

Independent evaluation of the Dorset Vanguard Programme



Using the Normalisation Process Theory [NPT] framework to evaluate One Dorset Pathology [ODP]

Author: Dr Catherine Brigitte Matheson-Monnet
Senior Research Fellow

Date: 5 June 2018

Evaluation team

Dr Catherine B Matheson Monnet, Senior Research Fellow, Centre for Implementation Science, University of Southampton (Principal Investigator).

Dr Catherine B Matheson-Monnet undertook the literature review, designed the evaluation plan, data collection instruments, carried out the fieldwork, analysed data and wrote the evaluation report.

Correspondence

Dr Catherine B Matheson-Monnet, Senior Research Fellow, Centre for implementation Science, University of Southampton, Southampton SO17 1BJ, Faculty of Health Sciences - Building 67/E2007
Mobile telephone: 07469 884267 Email: c.b.matheson@soton.ac.uk

Disclaimer

This report presents the findings of an independent evaluation comprising a survey of ODP staff and 12 face to face interviews with a balanced sample of staff. The findings and interpretations in this report are those of the author and do not necessarily represent the views of ODP or Developing One NHS in Dorset.

Acknowledgement

Many thanks to those who completed the survey and those who took part in face to face interviews. Thank you also to Sally-Ann Webb for her help and support and to Samuel Opkosin and Sandy Bruin for circulating the survey and booking rooms for interviews when required. Thank you to those participants who provided helpful background information in relation to the progress of ODP. Many thanks to Hazel Orriss for proof reading and formatting this report within the overall report.

Contents

1	Background.....	4
2	Aims and Methods.....	5
3	Key findings.....	6
3.1	Context	6
3.2	Drivers and barriers to implementation of the ODP joint venture for shared services	7
3.3	How the ODP shared vision has been understood and implemented.....	9
3.4	Extent to which better collaborative working has developed or been enabled	11
4	Conclusion.....	12
5	Benefits and limitations	13
6	Recommendations.....	14
	References.....	14

1. Background

This report describes the findings of an independent evaluation of One Dorset Pathology [ODP], one of the 10 workstreams of Developing One NHS in Dorset Vanguard.¹ ODP can be conceptualised as collaborative journey towards a first-class integrated pathology service for the whole of Dorset and implementing a clinically led joint venture to improve both quality and efficiency supported by appropriate IT [a single Laboratory Information Management System], equipment [a Managed Equipment Services], pathology hubs and Essential Service Laboratories, and staffing skill mix. The ODP joint venture partnership between Dorset County Hospital [DCH], Poole Hospital [PH] and The Royal Bournemouth and Christchurch Hospitals [RBCH] aims to provide clinicians, patients and carers with timely diagnostic information to help them make informed decisions and to ensure a consistent and high standard of service across Dorset in which efficiency in the use of resources will be maximised and staff able to develop to their full potential and work to deliver continuous service improvement.²

The ODP journey takes place in a context of an increasing and ageing population and the expected increase in the demand for pathology services, DCH, PH and RBCH having been involved in several previous but unsuccessful attempts at collaborations to restructure the pathology services, a merger between RBCH and PH being prohibited by the Competition Commission³ and the challenges set out by NHS Dorset Clinical Commissioning Group [CCG] Clinical Services Review (CSR).⁴ Amidst this challenging landscape, a key driver for ODP was the Carter Report (2016) on unwarranted variations in operational productivity and performance in English NHS acute hospitals which recommended standardised procedures, more transparency and closer working with neighbouring NHS trusts in order to achieve the necessary efficiency improvements.⁵

Guided by the approved Strategic Outline Case [SOC]⁶ and the considered approach of pathology initiatives at both local and national levels (value for money, affordability and feasibility) and informed by organisational data from the partners involved and by work to improve pathology services previously commissioned by the Acute Trusts in Dorset, the Outline Business Case [OBC] articulated the case for a 'contractual joint venture' approved by the ESG in July 2017 and by three Hospital Trusts in October 2017. Thereafter, sub-groups began to work on the procurements of both a single Laboratory Information Management System (LIMS) and a Managed Equipment Services (MES) with specialty-specific reconfiguration groups of laboratory and medical staff (Blood sciences, Cellular Pathology and Microbiology) looking at Staffing and Skill mix and Estates requirements (including developing model footprints for hubs and Essential Service Laboratories).

¹Developing One NHS in Dorset is one of 50 vanguards across England selected to take a lead on the development of 'new care models'. It is one of the few Acute Care Collaboration vanguard site working with partners to make the most of NHS local resources now and in the future and is the joint response to the challenges set out in the commissioner-led NHS Dorset CCG Clinical Services Review (CSR). See <http://www.dorsetccg.nhs.uk/aboutus/vanguard.htm> and <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/vanguards/>

²See <http://www.dorsetccg.nhs.uk/aboutus/vanguard.htm>

³<https://www.health.org.uk/publication/mergers-nhs>

⁴<https://www.dorsetvision.nhs.uk/about/csr/>

⁵https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

⁶In the second quarter of 2016, the Vanguard's Executive Steering Group (ESG) Programme Board and the three Hospital Trust Boards approved the Strategic Outline Case [SOC] to improve pathology services in Dorset.

By the end of December 2017, the LIMS specification was complete and although the initial approach was to procure from a framework, in order to get best value for money, it was decided to progress with a fast-tracked competitive tender.

In early January 2018, the ODP Head of Service produced a document updating on progress and explaining the reasons for delays in the timetable for change (the LIMS and MES were to have been place by July 2018 and September 2018, respectively). Delays were due in part to interaction with the NHS Improvement proposal for 29 national pathology networks⁷ in September 2017 with ODP linked with the “South 6” network.⁸ Since then, the ODP leadership had been engaging with other Trusts within South 6 and had agreement in principle that they would adopt the system selected by ODP in a phased approach.

The update underlined that although the certain key roles (e.g. some medical staff and the Quality Manager role) were now being recruited on a One Dorset Pathology basis, the preferred organisational structure of ODP which had been for a contractual joint venture for shared services would be revisited and agreed upon during the progression of the Full Business Case [FBC].

2. Evaluation Aims and Methods

It is clear from the context that, although the new Head of Service and new clinical leads have been progressing the development of the ODP joint venture shared service, ODP itself was not going to be in place, least of all fully implemented, when the independent evaluation would take place.

At first evaluation meeting in early June 2017, the aims of the independent evaluation or evaluation questions were agreed:

- 1) to find out how the ODP shared vision been understood and implemented
- 2) to gain a better understanding of the main drivers and barriers to the implementation of ODP (the new integrated organisational framework joint venture for shared services)
- 3) to ascertain the extent to which better collaborative working has developed or been enabled

At second evaluation meeting in late August 2017 with the ODP leadership team, it was agreed to use the validated Normalisation Process Theory [NPT] framework⁹ to inform a mixed-methods evaluation:

1. **Sense-making** or mobilisation of a practice or new system [how it is conceptualised and held together in action]
2. Cognitive **participation** in a practice or in a new system [how team members decide to engage and actually engage and extent of ‘buy in’]
3. Collective **action** or enacting a practice or a new system [how the work is organised and activities structured and constrained]
4. Reflexive **monitoring** or the appraisal of a practice or of a new system [how it is appraised the effects of appraisal i.e. how it is understood and what changes can be made to improve the practice or new system]

⁷ See <https://improvement.nhs.uk/resources/pathology-networks/> for further information.

⁸ Other services in South 6 are: Hampshire Hospitals, Isle of Wight, Portsmouth, Salisbury and Southampton.

⁹ <http://www.normalizationprocess.org>

The evaluation surveyed all clinical and medical staff (n=350 approximately). Face-to-face follow-up semi-structured interviews (n=12) were held with as balanced and as representative as possible a sample of workforce in terms of AfC [Agenda for Change] grades, types of work, hospitals and pathology specialties to provide insights into how ODP was perceived and understood. Interviewees were selected among those who volunteered to be interviewed. Documentary analysis of the progress of ODP was used to contextualise the empirical findings.

3. Key Findings

3.1. Context

The OBC specified that a detailed timetable for Benefits Realisation would be developed as part of the FBC, including how each benefit would be delivered, responsibilities for delivery and required countermeasures to minimise risks associated with delivery.¹⁰ An initial Benefits Realisation document¹¹ described the ODP vision of a first-class pathology service for Dorset by way of a new single contractual joint venture for shared services. At the time of the evaluation (end of November 2017 to mid-March 2018), ODP was not yet in place and neither were the activities and system level changes articulated in the initial Benefits Realisation Document.

The ODP joint venture for shared services was slowed down by the proposal from NHS Improvement (NHSI), who are leading the implementation of the recommendations of the 2016 Carter Review (Gov.UK, 2016) to create 29 pathology consolidation networks across England to generate substantial savings. ODP have liaised with NHSI in relation to the proposed South 6 Hub, but have agreed that they are still forging ahead with ODP.

3.2. Drivers and barriers to implementation of the ODP joint venture for shared services

The evaluation identified a number of barriers to both the ODP joint venture for shared services vision and its future implementation.

Drivers

IT and equipment

It was agreed that a new seamless or joined up and up to date LIMS and a new MES for the whole of Dorset was needed to ensure that in future pathology results would be directly accessible.

¹⁰ See OBC Section 1.7.2. Benefits realisation and risk management p15

¹¹ a) New pan-Dorset Laboratory Information Management System (LIMS) [IT] [in place by July/August 2018]; b) Introduction of new pan-Dorset Managed Equipment Service (MES) contracts for major analysis equipment [in place by September 2018] c) Establishment of a new single shared service organisation for pathology [joint venture for shared services] d) Development of a single clinical and management leadership structure; e) Standardisation of operating procedures and training; f) Standardisation of test protocols and reference ranges; g) Implementation of a 'hub' model, whereby non-urgent tests are processed at one or more specialist labs, where operationally and economically beneficial

Standardising procedures and processes

It made sense to consolidate and make the pathology service to make it more resilient in relation to regulatory issues and standardising procedures. Improvements in transportation of samples should help as should repatriating 'send aways'.

More collaboration and co-ordination between DCH, PH and RBCH

Patient care will benefit if PH and RBH become one department. PH and RBCH already work as one department in histopathology. There has been greater collaboration between RBCH and DCH in relation to standardising procedures and quality issues in one specialism.

ODP leadership: furthest we have gone to restructure pathology

The main view of respondents and interviewees was that ODP would be worthwhile if done right and if set up correctly (the meaning of which could vary).

Barriers

Complicated contextual issues

The relationship PH and BH and the geographical East/West division were seen as historically problematic. A proposed merger PH and RBCH was blocked by the Competition Commission in 2013. The NHS Improvement proposal that ODP be linked to the 'South 6' Hub led to the already frustratingly slow ODP process grinding to a halt for months.

All previous attempts at restructuring pathology in Dorset had come to nothing

Over the last two decades all (costly) attempts at restructuring pathology in Dorset had ultimately been unsuccessful. Various attempts at introducing integrated pathology systems in England had encountered problems in the long term and not delivered the expected savings.

Unequal access to resources

Resources and organisational structures across ODP varied enormously, and could be inappropriately protected at each site with small fiefdoms being marked out. Recent expenditure in 2017 on laboratory equipment was a waste of money as now the premises will have to be vacated and new equipment purchased on a Dorset-wide basis.

ODP will cost a lot of money without improving quality and efficiency

There were concerns about unrealistic assumptions about anticipated savings and a lack of reassurance that quality had been sufficiently considered.

Limited communications

Just over half of respondents and interviewees had read pathology updates in Developing One NHS in Dorset *Staff Newsletters* and just under half had attended information workshops and stakeholder days. It was felt that only limited updates had been circulated and questions not answered at workshops and a number of ODP meetings with the leadership had been cancelled and rescheduled.

Feeling excluded from ODP process

Most interviewees bemoaned the lack of direct communication and meaningful consultation and felt excluded from the process and in some instances angry at being misrepresented in documentation and at having been misled about the process. There was a lack of understanding of issues from the perspective and concerns from the 'shop floor'. All sub-groups and with the exception of some Managers felt excluded from the ODP process. There was a perception that Managers were involved in the decision-making process. Not enough information was fed back to all staff and more staff should be involved in the decision making process.

Uncertainty of organisational ODP structure

Staff don't feel valued as ODP team members and the organisational structure of the ODP joint venture is still very uncertain with many decisions still having to be made.

Not enough clarity on 'how staff would fit in'

This was causing anxiety about job security: a fear of redundancy; a fear that roles would be changed gradually to something not fulfilling; a fear of those not qualified taking over technical work; a fear of having to regularly travel to the West or the East with changing jobs preferable to disruption in work and family life. Some Managers worried that highly skilled staff with embedded knowledge [tacit knowledge or know how] would leave if their conditions of service deteriorated to unacceptable levels and that they were not easily replaceable, because training new staff to the required standard took months rather than days.

Much will be asked of staff in context of already heavy workload

Conflicting demands were difficult to reconcile without working long hours and there was a fear that ODP would require extra workload in a context of an already heavy workload.

Working relationships likely to be disrupted

It was unclear what effect ODP would have on working patterns/relationships, but it was expected that relationships at work would be negatively rather than positively impacted and even that ODP had already disrupted working relationships. It was pointed out that disruption was likely if staff contracts were taken over by one site, the host hospital will boast it has taken over the other sites. This is already happening with staff at RBGH already boasting about how they are taking over PH.

Impact of ODP on routine practice not valued

Respondents agreed [58% agreed and 42% disagreed] that they valued what ODP was trying to achieve, but disagreed [38% agree and 62% disagree] that they valued the impact of ODP and disagreed that they valued the effect of ODP on their routine practice [42% agreed and 58% disagreed]. On the one hand, it was pointed out that it was difficult to value something about which there was not enough information, on the other hand, not enough information led to negative rather than positive perceptions of ODP and its impact or anticipated impact.

Resistance to change

Some interviewees said that change brings discontent and it is to be expected that the default position is often that people are against change, because it takes them out of their comfort zone and that past experience has shown many post holders struggle to accept change outside of their own pre-conceptions on what "needs to happen".

ODP leadership: not consistent and not effective

The leadership was perceived as well-meaning, but neither effective nor consistent, not driving things forward and involving others in an effective way. It was unable to prevent senior staff protecting their own jobs and blocking progress in a process that had been frustratingly slow.

Summary of barriers and drivers

Barriers	Drivers
<ul style="list-style-type: none"> <input type="checkbox"/> Complicated contextual historical issues <input type="checkbox"/> All previous attempts at restructuring pathology in Dorset have come to nothing] <input type="checkbox"/> Unequal access to resources <input type="checkbox"/> ODP will cost a lot of money without improving quality and efficiency <input type="checkbox"/> Limited communications <input type="checkbox"/> Feeling excluded from the ODP process <input type="checkbox"/> Uncertainty of organisational ODP structure <input type="checkbox"/> Not enough clarity on 'how staff would fit in' <input type="checkbox"/> Working relationships likely to be disrupted <input type="checkbox"/> Much will be asked of staff in a context of already heavy workload <input type="checkbox"/> Impact of ODP on routine practice not valued <input type="checkbox"/> Resistance to change <input type="checkbox"/> ODP leadership: not consistent and not effective 	<ul style="list-style-type: none"> <input type="checkbox"/> IT and equipment <input type="checkbox"/> Standardising procedures and processes <input type="checkbox"/> More collaboration and co-ordination between DCH, PH and RBCH <input type="checkbox"/> ODP Leadership: furthest Dorset have ever gone to successfully restructure pathology

3.3. How the ODP shared vision has been understood and implemented

Sense making

Respondents disagreed they made sense of the various ODP roles and responsibilities [38% agree and 62% disagree] with only Managers and SBMS agreeing. Respondents agreed they had a good knowledge and understanding of the purpose of ODP [51% agreed and 48% disagreed] with the BMS disagreeing. Respondents agreed that they valued what ODP was trying to achieve [58% agree and 42% disagree] with the BMS and the Consultants disagreeing.

There was little evidence of a high level of coherence or sense making associated with a clear and explicit shared vision. The main goal of ODP was 'saving money' which might compromise rather than improve quality. If quality was improved, it would be at considerable anticipated cost. ODP was

understood as disruptive. On the one hand, the disruption was worth it because the quality of services would be enhanced. On the other hand, the disruption was seen as a source of anxiety and frustration because of a lack of a shared understanding of how aims, purpose and benefit of ODP and various roles and responsibilities would impact on daily routine and future job roles.

Participation

Respondents agreed that they were open and willing to work in new ways to achieve the goals of ODP [74% agree and 26% disagree]. They agreed that ODP would impact on routine practice [86% agreed and 14% disagreed] but disagreed that they valued its impact [38% agree and 62% disagree] with only the Managers agreeing. Respondents disagreed that key individuals were driving ODP forward and were getting others involved [41% agree and 59% disagree] with only Managers and MLAs agreeing.

Just under half the interviewees agreed that it was the furthest Dorset had got to in terms of successfully restructuring pathology and that ODP was more likely to succeed than previous attempts at restructuring pathology because the leadership was better and ODP was necessary to avoid duplication of work and standardise processes. On the other hand, the leadership was perceived as well-meaning, but neither effective nor consistent. It had not sufficiently considered all areas and specialisms and should spend some time 'on the shop floor' understanding current issues before planning future changes. Goals were not transparent and senior management and consultants were protecting both their own jobs and own specialisms by blocking forward movement.

Action

Apart from MLAs, there was disagreement that changes in working practices linked to ODP would be easily integrated into existing work [30% agree and 70% disagree]. Respondents disagreed that work would be appropriately allocated to staff who have the required skills [40% agree and 60% disagree] but SBMS and Managers agreed. Respondents disagreed that training [23% agreed and 77% disagreed] and resources [24% agreed and 76% disagreed] were sufficient and that there was adequate support from the ODP management team or leadership [38% agreed and 62% disagreed]. There was a disagreement that ODP would not disrupt working relationships [2.9] [24% agree and 76% disagree]. However, there was agreement that trust was maintained in the work expertise of colleagues [7.2] [76% agreed and 24% disagreed].

Apart from the Laboratory Information System Management [LIMS] and Managed Equipment Services [MES] which all agreed would be beneficial, ODP would negatively impact on routine practice. Although the structure of ODP was still very uncertain since many decisions still had to be made, a certainty was that much would be asked of all staff in future (who already had a heavy workload). There was also concerns that those not qualified might be taking over technical work and that highly skilled staff with embedded knowledge would leave, for example if their conditions of service deteriorate to unacceptable levels or if they had to regularly travel East or West.

Reflexive monitoring

Respondents disagreed that they had access to information about the impact of ODP [39% agreed and 61% disagreed], but the Managers agreed. Respondents disagreed that they had the opportunity to modify how they worked with ODP [25% agreed and 75% disagreed], but Managers agreed. Respondents disagreed that they valued the effect of ODP on their routine practice [42% agreed and 58% disagreed], but both Managers and MLAs agreed. Respondents agreed that they believed that ODP was worthwhile [58% agreed and 42% disagreed], but BMS and Consultants disagreed. Respondents disagreed that their colleagues believed that ODP was worthwhile [22% agreed and 78% disagreed], but Managers were not sure.

Not knowing enough about the structure of ODP and how existing staff would fit in was a major concern causing much anxiety. A majority discourse was that any benefit would be at a considerable anticipated cost. A minority discourse was that disruption and hurdles on the way would be worthwhile in the end. Respondents cannot make sense, or have not signed up to ODP and believe that they will not be able to enact it in a way that works for them or they do not have enough information to meaningfully assess its effects and its value (May and Finch, 2009).

3.4. Extent to which better collaborative working has developed or been enabled

Valued as team members

Respondents from all sub-groups disagreed that they felt valued as ODP team members [28% agreed and 72% disagreed]. Slow progress uncertainty around ODP generated much anxiety and frustration.

Goals achieved

Three of the four ODP goals were likely to be achieved:

- ❑ ODP will achieve a consistent and high standard of service across Dorset (harmonised reporting, procedures, training and operational governance all aligned across Dorset) [62% agreed]
- ❑ ODP will ensure and maximise efficiency in the use of resource (with tests currently referred outside the region repatriated and turnaround times reduced) [52% agreed]
- ❑ Staff will develop to their full potential and work to deliver continuous service improvement [52% agreed]
- ❑ ODP will provide clinicians, patients and carers with timely diagnostic information to help them make informed decisions (improved quality and patient safety) [41% agreed]

A greater Dorset-wide collaboration and co-ordination

Interviewees agreed in principle that ODP would provide an opportunity for colleagues across PH, RBCH and DCH to work more collaboratively and more efficiently. This greater amount of co-operation and co-ordination i.e. integration would be beneficial, especially in relation to the LIMS, MES and regulatory issues and standardising procedures (reporting, training and operational governance). However, they pointed out that this would require necessary and sufficient conditions such more focus on quality and not bring about redundancies or having to re-apply for posts. Despite documentation underlining an intention to minimise redundancies, most interviewees believed that saving money could only mean redundancies or re-applying for jobs.

Some areas/specialisms have already been collaborating at the level of Dorset

Some Managers said they had been working collaboratively to achieve Dorset wide collaboration for years or said that their role already provided a service for DCH, PH and RBCH. Other said they had been working with colleagues [from the same specialism] in other sites to standardise operational procedures and quality control. Histopathology had been working within one management structure between PH and RBCH (overall clinical director, unified procedures and single pool of consultants reporting at sub-specialist level).

Integrated collaboration and co-operation not yet achievable on a Dorset-wide basis

Managers and consultants acknowledged that recently they had been increasingly collaborating across Dorset and that sometimes it was easier to work with colleagues in Dorchester than those in the Poole/Bournemouth area but that the main issue seemed to be merging Poole and RBH 'Pathology'. However, a Pan-Dorset co-operation and co-ordination was not yet achievable and there was a long way to go to achieve this. Some interviewees hoped that the process of change would pay attention to concerns about quality and adopt a more inclusive approach.

4. Conclusion

At the time of the evaluation (end of November 2017 to mid-March 2018), ODP was not yet in place and hence the activities of the Benefits Realisation Document and associated system level changes had not been implemented and the FBC had not been produced, least of all agreed by the ESG and by the Boards of DCH, PH and RBCH.

Nonetheless, progress had been made. After a working group completed the specification for the procurement for the LIMS, it was put out to tender at the end of January 2018. Another working group is completing the specification for the procurement of the MES. Certain key roles (e.g. some medical staff and Quality Manager roles) were being recruited on an ODP basis as part of a single clinical, medical and managerial structure. The Blood Sciences and the Cellular Pathology hubs had not been finalised. A specialty-specific reconfiguration groups of laboratory and medical staff was looking at Staffing and Skill mix and Estates requirements (including developing model footprints for hubs and Essential Service Laboratories). The structure of ODP or the content of the FBC including revisiting the OBC recommendation of a hosted contractual joint venture, all of which would have to be agreed by ESG and DCH, PH and RBCH Trust Boards were a work in progress and still to be finalised and agreed by ESG and DCH, PH and RBCH Trust Boards.

The evaluation focussed on how the process of the progression of the ODP vision (from SBC to OBC and then FBC) was conceptualised, the drivers and barriers to the implementation of the ODP vision and the extent to which better collaborative working had developed or been enabled.

The evaluation identified the following key drivers: IT and equipment; standardising procedures and processes; more collaboration and co-ordination between DCH, PH and RBCH; due to the ODP Leadership, it was the furthest Dorset had ever gone to successfully restructure pathology.

The evaluation identified the following key barriers: complicated contextual historical issues; all previous attempts at restructuring pathology in Dorset have come to nothing; unequal access to resources; ODP would cost a lot of money without improving quality and efficiency; limited

communications; feeling excluded from the ODP process; uncertainty of organisational ODP structure; not enough clarity on 'how staff would fit in'; working relationships likely to be disrupted; much will be asked of staff in context of already heavy workload; impact of ODP on routine practice not valued; resistance to change; and ODP leadership not consistent and not effective.

There was little evidence of a high level of coherence or sense making associated with a clear and explicit shared vision. Not knowing enough about the structure of ODP and how existing staff would fit in was a major concern causing much anxiety preventing staff from fully engaging and buying into ODP. At the time of the evaluation, it was likely that most staff believed that they would not be able to 'enact' ODP in a way that would work for them and that did not have enough information to meaningfully assess its effects and its value.

There had been a greater Dorset-wide collaboration and co-ordination and although some areas/specialisms had already been collaborating on a Dorset-wide basis, integrated collaboration and co-operation were not yet achievable on a Dorset-wide basis.

Although team members (n=61) disagreed they felt valued as team members, 62% believed that ODP would achieve a consistent and high standard of service across Dorset (harmonised reporting, procedures, training and operational governance all aligned across Dorset). Just over half [52%] agreed that ODP would ensure and maximise efficiency in the use of resource (with tests currently referred outside the region repatriated and turnaround times reduced) and that staff would develop to their full potential and work to deliver continuous service improvement. However, 59% disagreed [59%] that ODP would provide clinicians, patients and carers with timely diagnostic information to help them make informed decisions (improved quality and patient safety).

5. Benefits and limitations

Although the new Head of Service and new clinical leads had been leading the development of the ODP joint venture shared service, ODP was very much a work in progress at the time of the evaluation (end of November 2017 to mid-March 2018) with many key elements not yet agreed upon and approved and none the activities and system level changes finalised, least of all implemented, including the organisational structure.

Consequently, the evaluation could only focus on drivers and barriers to the implementation of the ODP joint venture vision for shared services, how the process of the progression of the ODP vision (from Strategic Business Case to Outline Business Case and then Full Business Case) was conceptualised and the extent to which better collaborative working had developed or been enabled.

To this effect, the views of 17.1% of the ODP staff were gathered, collecting both quantitative and qualitative data directly linked to the aims, objectives and conceptual framework of the evaluation. The sample of 12 ODP staff that was as balanced as possible in terms of role and grade, specialism and hospital were also gathered.

Nonetheless, this evaluation will be of national interest because the (second) Carter Review (2016) on unwarranted variations in operational productivity and performance in English NHS acute hospitals had made recommendations in line with what One Dorset Pathology is seeking to achieve.

6. Recommendations

Respondents and interviewees recommended better leadership, better communications, and a more inclusive approach with more opportunity to be meaningfully consulted.

They also recommended more emphasis on quality, including paying attention to a Dorset approach to Point of Care Testing. However, this is not part of the ODP scope (but arguably should be).

As Dorset will be a chosen site in the first wave for Accountable Care Systems and RBCH will become the major emergency hospital and PH the planned care hospital,¹² collaboration and co-ordination between DCH, PH and RBCH towards an integrated Dorset-wide approach should continue to focus on standardisation across Dorset, developing joint strategies, sharing best practice and learning from the process.

ODP will now be situated within One Acute Network [OAN] which builds on the achievements of Developing One NHS in Dorset. OAN is a portfolio within Dorset's Sustainability and Transformation Plan (STP) which encompasses the development of business support services, a network of clinical services across Dorset [Dorset Clinical Networks], the implementation of the CSR, and clinical redesign of services in the East of the county and the potential merger of RBCH and PH Trusts.¹³

NPT is well suited as a framework to evaluate an intervention before it is launched or as it is being launched as the 'diagnostic' dimension of NPT enables the identification of drivers and barriers and where to focus effort in building on enablers and in reducing barriers. The NPT framework based survey could usefully be repeated in future to assess progress made after ODP has been implemented.

References

Lord Carter of Coles (2016) *Operational productivity and performance in English NHS acute hospitals: unwarranted variations. An independent report for the Department of Health*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [Accessed 21 September 2017].

Gov. UK (2016) Review shows how NHS hospitals can save money and improve care. Department of Health. Patient safety and NHS efficiency. Available at <https://www.gov.uk/government/news/review-shows-how-nhs-hospitals-can-save-money-and-improve-care> [Accessed 21 September 2017]

¹² Developing One NHS in Dorset (2017g) One Dorset Pathology, *Pathology Newsletter*, December

¹³ Developing One NHS in Dorset (2017g) One Dorset Pathology, *Pathology Newsletter*, December