

# Does research help to inform a district health board's purpose? A qualitative thematic analysis of clinician researcher views

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## ABSTRACT

**AIM:** The outcomes from research should guide the decisions of healthcare providers, policymakers and funders. This study sought the perspectives of senior hospital clinicians and researchers from a New Zealand district health board (DHB).

**METHOD:** A series of interviews asked participants about the purpose and benefits of research to the DHB, and to reflect upon the enablers and barriers they had experienced in conducting and translating research in a DHB context.

**RESULTS:** Three key themes were identified. The first theme suggested research should inform the DHB's purpose. The second theme identified how the general busyness, lack of research funding and the differing motivations of clinicians and business leaders doesn't make it easy to do research in a DHB. The third theme suggested that research barriers could be seen as opportunities. Participants placed importance on an environment that inspires enquiry; that permits staff to stop and question what they do; that overtly informs its community that research is done to improve the delivery of care; that communicates a purposeful research agenda; and that regularly discusses the intersection of research and the purpose of the DHB.

**CONCLUSION:** This study found the absence of an organisation-wide research ethos affected staff engagement in and with research. As a consequence, the effective transfer and translation of knowledge from research was disrupted. Key recommendations were for the DHB to integrate research activity into practice, regularly discuss research evidence and celebrate research achievements.

Research is fundamental to informing and improving healthcare outcomes<sup>1</sup>. A research-enabled environment can engender intellectual curiosity, positive questioning of routine practice and robust research practices that can lift process and practice in general.<sup>2,3</sup> The outcomes from research can also guide healthcare providers', policymakers' and funders' decisions about resource and purchasing at a national, regional and local level.<sup>4,5</sup> Organisationally, a positive research culture can facilitate recruitment and retention of excellent clinicians and generally improve staff attitudes, commitment and values.<sup>6</sup> Importantly, it can

nurture a sense of inter-professional collaboration that is essential to meeting the changing and complex needs of the population.<sup>7-9</sup>

In New Zealand, the Government is the major health funder and supports the health of its people through the provision of a publicly funded, universal healthcare system, with district health boards (DHBs) being the prime recipients of healthcare funding. DHBs are also the prime locality for the conduct of the clinical research activity in New Zealand.<sup>7</sup> Yet, DHBs receive no direct capital provision for research in their annual government funding, and until 2020 DHBs' annual plans to the Minister of Health did not

require consideration of research. Little is known about how DHBs support their staff to manage their research, what things enhance or create barriers to conduct research in a DHB and whether the outcomes of that research are translated to inform practice and support the DHB purpose.

## Aim

The overarching aim of this study was two pronged. Firstly, to explore from a DHB-staff perspective what the enablers and barriers to doing research were. Secondly, to investigate whether the outcomes of a DHB's research activity helped to inform that DHB's purpose of providing best care.

## Method

This descriptive, qualitative research was a part of an explanatory sequential mixed method study that included documentary analysis, survey and a series of exploratory interviews, reported here. A purposeful sample of clinical leaders who are actively researching at a large metropolitan DHB were invited to participate in individual interviews, so we could ascertain their experience of conducting research and translating the outcomes of the research in the DHB context. Participants consented to the process after having read the relevant information sheets outlining the purpose of the study. The study was approved by Auckland University of Technology Ethics Committee (AUTEK), reference 17/204 AUTEK, and the DHB's locality approval was sought and given.

The semi-structured interview format explored the perceived enablers and barriers. Participants were asked: Do they consider that locally conducted research helped to inform the DHB's purpose? How had the DHB supported them in their research? Had they encountered any barriers? And what was their experience of translating the findings of research to practice? The interviews were conducted face to face at a pre-arranged time and place suited to the interviewee and were voice recorded. The recordings were transcribed verbatim, and participants were offered their transcripts to review. Only a couple of minor clarifications, which did not change the overall context of the interviews, were required.

The interviews were thematically analysed utilising a six-stage reflexive thematic analysis process described by Braun and Clarke.<sup>10</sup> This comprised listening to the recorded interviews multiple times to appreciate the nuanced tones, and reading the verbatim transcripts for documentary accuracy, before embarking on a recursive process of coding to capture the core semantics. In this process a series of experiential themes were inductively developed and reported in relation to the overarching research question.

## Results

Eight senior clinicians recognised as research leaders were invited to reflect on their experience. Six responded to the invitation, three men and three women, each with decades of experience conducting research in a hospital context. The interviewees represented the broad disciplines of general medicine, surgery, public health and psychiatry. Two of the interviewees were also recognised for their research into indigenous health and inequity. All but one had been recipients of, or were key members of, research collaborations that had received New Zealand Health Research Council (HRC) funding. Two had significant experience conducting industry-sponsored clinical trials in the DHB context. Additionally, all had either active or honorary co-appointments with universities in the region.

Three key themes were developed from the data. The first described the participants' universal opinion that research should help to inform the DHB's purpose. The second theme was struck from a comment that, while research should inform the purpose of the DHB, the DHB doesn't make this easy. The final theme came from the interviewees' largely optimistic reference to their being "opportunities" rather than barriers for the DHB to support robust research and knowledge creation to inform its purpose. Each theme comprised a series of sub-themes.

### Theme 1: research should inform the DHB's purpose

The interview participants generally concurred that research should inform the DHB's purpose (Theme 1), but that the DHB could only do this where ethically and meth-

odologically sound research was conducted and was translated to practice. A series of sub-themes emanated from the interviewee dialogue.

In the first sub-theme, interview participants defined the importance of enabling a culture of questioning within the organisation, which “makes a big difference to morale” and means “that we don’t just do things because we’ve always done it, that we’re interested in advancing knowledge to deliver better care”. They indicated that while pockets of a research ethos exist in the DHB, that ethos tended to be “enthusiast driven”. Participants felt the DHB could use its available resources to research more effectively and more prescriptively. In particular, they said the DHB should use the relatively untapped resource of routinely collected data focussed on specific health issues, and more generally that research should inform the DHB’s purpose of improving the broader social determinants that affect health equity.

In the discussion that led to the second sub-theme, interviewees emphasised the importance for research to always be inclusive and real world, where researchers “work together with consumers... having consumers raising the [research] questions” because this “leaves people in the organisation confident that the results really are results we should listen to”. They considered the outcomes of contextually relevant research to be more likely to provide decision-makers with the confidence that the associated costs of translation to practice would meet the organisation’s purpose.

The third sub-theme reflected on the participants’ views that DHB research should be conducted collaboratively and/or in partnership with external agencies or bodies. The interview participants universally considered that the breaking down of departmental silos to embrace interdisciplinary and cross-sectoral research collaborations was needed to support the DHB’s research capacity and capability. One interviewee noted her own research relationships with universities “bring[s] in people with particular expertise around design, around models of inquiry, around analysis”, who are not routinely available in a DHB.

Another commented that more clinicians are thinking that “it’s quite cool to work with other [non-health] people” who bring their diverse and complementary perspectives, skills and training. Moreover, research alliances with universities means that “we also bring in some young talent through people who are in training” and thereby foster the DHB’s future workforce. Participants did concede that such collaborations aren’t straightforward and can be complicated by the need for additional time and effort to nurture and maintain the relationships.

In the final sub-theme, the interview participants had a collective view that knowledge creation from research must be disseminated to be translated, and that the intent to disseminate and translate must be planned for from the beginning. Moreover, translation should be easier where “the research [was conducted] in the environment it’s going to be translated into” because the end users will have had the opportunity to “gauge [whether] this [is] going to be something that’s going to be useful”. One participant described “researching so other people will know”: “I try and involve the caregivers and the community [clinicians] so that they... [are] involved and know about what was going on. That makes a big difference”. Participants agreed that, for research to inform the DHB’s purpose, the DHB needed to encourage greater communication about research plans, create opportunities to share the outcomes and overtly celebrate the translation of research into practices that inform the DHB’s purpose when it occurs.

## Theme 2: the DHB environment doesn’t make it easy

In Theme 2 participants provided forthright opinions as to why research in a DHB is not easy. Four sub-themes explored the barriers encountered. The first reflected on hospital busyness, which sees research relegated rather than integrated in the organisational ethos. This issue is aggravated by a tendency for staff to resist changes in their routine, and by business processes that don’t easily accommodate timely translation to practice. The overall theme was encapsulated in one participant’s lament that “the DHB doesn’t make it easy”.

The first sub-theme also described the daily grind of hospital busyness being

a barrier to research. A participant commented, “it’s very difficult for people to prioritise doing something other than their job”, especially where colleagues perceive research as a distraction that doesn’t directly help to address the immediate issue of “queues of patients at the door”. The day-to-day busyness on the frontline of hospital operations impedes clinicians’ ability to accommodate time for research. One participant typified the comments by saying, “you have to do [research] for the love of it more than anything else, and you have to sort of find the time for it and make it an important issue for yourself”. Another noted, “There’s plenty of interest from clinicians [in research]... if they had a bit of brain space and a bit of kind of protected time”.

Translation of new evidence-based knowledge to practice should be the cornerstone of healthcare policy and process. However, the second sub-theme described a massive gap between research and clinical practice (a ‘know–do gap’).<sup>11,12</sup> One participant commented that “in terms of every day clinical practice I don’t think there’s an awful lot going on to really try and encourage clinicians to be thinking about putting research into practice”. Others referred to the cause being a general resistance to change, which one participant described as “partly the conservative nature of our training... and partly it’s just simpler to keep doing the way we’ve always done because everyone understands their role”. Change is seen as “just more work for people... and you have to spend quite a bit of time initially to figure them out before they become easier”.

To overcome the know–do gap in research, participants considered the potential for research translation must be nurtured right from the start, when the research question is being developed. This ensures the managers and clinical leaders approving the conduct of the research locally can “gauge [that] this is something that’s going to be useful... [because] the question itself is framed by the service”. The purpose of the research should be well communicated and involve the staff who may be affected, so that any practice change in the future will not be unfamiliar.

The third sub-theme addressed a barrier created by DHB business processes that

don’t easily accommodate research. Even where contextually relevant and well communicated research has provided the highest-quality evidence for change, translation can still be stalled by the business process. Participants recognised the restrictions imposed by the government-funding model, which frequently constrains the agility of business decision-making. However, they were universally critical of the inflexibility they had experienced when attempting to translate the outcomes of research. One account illustrated the frustration:

*“We developed a [research] programme here with our people, and we trialled it here with our people, and the decision-makers were involved in that all the way through, [but] now trying to get it implemented we’ve just been going around and around the traps! ... we’ve got to go through the usual big business case process, which is quite time intensive, resource intensive, nobody’s really sure who should be writing it, who’s championing it...”*

In the final sub-theme, participants acknowledged that “not everything is bad though”. Although conducting research in the DHB was not easy for the various reasons outlined, participants noted there are some purposeful pockets of positive action to support research. Participants noted that the DHB has a research office “that you can kind of bounce ideas off or [access] some specific skills”. Another commented on the research office’s coordination of external grant applications “... getting all the right bits together”. One participant remarked, “the most important things have been management’s kind of acceptance or sometimes even active encouragement of research as something I do”.

### Theme 3: opportunities, not barriers

In Theme 3 participants focussed on the opportunities moving forward, where research can be an integral function of the DHB. Two sub-themes detailed how the DHB should direct its efforts to enable research to better inform its purpose. Firstly, through overt communication that research is “what

we do to improve the care we deliver. And secondly, by providing competitive seed funding for research.

The first sub-theme centred on what was perceived as a missed opportunity for the DHB to overtly inform its community that “research is what we do” to deliver the best care for everyone. One participant articulated the point best: “I think if we made [research] more of a deliberate part of what we do... it’s not [seen as] our core business and so we don’t tell patients necessarily this is what we do... We don’t put up anything about results anywhere either, even to our own staff. We’re not very good at saying... there’s research going on all the time and its purpose is to improve services for our population”.

The second sub-theme discussed the importance of a purposeful research budget. Interviewees appreciated that the funding the DHB receives from the Government is limited, and that the Government looks to the HRC to manage its investment in health research. However, they vociferously considered that the government-funding model is wrong, observing in other organisations, both public and private, that a “percentage of their revenue stream is applied to research and development... But in health... it’s not there”. Interviewees saw the opportunity for the DHB to target research partnerships for bigger projects, and to provide a deliberate competitive research fund for small research projects, where seeking external funding would not be cost or resource effective. Interviewees felt if the DHB “can get the ball rolling and provide the seed structure and the facilities to allow [research] to grow then it will grow and be self-supporting”. Moreover, such a fund would allow its staff researchers to get the track records needed to apply successfully for the hotly contested HRC and similar types of awards.

## Discussion

This interview series has provided insight into how a variety of organisational factors influenced staff capacity and capability engagement with research.

The executive summary of this DHB’s research strategy clearly intended for the DHB to build on its research achievements

and become a centre of research excellence to support the organisation’s purpose. The New Zealand Health Research Strategy 2017–2027<sup>7</sup> likewise supports such a goal, stating that a culture of excellence in research is needed to improve the health and wellbeing of patients and communities. Similarly, the World Health Organization (WHO) has stated that “universal health coverage cannot be achieved without evidence from research”, and that to ensure the relevance of research findings to local context, all nations should both be involved as producers and consumers of research.<sup>13</sup>

Consistent with the literature, participants in this study considered that research was made difficult by the reality of busyness<sup>9,14–16</sup> and business process. Differing agendas and timelines exist between the hospital business decision makers, who must prioritise their decisions to the challenges of their business reality,<sup>17–19</sup> and the hospital clinicians, who focus on what they know can make a difference for their patients right now.<sup>3</sup> Participants in this study noted that research is frequently left to the enthusiasts to conduct on top of their business-as-usual activities. This can lead to clinicians being apathetic towards engagement in and with research, which won’t be simply overcome by the implementation of systems to support research.<sup>20</sup> Participants considered the inherent mismatch of intents between the organisation’s administrators and clinicians remains a key barrier to the conduct of research. It was also seen to impact upon whether the business accepts the cost–benefit of change, and also the effective translation of research outcomes into practice or policy,<sup>14,21</sup> where effective dissemination of the findings is dependent upon the time other health professionals have to be aware of, agree to, adopt and adhere to a practice or policy change.<sup>22</sup>

Interview participants in this study concurred that the key to overcome these barriers is an overt organisational research agenda supported by proactive and early engagement of the users of the ensuing knowledge. To this end, they considered that the DHB’s executive must deliberately engage with its staff (clinical and business) and potential research collaborators, to align their research questions to the DHB’s priority healthcare issues. A whole-of-organ-

isation approach would integrate research deeper within the DHB's core activities and thereby enable the effective transfer and translation of research knowledge that is integral to the DHB's purpose.

A potential limitation of this study was that interviewees were from the medical profession, and this may preclude generalisation across other health professions. However, the literature suggests nurses similarly describe a lack in the time, training, exposure to and support for research as inhibitors to their engagement in the research activities.<sup>23-27</sup> Likewise, allied health professionals, and public health and policy evaluation professionals, report comparable barriers, with the latter noting the additional difficulties of navigating the

conceptual and motivational divide between clinical researchers and public health and policy researchers.<sup>28,29</sup>

## Conclusion

This study has provided insight into how organisational factors can influence engagement in and with research and thereby negatively impact the potential for research to inform a DHB's purpose. These factors are all modifiable influences. The themes offer a direction for the DHB's future research strategy, where research activity is integrated into practice, where research evidence is discussed and where research achievements are celebrated. The findings from this study will likely resonate across New Zealand's DHB landscape.

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### Competing interests

Dr McKenna reports grants from Pacific Health Research Davis Award: HRC, grants from New Zealand Law Foundation, grants from Department of Corrections, grants from Ministry of Health, grants from Marsden Foundation Fund and grants from Borrin Foundation, all outside the submitted work, and that they have a joint professorial position with the Waitemata District Health Board as a Professor in Forensic Mental Health.

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