of been dotted around the place and had roles at the Department of Health as well as the strategic health authority as well at a key trust level. So that’s, that’s primarily my background. I was a critical care nurse, which is where [Jane and I] first met, and we, we both were founding editors of a peer-reviewed [nursing] journal, which is still going today, so we’re very proud of that really… I appointed [Jane] into her joint pastoral role with [place] university and [place] hospitals… It was entirely new [role], I appointed her as my associate director of transformation for… what Jane and I were able to do was co-design the way that that would work and obviously the way Jane works, is very much the way that she sort of embeds herself within, working within teams and within organisations and working with us and co-designing what, whatever is actually needed and through that process, you know, people are developed.

## Embedded activities

The breadth of activities which Jane was involved with as part of her embedded role was extensive and diverse. She communicated and built networks with numerous individuals and groups, contributed and influenced organisational and research strategy, undertook and disseminated research, built and supported the professional and personal development of individuals and teams, and acted as an advisor and facilitator for organisations outside of NHS and academic settings.

Throughout our time speaking to Jane and observing her activities, she was clear that her approach to research development and evaluation within the NHS trust centred on co-creation and co-production. An example of this co-creation work was observed during a development session to which she contributed with the local primary care network of multidisciplinary professionals. The session was entitled ‘Creating vision and direction for place-based learning in region’ and ‘Generating a vision using unfolding story approach’. The session was run by a Darzi Fellow, supported by Jane, who designed the co-creation methodology. The co-creation event was split into various sessions (taken from observational notes):

Part 1: Group work to discuss ‘what matters to you?’ in relation to successes, challenges, obstacles and opportunities of practice based learning.

Part 2a: The phrase; I believe the ultimate purpose of place-based learning across a primary care network is… Offers a starting point to discussion. The attendees are then encouraged to work together to complete a framework as a large group to prompt conversation and encouraging thinking.

Part 2b: Clarification exercise in relation to enablers to achieving, beliefs, indicators of success, other values and beliefs.

Part 3: The attendees are encouraged to work on collaborative theming, clustering similar ideas/items together, make labels and themes, initially working in groups and then feeding back.

On closing the event, the attendees sat in a large circle for an exercise entitled ‘Unfolding story’ and completed statements such as: ‘Wouldn’t it be radical, but what if…?’ The entire story was then read out, constructing a take-home message.

There was a strong sense that feedback from the session participants was positive and included phrases such as connection, networking, inspiring in relation to the day’s activities. These phrases permeated the broader Coxheath interview data and showed Jane’s strength in empowering and inspiring those she worked with.

The session was attended by GPs, GP trainers, GP managers, nurses and pharmacists. In terms of proposed outputs, the event aimed to create an implementation and impact framework for place-based learning (focusing on, for example, the enablers of practice-based learning). Participants were encouraged to share their experiences, which were then used as data to inform and subsequently, co-produce the framework. After all workshops were completed, the frameworks were amalgamated and sent out to participants to check. This framework was then to be used to influence activities at a strategic level, for example, influencing sustainability and transformation partnership decision-making.

In a second example of Jane’s work, we observed her run a training session for nurses. The tactful approach she took towards this activity optimised her inclusive and supportive style of working and offered insight into her personal skillset. The session was designed for Jane to share a new staff recognition program with front-line staff and encourage their participation. The program involved clinical leaders and their teams collating evidence to submit to a senior panel for review – working to show the trust board the good work being undertaken on the front line. Teams would then be awarded a status based on the quality of their evidence and work, the aim being to promote good culture, positivity, staff empowerment, commitment and collaborative working. We observed how Jane brought an overall sense of diplomacy and positivity – hope for change and improvement, shown through both body language and verbal language. Encouraging and hopeful in her approach, Jane filled the space between the initiative (research world) and clinical teams, and also between the various clinical teams and the trust board – there was a sense that there was little interaction or understanding between the two groups. We observed how Jane’s approach was to soak up the sense of disconnection from the front-line staff (very few seemed engaged with the recognition program) and work to transform it into positivity. Jane offered herself as a direct source of help for the staff, acting as a critical companion, diplomatically challenging staffs’ assumptions and ideas, and answering their questions with a sensitive approach.

## Achievements and challenges

Jane was working extensively to improve the trust’s clinical and systems-level culture for quality, workforce development, transformational applied research and raising the trust profile. This included facilitation and leadership at clinical to systems levels for learning; using participatory approaches to workforce development and modelling around shared purpose; participatory research to grow the evidence base for transforming quality services; and providing international exposure to the trust for development and leadership opportunities.

As part of this, Jane had led or been involved with a variety of projects. The following is only a brief snapshot:

* Safety culture work
* Transforming urgent and emergency care workforce
* Developed shared purpose framework focussing on workplace culture
* Facilitated the development of integrated service competences across the health economy
* Extensive embedding of culture change tools in practice
* Three publications directly linked to the trust
* Growing critical mass of facilitators
* Worked with service users to integrate development and quality
* Established process and piloting of quality peer review
* Aspiring consultant practitioner/clinical systems leadership programme
* Achieving and celebrating excellence process
* Quality improvement hub
* Facilitated individual effectiveness programmes
* Leadership academy
* Various peer-reviewed journal publications
* Mediated broken teams
* Provided masterclasses, sharing best practice.

Although Jane’s work was extensive and her success and achievements arguably undeniable, she shared strongly during our interviews the challenges faced within the initiative. Many of these related to barriers she had experiences from a strategic perspective, including organisation values:

**Jane, embedded researcher, Coxheath:** In this job the main challenges have been trying to enable the executive team, the people who have got the power to take a knowledge informed approach… not just to clinical research but quality safety and transformation, that’s a difficulty.

**Interviewer 1:** It’s about changing the mindset, the assumption rather than overthrowing…?

**Jane:** Yeah, there are one or two dinosaur consultants… consultants who will not free up their funding to enable nurses, midwives, AHPs to do what they can do brilliant, because they want to protect their way they… But there’s only one or two of those. Most of them understand that we’re working in a different age now, we have to work together… So I think the main challenge for me is to get strategic uptake… When I finish this I want to go and be a non-exec director in this trust, that’s what I’d like to do, because they don’t seem to understand, the trust board don’t seem to understand the values that they need to live by, to achieve the changes that are required… ’Cause I’m accountable here to the chief nurse, of course they’re responsible for quality, but my job crosses all the boundaries, so it crosses the workforce, it crosses learning and development, it crosses, erm, improvement, it crosses quality, safety, the lot and of course that’s very unusual and that’s what makes it quite challenging…

I’d like to dismantle silos, but it’s very hard when you’re having to work across silos because there’s no forum. You know, you have to have a bit here, a bit there, there’s no forum to integrate it and bring it all together, so that means I see a lot of what could be different… But I’ve done research also to su-substantiate all of that in, in other acute trusts in this job, so I can, and I bring the findings back but often the findings are so ahead of the time people can’t understand what they need to do with it, so 5 years down the line they begin to realise if only we’d done that 5 years ago we’d be in a different position [laughing].

We also spoke about the challenges Jane faced while completing the partner identification tool together. Here Jane reiterated the challenge of siloed working and of working across boundaries:

**Jane, embedded researcher, Coxheath:** Also the other biggest challenge is really helping to really focus on building on what we can do, rather than what we can’t do, and so I do a lot of my work is sort of trying to enable people to recognise that they can do things, there are things within their sphere of influence, that they can do… that would make a difference, and therefore, valuing them and supporting them to do those things, but not everybody wants support, so they feel that they maybe don’t need support, or don’t want support… there’s a barrier there usually um, and of course I need to… be able to reciprocate that and to learn. So therefore, it is important that you have a learning organisation whereby people can learn from each other, and they’re willing to be vulnerable and learn from each other, and of course that takes a, takes a particular type of, of value set as well.

… You see what happens is that people agree their values, but because everything changes all the time, you never get off the starting point, so therefore, it’s difficult to bring to fruition a vision, err, of what can be achieved.

… So that is a key, they are key, whether, that my sort of posts are successful, whether the evidence is used or not… It’s a difference between um wanting to collaborate and complement different expertise and evidence for a greater good isn’t it?... The need to do that, rather than working one’s own silos.

**Interviewer:**… Putting these… groups into different quadrants… almost puts a boundary between them… I wonder if that’s something you can relate to and if so, how [do] you work across these boundaries?

**Jane:** Yes… the type of research I do, is always going to be with stakeholders, so knowing who the stakeholders are and working with them is going to always be the focus of the research. So if you work in organisations… that are hierarchal or siloed, it means that you cross all of these silos, you can see the big picture, you can see what needs to be done, but it’s hard for other people to want to work in that way, for a range of reasons, some of them do and can, but others can’t.

**Interviewer:** … So you’re almost seeing your role… as working across those boundaries?

**Jane:** Yeah… only because… even if you take the search implementation as evidence, just knowledge translation… research shows you’ve got to attend to the culture, the context for leadership and of the facilitation, so I’m a facilitator basically, a skilled facilitator, but I’ve also researched the concept of facilitation and why that’s important.

# Porter

## Background

It was reported that the community health trust in Porter had a longstanding desire to lead and participate in applied health research with the goal of promoting evidence-based practices and improved service user outcomes. There was a long history of using clinical academic posts across the trust’s different specialities and departments. We found that each of the embedded initiatives had a relatively distinct development journey and timeline, with two research-type roles being in existence for more than 2 decades while others were more recent. Senior leaders within the trust appeared to view and value the knowledge produced through these initiatives as contributing to service delivery, staff experience and meet various external and internal requirements/targets.

**Carol, head of research and development (NHS), Porter:** Our aspiration is that everybody implements evidence-based care and then as you go up the pyramid then a smaller group of people will be the facilitators of research and evidence-based care and then at the top we’ll have the leaders, we’ll have the clinical academics. We might have 1 per cent and then maybe 2 per cent who are, the next 2 per cent who are maybe more research active, research engaged, but they won’t necessarily be postdoc, they won’t necessarily be grant writers, but they will be quite proactive; whereas the facilitators, they could be, well the facilitator could be the receptionist who’s handing out a leaflet or making a study known to individuals or it could be the manager who’s saying yes we’ll take on board supporting this study or yes, I’ll allow my staff to develop an application to funding…

## Rationale, specification and relationships

Although we describe these initiatives as representing a portfolio of embedded research, it is probably more accurate to see them as a loose collection, and there was little indication of a strategic intention to develop a coordinated programme of interlinked research activity. Rather, each had a distinct developmental history within a given clinical area, based on the model of applied or clinical research but now involving more evaluation and improvement research. With subsequent and more recent developments in the trust’s research strategy, these initiatives had been brought together to represent a form of portfolio of activity and to provide a basis for building the research culture of the organisation. Each of the individual embedded researchers currently involved in these initiatives spoke about their past and current experiences in clinical or applied research as helping to justify and sustain their position. They also talked of themselves as a type of community or collective that aimed to increase research capacity and build local and academic insights, in addition to contributing to the trust’s prestige and credibility.

The trust was split into four directorates: enabling services; community health services; adult mental health and learning disability services; and family, young people and children’s services (see *Figure SM4.4*).

Access to the embedded research portfolio was coordinated by the most senior team member, Carol, as head of research and development in the enabling services directorate. One embedded researcher, Rachel, was based in the community health services directorate but with the premise of providing research support across the trust. Four embedded researchers, Victoria, Karla, Bev and Katrina, were based in various divisions of the family, young people and children’s services directorate. All held substantive employment contracts with the NHS trust.

Each embedded researcher had different line management, funding, colleagues and relationships according to their pre-existing governance structures within each directorate or division. Therefore each filled out a separate partner identification tool and these have all been included here for clarity.

Victoria
Divisional research lead, NHS research consultant & trust/directorate QI

Karla
Service evaluation, business team & trust/directorate QI

Bev and Katrina Directorate service evaluation (x2 part-time, = 1 full-time equivalent)

Healthy Together

Child & adolescent mental health

Adult eating disorders

Rachel
0.5 directorate capacity building, 0.5 CNF funding portfolio studies

Carol
head of R&D, NHS trust

Family, young people and children’s services

Adult mental health & learning disability services

Community health services

Enabling services

Local universities x2

Porter
community health partnership trust

**Formal link
Informal link**

Figure SM4.4: Porter embedded research structure

Carol acted as the gatekeeper for the Porter initiative, as head of research and development in the enabling services directorate. Her work related to building research capability and capacity in the trust. She had various levels of input into the work of each embedded researcher, but had most contact with Rachel, who worked to a similar remit.

***Rachel, research support and portfolio research: community mental health***

Rachel was a senior research associate at the NHS trust, and an honorary fellow at the university). Prior to her current role, she had worked for 25 years as a research assistant in the university. She was now employed by the university but funded by the trust. Rachel explained that changing government funding priorities meant the stability of her university position had become increasingly uncertain until she was finally informed that it would no longer be funded:

**Rachel, embedded researcher, Porter:** The professor that I was working with retired and… a senior research fellow that I worked with… decided to leave and… I was basically left on my own, all the clinical academics that I had been working with had retired or left and not been replaced… So they decided to make me redundant because they didn’t have any other sort of dementia, psychiatry… specialists left in the university.… and at that point I’d been working largely on clinical research network portfolio studies… so I’d always worked very closely with [the trust] because they’d funded me and a lot of the research projects I was helping to deliver were hosted within their trust… So when they heard that I was being released or made redundant from university… they created a research post with me in mind… The director for community health services had been working very closely with our head of research and had been coming round to the idea of how important research is to the development of services and culture… So my role now is half and half… half of my post is funded by the clinical research network… to work and deliver portfolio studies, and the other half… is funded by community health services within our trust … to encourage and support staff to become research active whether that be supporting portfolio studies or doing their own research … or just at a very basic level of using research to inform their clinical practice… to build a culture within the services that research is… core business for their NHS work… and… support staff into their first steps of becoming a clinical academic researcher.

Rachel’s formal contract was with the NHS: 50 per cent of her role was funded by the NHS trust and the other 50 per cent by the clinical research network. She sat within the research and development team and, as such, had the most tangible and formal links with our initial gatekeeper for this site, Carol, the head of research and development – her line management was within the research and development department (see *Figure SM4.5*). Rachel also had honorary fellow status with the university and extensive contacts and relationships there from her previous role. Her desk was in the NHS organisation.

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

Porter: Rachel

R&D (directorate level)

Students
(health sciences)

Trust board level management

Academic professors, neuro (university 1)

R&D (acute trust level)

Academic professors, neuro (university 2)

Head of school

Senior researchers

Figure SM4.5: Embedded researcher key partners, Porter – Rachel

Directorate level management

***Bev and Katrina, service evaluation: family, young people & children’s services (adult eating disorders)***

Service evaluation and research associates Bev and Katrina shared one full-time equivalent role. In one form or another, this role had been in existence for around 25 years, being first introduced by a ‘forward thinking’ service leader who saw the value in collating and monitoring patient demographics. Bev and Katrina were solely employed by the NHS trust and worked in the eating disorder service (four days a week with the adult service and one with the children’s service) where they shared an office. Their line management was through their team managers, one for inpatients and one for outpatients. Both had primary clinical backgrounds and described themselves as now working in the area of service evaluation and, in particular, the generation and dissemination of annual reports that collated data in relation to various outcomes including patient experience.

**Bev, embedded researcher, Porter**: Our bread and butter is service evaluation, so we’re getting outcome data for our service, that’s, that is what we have to do on a daily basis; but in conjunction with that, we do have other projects going on. So at the moment I’m recruiting for a national study which is an inpatient recruitment thing, and really my involvement on that is just limited to recruitment… If we want to do a bit of research, that is encouraged, that is supported… We say, ‘Oh it’d be really good if we had a look at x, y and z’… they would be supportive of that… We have had quite a few papers published and we’ve done that really through our outcome data… We used to have a consultant psychiatrist who was very into research, had a lot of… network[s]…

**Interviewer:** And does that make a difference?

**Bev:** Yes it does, in terms of applying for grants, you really need somebody of that sort of status. So we have applied and been successful in getting small grants, local sort of small scale things, with which we’ve done the research on the back of, which is great, but in terms of funding an RCT [randomised controlled trial], we aren’t going to get that, we’re under no illusions, the only way we can take part in something like that, is if we are a recruiting site.

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

Porter: Bev & Katrina

Other academic collaborators

R&D team

Psychology students with similar research interests

Eating disorder clinical team

Clinical team
managers

Figure SM4.6: Embedded researcher key partners, Porter – Bev and Katrina

Colleagues with eating disorder interests

Bev and Katrina said their input and involvement with research had reduced. They felt this was in part because a key, research-active consultant psychiatrist and professor had left the department. They had previously written and published papers as a team and secured small project funding and grants to support their work. The service was often used as a site for national and international clinical trials and subsequently their role also involved the recruitment of patients to these trials. Their contact with academic institutions was through involvement in RCTs and informal connections and relationships which remained from previous RCTs (see *Figure SM4.6*).

***Karla, service evaluation analyst: family, young people & children’s services (healthy together)***

Karla’s role was full time and she was solely employed by the NHS trust. Her position was with the child and family division of the trust, where she provided support to a range of evaluation projects. Prior to this position, Karla worked in the research and development team, building the research capacity and capability agenda. In her current position, she was line-managed through the divisional management structure but had strong, informal relationships with senior clinical leaders, service managers and the directorate lead (see *Figure SM4.7*).

The main focus of Karla’s work was service evaluation in relation to the collation and distribution of qualitative data, driven by the need to meet requirements from the commissioning group.

**Karla, embedded researcher, Porter:** The commissioner said can you deliver on all these KPIs… they’re all numerical and our service turned around and said we can deliver on all of that, but it will be quite resource intensive for us to change some of our systems to be able to give you that data and actually won’t give you a lot of useful information. So what was suggested and negotiated is that every quarter we deliver what we call a narrative report so it’s more of a deep dive into a particular area of the service… to describe what’s delivered and how we know it’s working and then gives us an opportunity to identify where we can improve things … and so that’s the main remit of my role to deliver on those every quarter.

In addition to the service evaluation work, Karla was also now involved with the organisational quality improvement (QI) agenda, which, as she explained, had been a recent, somewhat informal development and additional to her contracted role. Karla also offered insight into her involvement with research, or as she explains, her interpretation of the ‘NHS definition’ of research.

**Porter: Karla**

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

QI team

Line manager (intelligence)

Clinical lead x 2 specialities

Family services managers

Key management influencers

Services users

Public health nurses

Embedded colleague

Figure SM4.7: Embedded researcher key partners, Porter – Karla

Older people services

**Karla, embedded researcher, Porter:** I mean my role’s kind of exploded from there… now I’ve got quite heavily involved in quality improvement within the service itself… [and] then the trust quality improvement agenda… in all honesty in my role I don’t really do or come across research at all, in its kind of NHS definition of research. I don’t see it; people aren’t doing it. What people are wanting to do is quality improvements, service evaluation…

Within this, Karla worked closely with Victoria (see next section). Other than Karla’s contact with Victoria and associated colleagues, her connections and relationships with the university were minimal and informal.

***Victoria, research capacity and capability building: family, young people and children’s services***

Victoria was an associate professor of communication in mental health at the university and a research consultant and associate research lead at the NHS. Employed full time, Victoria was jointly funded by the university and the NHS trust. The contract was set up as a university post, with trust partnership. Although a certain number of days were allocated to each organisation, Victoria actually divided her time on hours as the nature of her work was variable.

Her role had a complex history. She explained this and her motivation:

**Victoria, embedded researcher, Porter:** I don’t want to be a full time ivory tower academic that does research that’s philosophical or abstract or metaphysical or any of those kind of things, I wanted to do research that had some applied meaning that would mean something to children, children and families, which was always my area of research… I came across this post in [Porter] that looked really interesting, that was part-NHS, part-university, working with clinical staff, in research, and the job description was really vague… and I have to say it took me about 2 years to work out what the job actually was… and to some extent, I was involved in writing my own job description.

**Interviewer:** So you got the job and then that process started?

**Victoria:** Yes exactly, because they had somebody in post before me… But he was much more academic, he didn’t do a huge amount of NHS-type stuff… But they wanted someone to do more than that, I mean we’re going back 16 years, so it’s quite a long time, and they didn’t really know exactly what they wanted, or what they needed.

When examining the researchers based at Porter, Victoria’s role was arguably the most ‘split’ in terms of tasks, responsibilities and contract. She felt very much that she had two roles and thus two sets of expectations. She described her efforts to meet both:

**Victoria:** There’s always things going on in both organisations that you need to be at, and some of those events actually benefit both organisations and that’s great when it benefits both organisations, it makes me happy because that way I can do a bit of both jobs in one afternoon and both organisations benefit from it.

**Interviewer:** By benefit what do you mean?

**Victoria:** So for example… I’m going up to [place] to present [at a conference] in November: that really benefits the trust – I shall, you know, put the [trust] banner on my presentation and it’s all kind of clinically relevant research, but I can also count that as academic work, because it’s research and research is part of my academic job as well… So it has a double benefit.

**Interviewer:** It sounds like there’s two sets of priorities then?

**Victoria:** Oh yeah, very different sets of priorities as well. So a great example of that is, is I publish my research for the trust, and the kinds of journals I select if I want it to have clinical relevance and I want it to be read by clinicians, and I want to promote the [trust] banner, they’re quite low impact, in academic terms… The university, they just don’t count publications like that, they’re too low-brow in their view, they don’t count for the ref and all of that kind of stuff. So I also publish research in the higher academic journals to keep the university happy, and then I put the university as the primary banner and the [trust] as secondary and they’re university publications, versus [trust] publications…

**Interviewer:** So you’re juggling?

**Victoria:** Yes.

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

**Porter: Victoria**

PhD students – clinical academic

Wider clinical team – neuro development strategy group

University colleagues

Clinical trust division

CAHMS

Clinical speciality colleagues

QI group

Consultant group – psychiatry

Figure SM4.8: Embedded researcher key partners, Porter – Victoria

Trust improvement group

Victoria had an office in both the university and the NHS trust but said that much of her time was spent between offices and at various meeting places. In terms of crucial relationships (see *Figure SM4.8*), Victoria’s line managers were the clinical director of family, young people and children’s services at the trust, and two school heads at the university.

## Embedded activities

As noted above, service evaluations now represented a major focus of work for the embedded researchers, especially Karla, Bev and Katrina (where it was the main focus of their role). This service evaluation involved the collection and reporting of large outcome data sets (often through annual reports) to ultimately improve service provision. Much of the work was formally required outside of the organisation for monitoring purposes (e.g. for NHS England and various commissioning groups). Although the nature and work of the roles varied, there was a strong sense, particularly from Rachel, Victoria and Karla, that their roles were also concerned with promoting research capacity and capability in the NHS organisation. This could be seen, for example, in Rachel’s job specification:

The CHS Senior Research Associate is a hybrid role (funded by both the Trust and the Clinical Research Network) and will be responsible for the provision of an efficient and high-quality research support and delivery service across all of the services by the Trust Community Health Services. In the Trust element of the role, this is intended to match the ambitions of CHS to see research embedded in everyday practice. The role is to facilitate the implementation of the R&D strategic goals of the Trust within this Division and its aspiration to build a strong and visible reputation for an excellent research culture, where there is the embedding of research into the delivery of care and for the conducting and delivery of interdisciplinary research.

Although Victoria was also heavily involved in research capacity and capability building, her activities and responsibilities included additional elements:

**Victoria:** I undertake work for [trust] as a research consultant, which means that my primary role is to educate about how to do research, facilitate the research going on in the trust, supervise research, undertake research and contribute to the research profile of the trust. I contribute to several of the training programmes for [trust]. I have provided teaching for trainee, junior and consultant level clinical professionals, which has included contributions to research teaching on clinical programmes for junior doctors and trainee psychiatrists as well as the psychologists, and AHPs. Some of this is done through the university (for example, the MSc in child mental health, the MRPsych, and the D Clin Psy), and some through the trust, hosted at the [name] institute… I also provide mentorship for bronze award students. Iprovide one-to-one research consultations for clinicians working and supervise their CPD [continuing professional development] activities. These one-to-one supervision sessions range from providing core research skills such as undertaking a literature review as part of the inherent training requirements of particular clinical qualifications, to more bespoke supervision for research tasks such as producing a journal article, small grant applications or writing books… In addition, I provide drop-in clinics for clinicians to accommodate the busy working schedules of clinical staff as well as creating customised research packages through email communication for those who have difficulty attending face-to-face.

Victoria was also involved with the trust’s QI agenda and was working closely with Karla to set up a divisional group. We observed one of the meetings, focusing on outcome measures (facilitated by Karla and Victoria, with Bev also present). It was attended by healthcare professional leads of various specialities in the trust, those involved in traditional research roles, and evaluation leads from various directorates, trust-wide. The emphasis of the event was on a trust-wide QI initiative and the promotion of various associated networks and conferences. The initiative was introduced as a result of commission feedback, and aligned with trust priorities for improvement, encouraging individuals to record the QI work that they were doing or planning and ultimately measuring impact. The event also included presentations from successful QI projects which had been completed within the trust with tangible service benefit. Karla very much facilitated the session; she spoke between presenters and explained the content in further detail. She made the technical elements accessible for attendees, offering reassurance and support about the process. This observation represented the role of the embedded researcher who often acts as a translator and facilitator for others, enabling accessibility and potential.

## Achievements and challenges

There was a strong sense in discussion with close contacts such as line managers that all members of the Porter initiative were positive and valuable members of the organisation. This was supported through the long history of the research initiatives and the sense of permanency and support to sustain roles. A sense of achievement could also be seen through the progression of each role: across the initiative there was growth, new programmes of work were being set up, additional funding was being secured and there was success in academic publication and dissemination.

At the same time, there were still challenges associated with the initiative; these were quite individualistic for each researcher. For example, a significant challenge for Victoria was workload, driven in part by competing expectations (and the lack of monitoring associated with this):

**Interviewer:** In terms of where you spend your time on a daily basis then, you’re not allocating a day here, allocating a day there?

**Victoria, embedded researcher, Porter:** I do it on hours instead… technically devote 16 hours to [trust], but the reality is I do a bit at home, on top, because you can’t squeeze it into 16 hours, that’s a nonsense… The other 24 hours then are university hours, but again, it’s impossible to fit my university job into 24 hours. So I do an awful lot of the evening work, an awful lot of weekend work, a lot of juggling between posts, and a lot, wherever possible, double weighting, to try and make up some of the shortfall, because I work about 80 hours a week. The problem is that both organisations to do the job properly, and I can’t bear not to, haven’t got enough time to do either job properly, unless I put in extra hours.

**Interviewer:** So it’s two full time roles really?

**Victoria:** Well yeah I suppose it is, I do an awful lot of work on Sundays, Saturdays, mornings, yeah, evenings, you know, and the thing is if you do international work, there are time zone differences. So I can be on Skype at 8 o’clock in the evening, doing a 2-hour meeting with America or whatever.

In relation to broad challenges influencing the initiative as a whole, although there was a degree of security with the individual roles, with a sense that this was attached to the ‘buy-in’ of one or two key individuals who they saw as intrinsic to their success. Without these individuals, there was a sense that the story told would be different and less positive. This related to the broader value assigned to non-clinical staff, particularly in terms of funding. Carol, head of research and development, shared her experiences of these challenges, giving a helpful, initiative-wide perspective:

**Carol, trust head of research and development, Porter :** I’m absolutely delighted we’ve got them, I think they have a fantastic role to provide us with, they’re great and I think they’re right for us as an organisation where we’re at now… I think my role is much more about helping that bottom tier of the triangle, helping build a culture where we value research, we know how it helps us do what we want to do, we understand how to digest, how to read, how to implement the NICE guidelines, the latest research coming out.

# Evansville

## Background

This initiative was premised on a relatively longstanding and far-reaching collaboration between a university hospital and research-intensive university, which over several decades had involved various applied and organisational research projects. The embedded initiative extended this model of collaborative working on the premise of carrying out rigorous university-standard research that was more aligned with the challenges facing the hospital trust, with findings informing practice and service delivery. The extract below, from an original job/person specification for the embedded researcher role, offers insight into the historic intentions and aims of the initiative, particularly the perceived strength of adopting an embedded approach. This extract also reaffirms the desire to produce both formal academic knowledge and local practice insights:

… to undertake and develop funding applications for high quality research in close collaboration with health professionals and managers. By being ‘embedded’ within the healthcare setting, this will increase the potential for well-designed research, applied directly to the context in which solutions will be adopted, to facilitate successful implementation and improve healthcare for patients. This model will allow researchers and healthcare professionals and other staff to understand and value each other’s roles, knowledge and approaches and to develop their complementary skills. The team will undertake research of value both to [hospital] and the wider NHS…

## The embedded researcher(s)

The Evansville initiative could be described as an embedded team, with each team member coming from and bringing to the initiative a distinct disciplinary perspective, including anthropology, operational research, qualitative and quantitative methodologies, and health economics. The case description presented here draws primarily on Bella’s experiences as one embedded researcher within this team. She saw the role as a unique opportunity to apply her knowledge and skills to the wider team and, in turn, to the development of health and care services:

**Bella, embedded researcher, Evansville:** I'm a medical anthropologist by background… From early stages quite a direct interest in using research findings in a way that they can you know inform changes and practice in policy… My first exposure to postdoctoral research was already in that type of dual role which was really interesting… [This role] appealed to me, the fact that there was an applied focus definitely. I think one of the biggest things was that they recognised in the advert that they wanted someone with kind of field-related expertise and an anthropological background… So I thought, well you know great place to put all of that training you know into practice.

… I think it's a role that… you need a person with specific qualities… be able to work well with other people, to be able to recognise the different contributions people can make to a project regardless of where they come from you know. If they're clinicians, if they’re managers, if they're you know statisticians you know to be able to have, to really open, to have a way of dealing with people and to foster collaboration I think it requires that, it requires a knowledge of context. I think knowing how… to understand how the context and the workings out ultimately shaping your experience, people’s perceptions of you, your perceptions of other people, you know, it's that kind of really dynamic relationship between individuals in context. So I think an anthropological mindset gives you that in a way because we’re trained to do that I think from the start.

In a further helpful example of the embedded researcher profile, the data below is taken from an interview with Tim, another member of the embedded research team. Tim’s background offered a helpful contrast to that of Bella’s – Tim was a health economist showing a degree of skill set diversity, but his motivations echo Bella’s:

**Tim, embedded researcher, Evansville:** I did a Masters in health economics… My career was sort of research career in that sense, it started in psychology and then moved to health economics… And I found that in my experience with decision-makers, as a psychologist trying to get more money or trying to get funding to do psychological work or interventions, they only responded whenever I talked about saving money... or saving patients or something – you know, their eyes sort of lit up when I talk about reducing patients’ depression or anxiety or something to do with whatever intervention we were studying... They were pretty glazed, but the moment pound signs came into it they became interested so I figured I needed to learn how to speak money a bit more if I wanted to make a difference and that’s clearly where people’s interests lie, or at least decision-makers in the NHS’s interests lie.

… I like the idea of doing something for work that has also got some sort of social benefits to it… I’m not motivated by desperately trying to find the eureka moment or the next, you know, universal theory of everything or whatever. I’m more than happy to work on something that’s sort of chipping away at unknowns and working on new knowledge and that is sort of my motivation certainly for staying in research and working here because the other incentives such as finances aren’t particularly great, as I’m sure you are aware…

One thing that keeps you going is the idea that what you’re doing has benefit beyond just you, social benefit rather than just private benefit… Research in general I would say has social benefit… because you are trying to contribute something to the database of human knowledge or... that doesn’t exist already so there is benefit in your work over and above just the financial pay that you get. Applied research in health has a sort of particular appeal because it’s sort of a... to me, I mean health is everything, everyone is affected by health, if you’ve... you know someone in your family or you have someone... or yourself you know, everyone’s got a health issue and if you don’t, pretty much just wait and you will… So yes, that applied, particularly health and applied research I would say it’s such an immediate social benefit, relative to something more theoretical.

## Rationale and specification

Initially, the embedded team comprised two full-time researchers (one anthropologist and one operational researcher). Once the initiative was underway, the team was reconfigured to include five part-time members: two anthropologists, two operational researchers and one health economist. The change in structure was a bid for the researchers to maintain a connection to more ‘traditional’ research when not part of the embedded team (to support their career development). The researchers were employed by the trust, and the embedded team worked on individual research projects driven by the needs of the trust. These research priorities were identified and constructed through regular formal meetings which were attended by senior NHS managers in addition to the academic team.

The researchers had various levels of formal and informal support (both clinical and academic) – this senior ‘buy-in’ was seen as crucial to the sustainability of the initiative. The researchers were under the direction of Julie, a senior academic, but also had the close collaboration of senior trust members. The configuration involved the construction of a steering group to provide advice and guidance on the work of the embedded team.

The researchers had desks at the university and a shared desk at the NHS organisation and split their time between the two settings. Limited resources at the NHS resulted in the team often completing much computer work (analysis, writing up, etc.) away from the trust and in the university.

## Relationships

Bella’s completed partner identification tool (see *Figure SM4.9*) offers insight into the individuals and groups she perceived as important to her role. The inner circle shows those most influential to her role: her team mates and the trust/academic champion – these individuals were fundamental in terms of access and also relevant for sustainability. Moving outwards, Bella described the important relationships which filled the second quadrant of the tool and in particular the importance of relationships with senior NHS trust managers:

**Colour code:**

**Embedded researcher**

**NHS University Other**

**+**

**Perceived degree of importance**

**–**

**Evansville: Bella**

External organisations – NHSE/NHSI

Academic champion (senior)

Local trust champion

Steering group – NHS

Embedded teammates

Other embedded researchers, outside
of trust

Clinical project leads

Figure SM4.9: Embedded researcher key partners, Evansville – Bella

Academic research colleagues

**Bella, embedded researcher, Evansville:** If you go to the second circle and I think I would divide that into two quadrants so you could be the lead for the different projects that we have at the trust, so when we were doing the [place] project we, there was a point where we were doing five different studies at the same time… And these were in completely different areas, from [speciality] to [speciality] so completely different topics and areas and… we had a key person within each of these services or team who were interventions, who was our main point of contact… who helped us, we co-designed the evaluations when we did them… they took on a sponsorship or a champion role but at a more local level, guaranteeing access to people to areas…

**Interviewer:** … Are we calling them like project leads, or…?

**Bella:** Yeah, I think project leads within the healthcare organisations I think… And then I think even within that circle but in a different quadrant I would put senior members of the organisation as well… In the form of our steering group… we set out from the very beginning a group so people could call it a steering group or an advisory group… and basically it has representation from the health organisation across different areas. We try to make it at all levels but I think one of the levels where it needs representations is at a more senior level, so I’m talking medical director level or… even it could be divisional managers, it really depends on the type of work that needs doing and having them involved… in a group that meets regularly where you can share interim findings where you can… feed-in to, the design, and feed-in to the analysis I think, that’s the key for any type of embedded work and really, one of the key things that we look for in embedded research is not only examination of the findings, but we want the findings to be incorporated into changes in practice, so I think they need to have engagements from the, the kind of group in order for that to happen.

Bella also discussed the importance of informal relationships to her embedded role, particularly in relation to peer support:

**Bella, embedded researcher, Evansville:** And I think the last circle, the biggest one… [that] quadrant [needs] to include other embedded researchers… I think that type of networking is good. There was one group that was created by some of the other researchers working as crew under [name] work… they created a little support group… We got together and talked about the problems and things we were facing and trying to find out what the strategy that other people were using. It was a really good group. It lasted I guess for about a couple of years and then people moved on and it was difficult, to keep it going, but…

**Interviewer:** But they were important to your role?

**Bella:** Yeah, I think especially initially when we were setting things up for [place] that was a good group and then I’d include other researchers in my department… I guess, they’re a normal part of research where you can quote other people who might have done similar things or… you want to run by, by another person, you know, more types of that support between colleagues I guess, so I think that’s important… maintaining these connections… to get more academic support… if you are too immersed in an organisation you can get a bit lost.

## Embedded activities

As the initiative was retrospective, we were unable to complete any direct observation. Instead, the interviews drew out the researchers’ experiences of the role in relation to the nature of the work undertaken. The embedded team were involved in a variety of research projects based in a variety of clinical and non-clinical areas, from pain management to emergency department to accreditation. Within these projects the activities of each embedded researcher varied in relation to the aims of the project and also the skills of each researcher (for example, qualitative or quantitative methodological skills in addition to health economy expertise). In some instances, the team worked in an advisory capacity and did not collect or analyse data. In one particular instance, the team worked closely with two clinicians and ‘trained’ and guided them through the different stages of the research process and on to publication.

Conversely, the team was also involved with a more traditional researcher role. Tim offers his account of a project related to the pain management service:

**Tim:** So an example of a project I felt would work, worked well was, there was... they tried to do a new service for patients with complex pain issues. And I’m not exactly sure what that entails, they have their own diagnostic criteria so that’s fine. But they basically ordered a trial, a sort of a bells-and-whistles, gold star service for people with... complex pain and they wanted to evaluate it, so I helped the registrars who were assigned to this, to do the health economic analysis of it. I helped them design the data and do some of the statistics and I trained them in these and I invited them... and linked them to various courses and text that would help do that. So they did and then we produced a report and they got their protocol published… Anyway so that all was very neat and it all worked fine and it was, it was kind of great.

The following information is taken from the original job specification for the senior research associate/research associate in applied health research. It offers helpful insight into the role’s functional activities, necessary skill and expertise, and other relational aspects:

* To develop an agreed research agenda with [trust], under the direction ofProf [name]
* To carry out research as part of the [trust] embedded research team, under the direction of Prof [name]
* To liaise closely with other members of the embedded research team and staff at [trust] to contribute to the success of the work of the team
* To review the relevant literatures, depending on the topic of the research undertaken
* To develop proposals for external research grant funding, under the direction of Prof [name] and in collaboration with appropriate [trust] staff, and other members of the embedded research team
* To ensure that appropriate ethical clearance and research governance approvals are obtained for all empirical research activity
* To carry out qualitative research within [trust] and other participating NHS organisations, in collaboration with others in the embedded research team
* To develop the qualitative research instruments
* To lead on (contribute to) the analysis of qualitative data
* To lead on (assist in) the delivery of dissemination activities
* To (help) draft progress reports as required by the PI [principal investigator]
* To lead on (contribute to) drafting papers arising from this project for publication
* To report progress to Prof [name] and the relevant steering group
* To contribute to presenting findings to different audiences and attend relevant conferences
* Work as a conscientious and committed member of the team in order to achieve its aims
* Facilitate collaboration and networking which engages and supports activities of the embedded research team
* Participate in educational activities as appropriate to the stage of your career
* To be committed to your own personal career development
* Liaise with the relevant administrative team for the support of the project
* Ensure confidentiality on all matters and information obtained during the course of employment
* Subject to the regulations of the funding bodies, appropriately qualified members of research staff will be expected to contribute to teaching or other departmental activities. At the present time this is estimated to amount to an absolute maximum of thirty contact teaching hours per annum for full time staff.

In addition to the elements above, Bella noted the degree of time spent on capacity and capability building activities, many of which were informal in nature. This work ran alongside the assigned embedded research projects. Bella, one of the embedded researchers, offered her experience of this ‘extra’ work:

**Bella:**… We did quite a bit of [research capacity in health services research] which wasn’t necessarily linked to the official projects… which took a lot of our energy and a lot of our time, and I think those were some of the things that the staff valued the most to be honest. Now our problem with the research is that we did all of this work but we couldn’t, I don’t think we cracked how to document it properly or how to demonstrate the impact properly for the trust to see it… I'm no longer there and I still get emails from people saying ‘Oh, are you guys still doing some work?’ … We’re still that link for many staff there because those relationships… were quite strong when we were there… So if they need that input I'm still [there].

## Achievements and challenges

In the extract above, Bella also introduced one of the main challenges of the embedded initiative: determining and measuring the relative success and impact on the work undertaken. The act of disseminating findings within the organisation (and the nature of this dissemination) was seen as challenging and, on reflection, not used effectively to show the work and success of the researchers. These observations were particularly relevant to understanding the sustainability of the initiative and also linked to the value of the initiative more broadly, in terms of organisational perceptions. There was a strong sense during the interviews that the success and then subsequent sustainability of the initiative was dependent on specific senior managers (and the degree of their ‘buy-in’). As a result, when these individuals moved organisation, the continuation of the initiative and its funding proved more challenging. ‘Buy-in’ from a senior level was critical at all stages of the initiative, and ongoing dissemination, especially of influential findings, in an accessible manner was critical.

Despite this initiative ending, there was a strong sense that a degree of success had been achieved. In addition to the impact on clinical practice from individual research projects, numerous academic papers had been published with the clinical teams involved. A further example of initiative success was seen through the relationships that had been developed, and the ongoing nature of these relationships:

**Bella:** That was about helping local reach capacity…Now the good thing about that is both have actually continued on to develop clinical academic careers. One of them is still finishing up the MD, but the other one moved on to do a PhD, and actually for his PhD, our local lead which is one supervisor [name] submitted one and I think a third supervisor or something like that for his PhD. I guess that’s an example of how these relationships can continue after the embedded bit… We finished working at [Evansville] in I think it was in 2017 and he’s still one of my students and he’s about to submit the PhD.