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The adoption of Coordinate My Care in North West London

Qualitative research report

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IMPERIAL COLLEGE HEALTH PARTNERS

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1 Summary

1 Summary

This report presents the findings of a research study conducted by the Ipsos MORI Social Research Institute on behalf of Imperial College Health Partners (ICHP).

The study explored the spread of innovation in healthcare settings in North West London. This report focuses specifically on qualitative research exploring the enablers and barriers to adopting and diffusing Coordinate My Care (CMC).

This research involved eight qualitative in-depth interviews conducted between October 2014 and January 2015 by Ipsos MORI either face-to-face or over the telephone. Participants had all been involved in CMC.

1.1 Key findings

- Participants agreed that there is a need for an urgent care planning tool such as CMC to ensure that the urgent care needs of palliative care patients are considered, even in an emergency.

- CMC also seemed to fit well with a range of national healthcare policies and best practice guidelines, further reinforcing their impressions that CMC is a worthwhile area of innovation.

- Training on CMC is available for users who are new to the system or who request it. Participants thought this was important and were generally positive about the training offered. Small issues impacted on maintaining momentum and interest in CMC for some users. This was partly attributable to resourcing among the CMC team, who were making more use of cascade training to address this.

- The administrative burden and subsequent resourcing challenges acted as a barrier to uptake of CMC, as records could take time to complete. Adjustments were being made to address this, such as using administrative staff for some parts of the record, speeding up the process of logging in, and plans to employ Clinical Nurse Specialists at the London Ambulance Service hub.

- The administrative burden was partly related to technological barriers to using CMC. This included: difficulties accessing the system, particularly in community settings or in the field (for paramedics); potential to improve how user friendly and

intuitive the system is[1]; and linking CMC to other systems for storing patient notes.

- The main incentive for staff to complete CMC records was being able to see the impact on their patients. This included providing data as evidence of the impact of CMC on outcomes, and also anecdotes about individual events where a patient has benefited as a result. Some organisations were incentivised financially through a CQUIN (Commissioning for Quality and Innovation) and this worked to some extent, but not to incentivise individual staff.

- In order to further improve uptake of CMC, it could be diffused more widely beyond palliative care professionals, for example to those working in the community and to staff who are not palliative care professionals but are specialists treating patients towards the end of life. This would increase the number of people completing records as well as the number implementing the information saved in the records.

- Another potential way of diffusing the innovation was to stimulate demand among patients and their carers by making them aware of CMC and its potential benefits for them.

[1] Please note: At the time of writing, a new CMC IT system is scheduled for launch on November 24th 2015. According to the CMC team, the new system has been designed to be 'quick, easy, user friendly and intuitive', (based on feedback from their own research among users).

2 Introduction

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This report presents the findings of a research study conducted by the Ipsos MORI Social Research Institute on behalf of Imperial College Health Partners (ICHP).

This chapter provides a brief background to the study; the aim and objectives for the research; the research approach taken; and details of the case study to be discussed within this report.

2.1 Background to the study

This study explored the factors influencing the adoption and spread of healthcare innovations in North West London through qualitative research.

The research focused on three case studies, exploring the diffusion of different healthcare innovations:

1. Coordinate My Care;
2. Human Resources Streamlining Programme; and
3. Novel oral anticoagulants.

This report relates to the first innovation – the spread and adoption of Coordinate My Care (CMC).

2.2 Research objectives

The research objectives for this case study were as follows:

- to gain insight into the barriers and enablers affecting the adoption and spread of CMC in North West London;
- to identify, where possible, ways in which the use of CMC can be further diffused within North West London; and
- to explore key themes emerging across the three case studies that have an implication for the diffusion of innovation in North West London more generally[2].

2.3 Background to CMC

Coordinate My Care (CMC) is an urgent care-planning tool, which provides care plans for those at the end of life. It allows people with chronic health conditions and/or life-limiting illnesses the chance to

[2] These findings are provided in a separate report.

express their preferences for treatment, especially what they would like healthcare professionals to do for them in an emergency.

The care plan consists of an online tool which healthcare professionals update after they have obtained patient consent to do so. Professionals who can access the tool include staff in the ambulance control hub, NHS 111 operators, and professional groups such as doctors, nurses, care home staff and hospice staff.

The information stored on the care plan contains details of the patient's diagnosis and information relating to their treatment, the contact details of their carers, and their wishes should their condition deteriorate. The main benefit of CMC is that the details are all stored online so that when the information is required urgently, healthcare professionals are able to access it, even if out-of-hours.

The CMC team reported that an average of 650 patient records were being completed each month. At the time of the interview, they said that 12% of the end of life population was represented on CMC across London. They were aiming for that to rise to 25% within one year and 50% within two years.

2.4 Research approach

A qualitative case study approach was used to explore how the innovation spread in practice. This approach triangulated a range of different perspectives across the case study.

In total, eight in-depth interviews were conducted with a range of participants familiar with CMC, as shown in table below.

Interviews lasted between 20 and 75 minutes and were conducted between October 2014 and January 2015 by Ipsos MORI either face-to-face or over the telephone.

Table 1: Participants in the CMC case study by job role

Roles	Number of interviews
CMC team member	1
Clinical Nurse Specialist	3
GP (including one CCG chair)	2
Consultant in Palliative Medicine	1
London Ambulance Service senior paramedic	1
Total number of interviews	**8**

The sample of participants for this research was provided by ICHP.

Participants were contacted by a member of the Ipsos MORI research team and invited to take part in a voluntary qualitative interview.

2.5 Interpreting the results of this study

Qualitative research is not designed to provide statistically reliable data, but is designed to be illustrative, detailed and to reflect the perceptions, feelings and behaviours of people taking part. The goal of this research was to consult a specialised set of participants who had knowledge of the innovation of interest.

When interpreting this data, it is important to note that the number of interviews conducted around each case study was small. This means that results cannot be extrapolated to represent North West London as a whole, but provide some insight into the experiences of specific individuals for further consideration. Some of the themes commented on in this report will only have been mentioned by a small number of individuals.

Neither is it possible to say that the findings are representative of the views of specific organisations. It should also be noted that due to the nature of the research recruitment, an equal opportunity for all organisations across in North West London to participate was not possible. It is likely that those taking part in the research are more engaged and familiar with CMC than others in North West London.

Quotations should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic expressed at a particular point in time. These have been anonymised to protect the identity of participants.

3 Key findings

3 Key findings

Sharing clinical information between healthcare providers

This chapter explores participants' views of the factors that have influenced the adoption and spread of Coordinate My Care (CMC), alongside how the innovation could be further diffused.

3.1 The conditions for change

In order for an innovation to be adopted and spread, those it is aimed at must accept that there is a process or product that could be improved. This section of the report explores acceptance of the need for Coordinate My Care (CMC), including how existing policy contributes to that acceptance.

CMC was felt to be a useful and relevant tool for healthcare professionals.

Participants agreed that there is a need for an urgent care planning tool such as CMC to ensure that the urgent care needs of palliative care patients are considered, even in an emergency. This was a key enabler of the adoption of CMC: that it responds to a genuine unmet need for a better system of recording the urgent care needs of palliative care patients, in particular through using technology.

The LAS paramedic interviewed as part of the research explained that CMC has provided information that can enable paramedics to do the right thing for the patient at the appropriate time; whereas previously their decisions in these situations required them solely to use their judgement. It also allows care to be transferred across care settings more seamlessly. A clinical nurse specialist remarked that CMC allows an immediate context to be provided to their patient's situation and wishes when they arrive in hospital.

In this way, participants thought a benefit of CMC was its ability to overcome some current frustrations in the system. For example, a patient's advanced care planning needs are historically paper-based and not always available in an emergency. In addition, it could provide a solution for inconsistent approaches to record-keeping across services as records can be accessed across the whole of the capital, even if out-of-hours.

> The benefit of CMC is that information is readily available and therefore when the paramedic gets on scene they immediately know how they should be treating that patient.
>
> Paramedic

Healthcare policy and best practice guidelines also supported views that CMC is a valuable area of innovation.

Participants thought that CMC fit well with a range of national healthcare policies and best practice guidelines, further reinforcing their impressions that CMC is a worthwhile area of innovation.

Participants mentioned examples of policies and guidelines that they felt affected the implementation and spread of CMC at an NHS-system level. For example, the End of Life Care Strategy published by the Department of Health in 2008 identified several major issues regarding dying and death in England. CMC was seen to be helping to address some of the problems this report uncovered – for example, poor coordination between service providers in primary and secondary care, and between daytime and out-of-hours services. In addition, the National Gold Standards Framework (GSF) provides guidance and accreditation for services wishing to provide a high standard of care for people nearing the end of life. It was claimed that CMC has been useful to help facilitate improvements in care for patients, especially in settings that are, or wish to become, accredited.

> The Gold Standards Framework for London – this is an enabler. It has helped them to understand the need (for better palliative care), and then we have come along and provided the tool.
>
> CMC Team

Alongside this, CMC was felt to be relevant in relation to well-known improvement areas for the health service, from the patient choice and information agenda, to the leadership drive to improve provision of palliative and out-of-hours urgent care.

CMC therefore seemed well-supported in both principle and in policy. This starting point was a clear enabler of the adoption of the system.

3.2 Stimulating uptake of CMC through training

Potential users of the system are therefore bought into its concept early in the process. They tended to find out about CMC from presentations and outreach work by staff from the CMC team, following which individual staff members were trained on how to use the system.

Training on CMC was well-received, although small issues impacted on maintaining momentum and interest in CMC for some users.

> We have our 'super-user' training – so where there is that support to allow people to be released to have that extra level of engagement and training.

Training on CMC is available for users who are new to the system or who request it. Participants thought it is important to coach people on how to use the system properly, and the CMC team noted that users are not provided with a password to CMC until they are deemed as a competent user.

CMC team

Training was mentioned as a way of helping to raise the profile of CMC and communicate the benefits of how it can work. Participants were generally positive about the training, stating that it provided them with the relevant information to help them use the system. Even those who found the system less user-friendly acknowledged that the CMC team were supportive.

The timing of training was felt to be important for maintaining momentum and interest in using CMC. Some participants noted that they been trained before the system was launched in their area, and so their knowledge had slightly faded by the time they started using it. Others noted that a delay with the provision of passwords after training in some cases had slowed the momentum and enthusiasm created. From the CMC team's perspective this was owing to the demand for training outstripping their capacity to provide it.

Cascade training has helped the CMC team meet increasing teaching demands.

One particular aspect of the training provision that helped address the issue of capacity was cascade training, through which those who have been taught to use CMC train others. Such training has enabled the diffusion of CMC as it has helped the central team cope with the demand for training. It has also encouraged the formation of advocates, or 'super-users', who were viewed by the CMC team as a key asset in helping spread use of the tool.

> There's training once a year/6 months. Once someone in the practice is quite good with it, they can then pass their training on.
>
> General Practitioner

3.3 Resourcing and administrative challenges

The administrative burden of completing a record can act as a barrier to uptake once users have been trained and are ready to use CMC.

All participants in this research had some experience of using CMC – some used the tool very frequently (daily), whereas others had only used it a few times.

When asked about the experience of filling in a CMC record, participants said that it could be quite laborious and described a lengthy process of at least 20 minutes to create a record. Particularly given the time pressures facing front line staff, filling in a CMC record could be viewed as a chore. Indeed, some said they do not always have sufficient time to have the conversation necessary to even create a plan, let alone fill in the record. One nurse mentioned that

they had requested another 15 hours of a Clinical Nurse Specialist (CNS) as part of their Commissioning for Quality and Innovation (CQUIN) framework to enable them to get on top of the time commitment.

Even those who were more familiar with the tool described challenges with using it. As it often took a while for records to be created, some were concerned that their notes suffered as a result and were too brief. This in turn impacted their views of how useful their entry was and could reduce general enthusiasm for completing records.

> Admin staff help us to input data…I find it quite useful to have non-clinical people inputting the data because it's time-consuming for us to do that. So I just copy and paste my clinical bit into the record.
>
> Clinical Nurse Specialist

3.3.1 Adjustments already made

In order to address these resourcing and administrative challenges, a number of different adjustments have already been made.

The need for administrative staff to assist with this process was mentioned as a key enabler, to relieve some of the pressure and time constraints on clinical staff.

Having administrative staff to search for and/or to populate certain parts of the record, such as the demographic data, can help speed up the process and prevent people from giving up on the tool. Where this was happening,

staff said that the burden on their time had been significantly reduced, allowing them to focus on writing the clinical notes section.

In addition to administrative staff, other time-saving innovations have already been introduced such as the use of NHS smart cards to speed up the process of logging in, which have helped to encourage the continued use of CMC.

Plans for better resourcing in the clinical hub at LAS have been welcomed as a way of increasing CMC usage.

The LAS participant stated that while uptake of the information on CMC by paramedics is rising steadily, resourcing in the clinical hub was slowing down the current spread because there are not enough staff in the clinical hub to access records and provide accompanying advice.

A solution already in motion for this is a new service model starting up in the LAS hub, which will allow to them to better disseminate the information on CMC to paramedics in the field. This will involve the recruitment of full-time nurses into the hub.

3.4 Technological barriers to using CMC

Issues with administration and resourcing can therefore lead to attrition once users have signed up to CMC, although strategies are being put in place to address this. These issues are partly related to the technology that the system uses, which has implications for the usability of the tool. Collectively, these issues made it more difficult for staff to discontinue the old ways of working.

There were some technological barriers to using CMC.

Participants were asked about their views on the information technology (IT) interface and its impact on their usage of CMC. Several issues were identified which could impact on staff members' desire to use the tool: difficulties with accessing the system; complications with creating a record using the online form; and its general user-friendliness. The impact of this was felt to be that fewer records might be created, or that some people might stop using the tool.

One set of challenges surrounded access to the CMC system.

Several problems were mentioned with regards to **accessing** the CMC system:

- a delay in first time access;
- not being able to access the NHS N3[3] network remotely;
- a lack of institutional access to the NHS N3 network; and
- a lack of access for paramedics in the field.

One issue mentioned by a number of respondents was that there had been an **initial delay in access** to CMC following their induction training on the system. In one case, this was due to a local IT department having blocked access to the tool through their firewall. Another highlighted that there had been a delay in getting their password sent through to them by the CMC team. While these issues were resolved, it is worth noting that an initial delay can cause a break in momentum and enthusiasm for a new user, and should be minimised to capitalise on their initial interest in getting started right away.

> There's a lack of remote access. Currently you can only access it from the N3 network, so when you're on site, surgery, or clinic, but you can't do it from home. Sometimes that'd be useful, if you were at home and wanted to complete a re
>
> Ge Practitioner

> The biggest problem we had when starting was that our IT department tried to block access to it inadvertently several times. For some reason it got onto a blocked list.
>
> Clinical Nurse Specialist

[3] N3 is the national NHS broadband network

A **lack of remote access** was also mentioned as a frustration for one user. This was related to the fact that they could not access the NHS N3 network at home. It was felt that home access could enable busy healthcare professionals to find the time to complete the forms.

Others mentioned a more widespread issue concerning N3, that **some providers such as nursing homes are not currently connected to it**. This is because connection to the network is expensive and the process of getting connected can be lengthy – from 9 to 18 months in some cases. As a result, uptake of CMC can be delayed. This was said to be unfortunate as they are an important group to engage – nursing homes often refer to 999 if a resident receiving palliative care becomes unwell, particularly out-of-hours. Some participants noted that nursing home access will be an important consideration to further spread CMC.

> Nursing homes have been forgotten about in the first iteration (of CMC). They have so many high risk patients in these private organisations and it's expensive for a non-NHS organisation to get connected to the secure NHS backbone…
>
> CMC team

However, the CMC team noted that there is now an N3-version of the system with surrounding information governance policy to allow better community access to CMC. Another solution suggested to improve access for community providers was to use other organisations that *do* have access to CMC to enter the data for community settings that *do not* have access – although it is worth noting that capacity and staffing for this in reality may present a challenge.

Accessibility issues were also apparent in relation to the use of CMC records by LAS. It was explained that **ambulances don't have access to other systems in the field** apart from their information screen, and the record itself is not uploaded onto this. Instead, they have to call back to the clinical hub where a clinician can access the plan and relay the information to them. It was recognised that making an additional call can sometimes be forgotten in the midst of an emergency. Despite this, the LAS paramedic asserted that LAS are able to operate within this system, and staff are getting used to it over time.

Implications for further improving uptake of Coordinate My Care:

If the CMC system can be made easier to access, then its use may diffuse more widely, for example into community settings. It could also enable better use of the records that have been

Issues were also raised about how user friendly CMC is and how it fits with other IT systems for storing patient notes.

As well as challenges to the accessibility of CMC, participants also spoke about difficulties relating to creating a record itself. For example, searching for records could be long-winded; regular changes to the user interface were said to be frustrating if not accompanied by training and guidance; and updating records or discharging patients who have died was said to take too much time.

As well as issues with accessibility and inexperience in using the tool, a more tangible frustration was related to CMC being a separate system to other systems for storing patient notes. This led both to double data entry and needing to access patient information from more than one source. It was explained that GPs' electronic notes do not automatically upload onto the CMC system and therefore automated synchronisation between other patient record systems cannot take place. One GP mentioned that in some cases there was duplication where notes had been written in the patient record but not CMC or vice versa. This was a barrier to use for some participants because it doubled their workload and was therefore an inefficient use of time.

These issues were said to influence desire to use the tool, particularly among those less experienced with online systems and those who are less IT literate. Solving barriers related to the IT system was said to be fundamental in improving the spread CMC.

In addition, although a number of records may be created, participants explained that due to the issues outlined above, in some cases their quality may be low. For example, users might only enter a few details, or update the record infrequently, leading to out-of-date information.

As a result, participants questioned the value of the records they had created for other users such as the London Ambulance Service (LAS). Nevertheless, many of these frustrations were said to be due to the frequency with which users accessed the system. Those who persisted with CMC and were heavier users found that they became quicker and more experienced.

> The main reason why they won't put people on CMC is because it's a complete and utter pain. I ring the helpline every time I try to do it. Not user-friendly is an understatement.
>
> General Practitioner

> I think registering a patient on CMC doesn't define the quality, so I could just put the patient's basic demographics and I could tick a lot of 'don't know' so if a patient already happens to be on there, it doesn't mean that the quality of information is of any use.
>
> Clinical Nurse Specialist

Implications for further improving uptake of Coordinate My Care:

Further work on making CMC more user friendly may increase use of the system and the quality of the information recorded.

In addition, if CMC could be linked with other systems, this would require less resource as well as again improving the quality of the information recorded.

> Something that would motivate you to use CMC is an understanding of how your colleagues in the ambulance service are actually accessing and using it.
>
> Clinical Nurse Specialist

This discussion has emphasised the need to create a strong motivation for users to use the system regularly in order that they can build the experience and familiarity with the tool. In relation to the suggested linkage with other systems, following the completion of this research, the CMC team note that more work has already begun in this area[4]. Another of the main factors influencing participants' motivation to use the tool was the presence of clear incentives to use it, as discussed in the following section.

3.5 Incentives for completing CMC records

A range of incentives encouraged the spread of this innovation.

As outlined above, filling in a CMC record can be time consuming, and difficult to master initially, and this can impact its usage among healthcare professionals. Incentives and rewards were explored as part of this case study in terms of the potential impact they might have on users. It was found that a range of incentives were effective in encouraging uptake of CMC, and these took various forms:

- ***Evidence of usage**:* reassurance that CMC is actually being used by LAS incentivised participants to fill in records, as this justified their efforts to complete it.
- ***Evidence of effectiveness***: evidence of CMC creating positive patient outcomes was also strongly motivating.
- ***Incentives for the trust or CCG**:* namely, a Commissioning for Quality and Innovation (CQUIN) framework quality improvement goal or relating to the use of CMC, or its presence on the Quality and Outcomes Framework (QOF) – the reward and incentive programme for GP practices.

> If we know that the information is helping patient outcomes that would be an incentive.
>
> Clinical Nurse Specialist

These incentives are discussed in turn below.

[4] Please note: At the time of writing, Ipsos MORI were informed that CMC's new IT system will offer 'increasing interoperability with GP, community services, acute and urgent care systems, culminating in the delivery of full interoperability allowing users to use the CMC service from within their host systems where appropriate'.

Evidence that individuals and organisations are using CMC incentivised the creation of records.

Participants said that evidence that the records they are creating are being used by LAS or other healthcare professionals was motivating, because it justified their efforts.

Given this, it was claimed that providing evidence of positive patient outcomes as a result of using CMC was another effective incentive.

> When you do get feedback that what you have put on there has guided how another clinical person has behaved and prevented the person from being admitted, that's great.
>
> Clinical Nurse Specialist

Evidence of positive patient outcomes owing to CMC also incentivises continued use of the tool.

Similarly, frontline staff were encouraged to use CMC through seeing evidence that it improves patient care. One of the ways that evidence has been used to good effect is through the release of audit data, for example, showing that the frequency of deaths in the patient's preferred place of care is higher in areas that use CMC than without. However, it is worth noting that not all those interviewed were aware of this information, suggesting that more can be done to spread awareness of supporting evidence more widely.

While some were motivated by the provision of audit data that shows the effectiveness of CMC, others were motivated by more descriptive evidence of the effectiveness of the tool. For example, feedback on specific cases of how records have affected the treatment of a patient were viewed as quite powerful. One specialist palliative care nurse highlighted that they had been using the tool for a while, but following feedback from LAS that one of their patients had been successfully treated at home as per their wishes, they were encouraged to keep using it. In this way, the provision of case studies which showed positive outcomes provided an **emotional incentive** for them to continue using CMC.

The final form of incentive that was discussed was financial incentives for the trust or CCG.

> It's not a great deal of money, around £30 for putting somebody on, but my impression is it hasn't made any difference at all for people putting people on the record.
>
> General Practitioner

Financial incentives can provide enticement for an organisation to take up CMC but have little effect on individuals.

Several participants mentioned their organisation had a Commissioning for Quality and Innovation (CQUIN) framework improvement goal relating to their use of CMC. For example, a specific CQUIN for training junior doctors (FY1 and FY2) to create a CMC record. For some, having CMC as part of a CQUIN was thought to help stimulate an organisation to start using the tool, and ensure that resources are available to allow staff to use it. For example, in the

past CMC has also appeared on the Quality and Outcomes Framework (QOF). As noted by the CMC as it was not part of the 2013-2014 QOF framework, uptake 'trailed off'.

However, where financial incentives had been provided, some thought the value was low. Further, it was claimed that financial incentives are not motivating to individual practitioners who have to do the work in creating the record.

On the whole, financial incentives were felt to be appropriate and helpful, particularly in rewarding organisations for initially adopting the innovation. However some warned against financial incentives because they might provide initial motivation to create the records, but not necessarily high quality ones.

An issue related to this was that communication to the CMC team about having a CQUIN was lacking. This was viewed as a missed opportunity for organisations to be better supported.

To encourage the longer term use of CMC, including keeping staff motivated to use the tool, reassurance that their efforts are helping create improvements for patients seemed to be more effective.

> The knowledge stayed within our team. In retrospect I think that was a bad move as I think that has meant it is a narrow focus of the people that use CMC when in actual fact I think it could have a better benefit for a broader range of people.
>
> Clinical Nurse Specialist

Implications for further improving uptake of Coordinate My Care:

Additional communication to those using CMC, providing evidence of the impact that the system is having on patient outcomes as well as individual events where a patient has benefited as a result, would further incentivise staff to complete

3.6 Targeting of CMC

The effectiveness of CMC would be further improved by spreading its use across different groups beyond palliative care professionals.

Participants noted that palliative care professionals have been a key audience for CMC so far. This was said to be a relevant and appropriate audience, and targeting this group had raised awareness and usage of the tool. The CMC team explained that this has also allowed them to begin building up a network of professionals who can be advocates for CMC, as well as to train others in how to use it.

One suggestion was to target those from more general backgrounds such as GPs and healthcare professionals based in nursing homes. This raises different challenges for convincing professionals of the value of

> I think it would have been better to get other key departments or other key figures within the hospital on board, particularly some departments like A&E and the AMU who would probably find CMC quite useful and then probably disseminate training in those departments.
>
> Clinical Nurse Specialist

the system. For example, as actively dying patients account for a relatively small percentage of a GP's list, some participants suggested they may need extra support to see the value of the tool for their patients.

Another group who could use CMC more was staff who are not palliative care professionals but are specialists treating patients towards the end of life. Some participants said that they have already started this process in their organisations, for example rolling out the tool into other departments from elderly care to heart failure.

Some emphasised that the lack of involvement of other teams can mean that the palliative care team takes responsibility for completing the record, while this would ideally be a shared responsibility across multi-disciplinary teams. This would make CMC more effective in achieving its aims, both through recording more information for patients and increasing use of records.

A practical solution to help achieve the spread of CMC would be for palliative care teams to support other teams, perhaps through the use of cascade training. To enable this, some highlighted the importance of senior leadership in supporting the use of CMC.

However, a potential barrier to spreading CMC beyond palliative care was identified around whether teams not used to advanced care planning may find the nature of the subject difficult and challenging to discuss. Given this, it was suggested that broader work and education with non-palliative care teams around advanced care planning could also help improve the uptake and spread of CMC.

Implications for further improving uptake of Coordinate My Care:

The CMC system could be diffused more widely beyond palliative care professionals in order to increase the number of people completing records and implementing the information saved in the records.

As part of work to encourage wider uptake of CMC it was suggested that better networking between primary and secondary care, and LAS, will be important.

The LAS participant thought that better communication with GP practices was desirable in order to establish whether they use CMC. If this was to be clearly established, it would enable a better understanding of which practices had coverage. It was hoped that this will assist further uptake of CMC in the LAS.

Implications for further improving uptake of Coordinate My Care:

Better communications between primary and secondary care, and LAS, would assist further uptake as paramedics would know when there is a record to access.

Increased patient involvement was also suggested as a way of increasing the demand for CMC.

Participants thought that patients and their families only became aware of the concept of CMC once their healthcare professional had explained it to them. They suggested that creating greater awareness and publicity for CMC in healthcare settings could help to accelerate the dissemination of the innovation. Patients themselves (or their carers) may then raise the issue themselves and take a proactive approach.

Implications for further improving uptake of Coordinate My Care:

If patients and their carers are aware of CMC and its potential benefits, they may ask to be included on the system themselves

Further plans to involve patients and their carers in the CMC process were also mentioned as a future enabler, mainly by providing access to their own CMC record through the use of their mobile phones.

> Patient awareness is only when we bring the subject up of having a CMC record, if it was the other way round as well, if the patient was made aware of this earlier on, they may be able to start thinking about having a care plan and broach the subject themselves.
>
> General Practitioner

4 Linking the findings to the GDHI framework

4 Linking the findings to the GDHI framework

The following tables provide a summary of the findings of the research, relating them to the Global Diffusion of Health Innovation (GDHI) framework (please see Annex A for more information on the framework).

Table 2: A summary of the enablers and cultural dynamics affecting the uptake of CMC

Enablers: facilitating behaviours that can be present at multiple levels and influenced in a short space of time	
Vision and strategy	Underpinned by key healthcare policies – for example the End of Life Care Strategy 2008 and National Gold Standards Framework.
Incentives and reward	Three different types of incentive emerged: evidence that the records being created are being used; evidence of positive patient outcomes; and financial incentives.
Research funding for research, development and diffusion	Not mentioned.
Transparency of research findings and data on demonstrable success	Evidence of the usefulness and efficacy of CMC acts as an incentive to use it, although data are not systematic.
ICT capability	Challenges were identified around: the time taken to complete a record; the user friendliness of the system; problems with accessing the system; and issues around double data entry. Enablers were also mentioned such as the use of swipe cards for quick access.
Specific resources to identify and promote healthcare innovation	Not mentioned.
Communication channels across health care, with outside industries and the public	A need was identified to improve communication across teams and settings.

Development and renewal of healthcare standards and protocols	CMC was said to be useful to help facilitate improvements in care for patients, for example, in settings that are, or wish to become GSF accredited.

Cultural Dynamics: behaviours – organisational and personal – that are essential for rapid diffusion of innovation	
Harnessing efforts of patients and public as co-producers of well-being	Informing patients about CMC may drive demand for it, while there are also plans to enable patients to access their records.
Addressing concerns of healthcare professionals about outcomes and sustainability	Incentives also played a role here – the provision of evidence relating to the effectiveness of the innovation increased use of CMC. Sustainability also linked to ongoing developments with the NHS IT system.
Adapting innovations to suit the local context	Providing greater access to community providers such as GPs and nursing homes. The development of a new service model in the LAS clinical hub.
Identifying and supporting champions who embrace and promote change	Continuing work with palliative care teams to foster champions of the tool within their organisations. Identifying 'super users' who can use cascade training within their organisations.
Creating the time and space for learning and new ways of working	The provision and timing of training was said to be key.
Delayering or eliminating old ways of working	Not mentioned.
Improving the next journey of system transformation	Spreading the use of CMC among current user groups as well as broadening its reach to other settings.

Annex A

Annex A

Underpinning the research: the Global Diffusion of Healthcare Innovation Framework

As mentioned in the body of this report, Ipsos MORI conducted a desk review to look at the available evidence and guidance on the diffusion of healthcare innovation at a national and international level.

The desk review discussed how literature applies to the diffusion of healthcare innovation, specifically in North West London. It aimed to add to an understanding of the local context and the spread and adoption of healthcare innovation on the 'frontline' among ICHP's partner organisations.

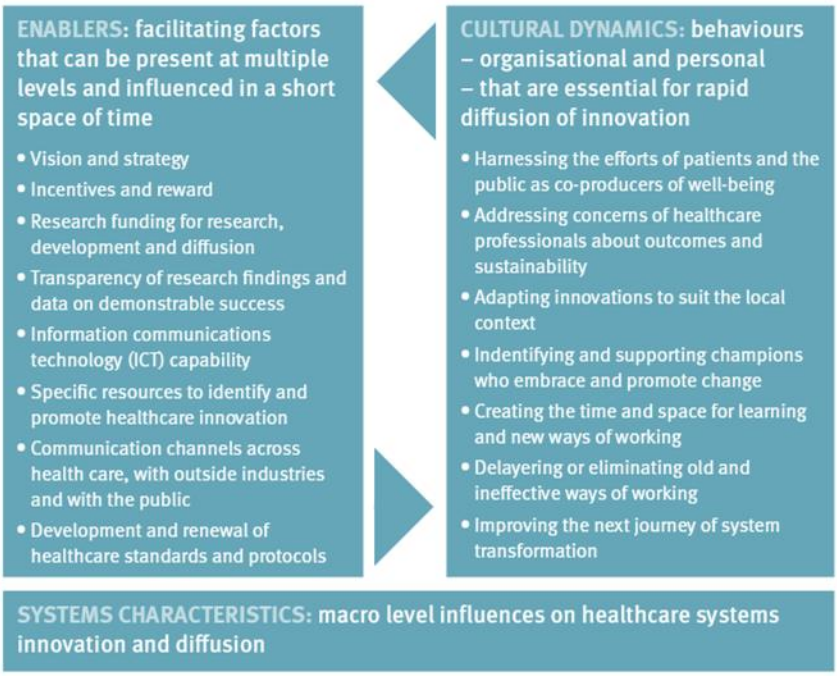
The review recommended that it would be appropriate to use the Global Diffusion of Healthcare Innovation (GDHI) framework to structure the study. The Global Diffusion of Healthcare Innovation (GDHI) report (IGHI 2013[5]), is based on a study of healthcare innovation in eight countries around the world. It provides a conceptual framework of the key influencing factors affecting the spread of healthcare innovation.

The GDHI framework for diffusion of healthcare innovation discusses how innovation and diffusion are affected by three levels of influence. These are defined as 'systems characteristics', 'enablers' and 'cultural dynamics'. A summary of the GDHI framework can be found below.

'Systems characteristics' are institutional and environmental factors which collectively determine the context in which healthcare innovators can either thrive or struggle. 'Enablers' are the specific characteristics that allow and encourage innovation to be facilitated. 'Cultural dynamics' are certain behaviours, beliefs and practices that are necessary to permit the diffusion of innovation at the front line. These enablers, cultural dynamics and systems characteristics identified in the GDHI framework were explored in our primary research.

[5] Institute of Global Health Innovation, (2013), From innovation to transformation, A framework for diffusion of healthcare innovation, Imperial College London

Figure 1 – The Global Diffusion of Healthcare Innovation framework



The desk review identified additional enablers and barriers to the diffusion of healthcare innovation in the literature, which were also explored in the primary research. These included probes around the commissioning structure; the impact of procurement; the existence of a common strategy or vision for the innovation; and the complexity and structure of social networks in supporting the spread and acceptance of new ideas. The discussion guide for the interviews included prompts on these aspects for use by the interviewer where relevant.

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