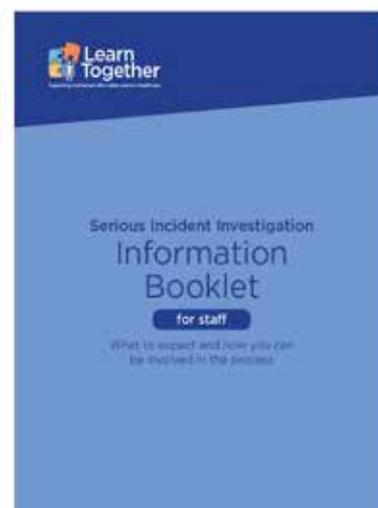
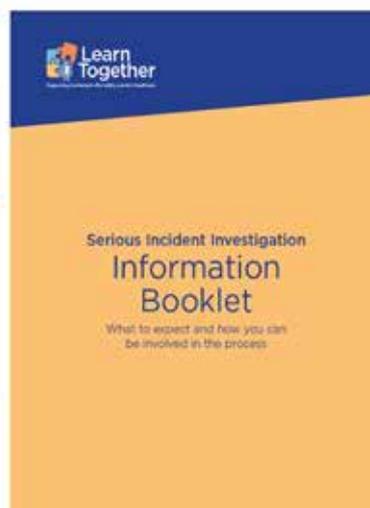
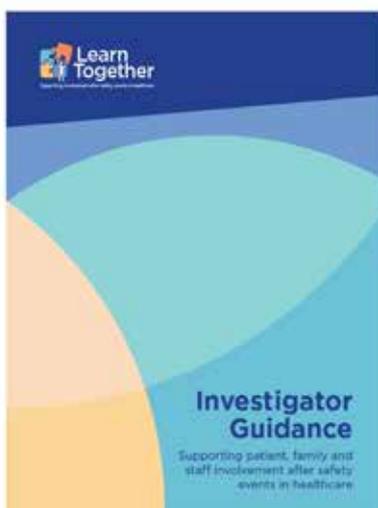




# Innovation

Research and Development Newsletter



**page 08** Patient and Family Involvement in Serious Incident Investigations (PFI-SII)

**page 10** Compassion in staff working in eating disorder services

**page 11** Investigation of patients understanding of physical health checks

03

Editorial

04

6 lead handheld ECG recorder compared to the 12 lead unselected cardiology patients

05

Exploring the cause and prevalence of memory problems in mental health: CAP-MEM Study

06

VIPP-FC

07

Cardiac monitoring in memory clinics: national survey of UK practice

08

Patient and Family Involvement in Serious Incident Investigations (PFI-SII): An interview study

10

Compassion in staff working in eating disorder services: Impact of workplace stress factors and emotion regulation

11

Investigation of patients' understanding of physical health checks for antipsychotic monitoring and barriers to their attendance

12

A narrative that needs to be heard: supporting people with severe and complex needs to participate in research

14

Library training dates

15

NIHR Funding Opportunities

16

Contact Details



## Editorial issue 47 Innovation

Welcome to Innovation 47. As a Research and Development department we support a wide range of research across the Trust. Sometimes to those on the front-line, research can feel remote, perhaps an academic exercise that isn't relevant to the work they do. But research is the way we create change in the NHS, it is the way we move forward. In this edition of Innovation, we have several research topics covered that I regularly hear as items through Trust governance. Managing staff stress, learning from serious events and physical health checks. These are current issues facing our Trust and research can provide us with new insights into these challenges and sometimes provides ways forward that we hadn't previously considered.

Emily Retkiewicz talks about her work on compassion fatigue in staff working in the eating disorders services. It's perhaps not surprising that increased workload creates increased compassion fatigue, she suggests clinical supervision as a way of supporting this or creating supporting groups where staff can share feelings. These are hard to provide in times of pressure, but this research highlights the need for us to find a solution to this challenge as an organisation. Ruth Simms-Ellis has explored how to involve patient and carer in serious case reviews, her research has created some common principles as a guide. They have produced some [resources](#) that are currently being adapted for national use by NHS England and Improvement to support involvement in the new Patient Safety Incident Response Framework. We also have a couple of articles that consider how physical health checks are managed, cardiac monitoring in memory clinics and patients understanding of physical health checks for

antipsychotic monitoring.

I also wanted to let you know about an exciting project we are starting up which will see us implement the Akrivia Health system within the Trust. Very simply, the Akrivia Health system sits on the front of our Electronic Health Record (CareDirector), it takes unstructured data and makes it structured. This will allow us to use our own data in a much more intelligent way. This will support a range of activities across the Trust including research, audit, service evaluation and service improvement. We will be working with a range of other departments across the Trust in the implementation of the system. We look forward to updating you on progress.



**Sarah Cooper**  
Head of Research and Development  
[sarah.cooper85@nhs.net](mailto:sarah.cooper85@nhs.net)



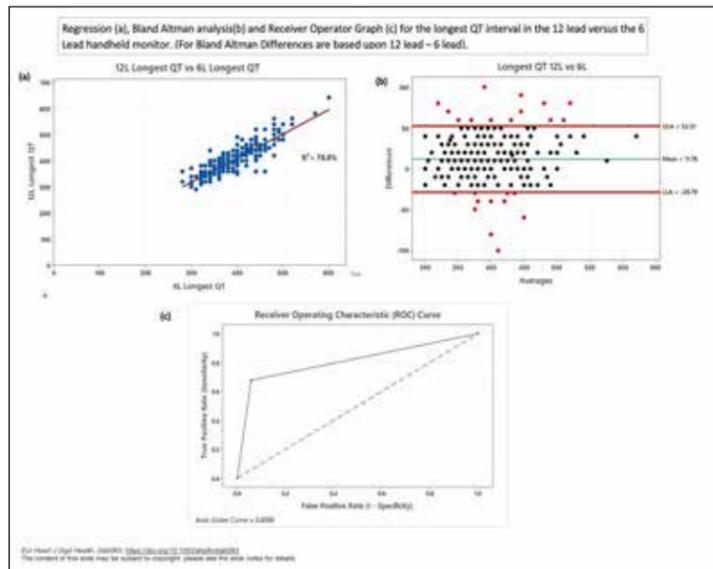
# 6 lead handheld ECG recorder compared to the 12 lead unselected cardiology patients

## Aim

Handheld electrocardiogram (ECG) monitors are increasingly used by both healthcare workers and patients to diagnose cardiac arrhythmias. There is a lack of studies validating the use of handheld devices against the standard 12-lead ECG. The Kardia 6L is a novel handheld ECG monitor which can produce a 6-lead ECG. In this study, we compare the 6L ECG against the 12-lead ECG.

## Methods and results

A prospective study consisting of unselected cardiac inpatients and outpatients at Leeds Teaching Hospital NHS Trust. All participants had a 12- and 6-lead ECGs. All ECG parameters were analysed by using a standard method template for consistency between independent observers. Electrocardiograms from the recorders were compared by the following statistical methods: linear regression, Bland-Altman, receiver operator curve, and kappa analysis. There were 1015 patients recruited. The mean differences between recorders were small for PR, QRS, cardiac axis, with receiver operator analysis area under the curve (AUC) of >80%. Mean differences for QT and QTc (between recorders) were also small, with AUCs for QT leads of >75% and AUCs for QTc leads of >60%. Key findings



from Bland-Altman analysis demonstrate overall an acceptable agreement with few outliers instances (<6%, Bland-Altman analysis).

## Conclusion

Several parameters recorded by the Kardia 6L (QT interval in all six leads, rhythm detection, PR interval, QRS duration, and cardiac axis) perform closely to the gold standard 12-lead ECG. However, that consistency weakens for left ventricular hypertrophy, QRS amplitudes (Lead I and AVL), and ischaemic changes.

**Muzahir Tayebjee,**  
Leeds Teaching Hospitals NHS Trust  
[muzahir.tayebjee@nhs.net](mailto:muzahir.tayebjee@nhs.net)

## Other researchers

Mohammad Azram,  
Noura Ahmed, Lucy

Leese, Matthew Brigham, Robert Bowes, Stephen B Wheatcroft, Leeds Teaching Hospitals NHS Trust; Marcus Ngantcha, Homeland Heart Center; Berthold Stegemann, Univeristy of Aston and George Crowther, Leeds and York Partnership NHS Foundation Trust.



# Exploring the cause and prevalence of memory problems in mental health: CAP-MEM Study

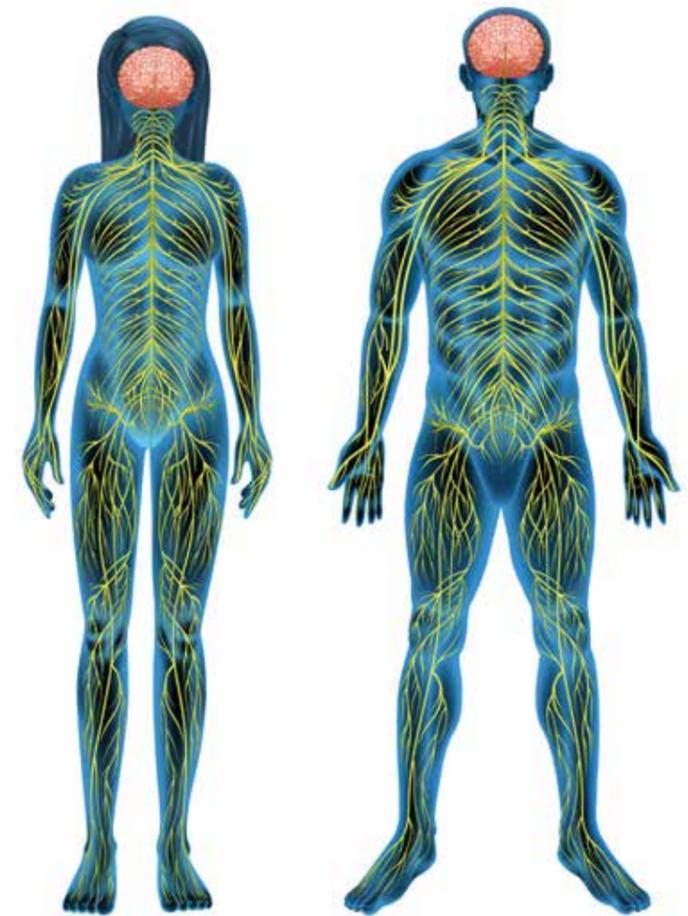
Alongside the Leeds and York Partnership NHS Foundation Trust we have completed recruitment to the CAP-MEM study. There are two branches of the nervous system and here we are focusing on the autonomic nervous system. This system controls all those parts of the body that we don't need to think about; the rate and strength of heart beats, activity in the bowel, the production and release of saliva from salivary glands etc. If control of the activity in these organs is even just a little bit out of whack, if we aren't pushing blood into our leg muscles when we need to run and into our brain when we need to think then we'll experience a whole range of sometimes quite subtle problems, for instance we'll feel tired and our thinking won't be as sharp as it should be.

We are therefore asking questions: is the autonomic nervous system regulated differently in some people with mental health disorders, what effect is this having and is it being made worse (not better) by medication?

With the Yorkshire team and others, we have asked 8,000 people about symptoms that may be related to dysregulation of the autonomic nervous system, half of these have a mental health disorder and half don't. We have asked about medication and asked a proportion of the participants to complete also tests of memory and concentration.

We'll analyse the data and tell you what we find. Thanks to anyone reading this who helped or took part. We think that this study is important. The more that we can find out about the biological factors that cause the signs and symptoms of mental disorders, the better placed we are to fight the stigma and to find effective treatments.

**Stuart Wilson, Newcastle University**  
[stuart.watson@newcastle.ac.uk](mailto:stuart.watson@newcastle.ac.uk)



Anatomy vector created by brgfx from www.freepik.com

Children in foster care typically have had a very difficult start in life, often as a result of abuse or neglect within their family of origin, and separation from caregivers. For these children, it can be difficult to trust new adults, and, for some, their difficulties in attachment may qualify for a diagnosis of reactive attachment disorder. This disorder is a pattern of behaviour among young children who have received extremely insufficient early care, whereby they fail to seek or respond to comfort from carers when hurt or distressed, and they can be very withdrawn. There are currently no evidence-based treatments for reactive attachment disorder.

The Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline is a treatment programme that was developed to promote secure attachments in young children and to help parents deal with difficult behaviour. A practitioner films the child and parent interacting at home and provides feedback in the following session. This treatment was previously adapted for use in foster care in the Netherlands. In this study, the treatment was modified further to ensure that it appropriately addressed the needs of young children in foster care in the UK who present with reactive attachment disorder symptoms. The study team worked with local authorities and linked mental health services to develop a system for identifying young children in foster care in need of this treatment. Finally, a small (pilot) study was conducted to gather information about the best way to provide the modified treatment in this context. Lisa Hackney, Clinical Studies Officer, for R&D in LYPFT delivered this intervention supported by the study team. The revised treatment was positively received by practitioners and foster carers. The majority of the processes involved in running a trial also worked well (e.g., good levels of attendance at assessments and at the treatment sessions). However, significant difficulties were encountered in recruiting foster carers to the study. It was concluded that a full-scale trial would be very valuable and could potentially be undertaken if difficulties with recruitment are overcome. It is recommended that greater resources be provided to local authorities to help them engage and recruit foster carers.

**Professor Pasco Fearon, University College London.**

### Other researchers

Paula S Oliveira, Anna Freud Centre; Dr Danya Glaser, Great Ormond Street Hospital; Dr Eilis Kennedy and Dr Rob Senior, Tavistock and Portman NHS Foundation Trust; Professor Sarah Byford, Professor Stephen Scott and Dr Matthew Woolgar, Kings College London; Mr Will Hausrath, NSPCC; Professor Barry Wright, University of York; Professor Jane Barlow, University of Oxford; Professor Paul Ramchandani; Professor Peter Fonagy, University College London.



Photo by Pixabay from Pexels

### Aims and method

People diagnosed with dementia are often started on acetylcholinesterase inhibitors (AChEIs). As AChEIs can be associated with cardiac side-effects, an electrocardiogram (ECG) is sometimes requested before treatment. Previous work has suggested there is little consensus as to when or how ECGs should be obtained. This can create inconsistent practice, with patient safety, economic and practical repercussions. We surveyed 305 UK memory clinic practitioners about prescribing practice.

### Results

More than 84% of respondents completed a pulse and cardiac history before prescribing AChEIs. Opinion was divided as to who should fund and conduct ECGs. It was believed that obtaining an ECG causes patients inconvenience and delays treatment. Despite regularly interpreting ECGs, 76% of respondents did not update this clinical skill regularly.

### Clinical implications

The variation in practice observed has service-level and patient implications and raises potential patient safety concerns. Implementing national guidelines or seeking novel ways of conducting cardiac monitoring could help standardise practice.

**George Crowther, LYPFT**  
[georgecrowther@nhs.net](mailto:georgecrowther@nhs.net)

### Other

Noura Ahmed, University of Leeds; Deepa Kasa and Zoe Goff, LYPFT; and Muzahir H Tayebjee, Leeds Teaching Hospitals NHS Trust.



# Patient and Family Involvement in Serious Incident Investigations (PFI-SII): An interview study

When a serious incident occurs in healthcare, the NHS Trust undertakes an investigation to learn about what happened to try to reduce the likelihood of a similar incident happening again. Current NHS policy states that patients and families affected by a serious incident should have the opportunity to be involved in the resulting investigation, to aid the learning about the incident. Unfortunately, this does not commonly happen.

The National Institute for Health Research are currently funding a team of researchers at the Bradford Institute for Health Research and the Universities of Leeds, York, Birmingham and Nottingham to design processes and resources to guide better patient and family involvement in serious incident investigations.

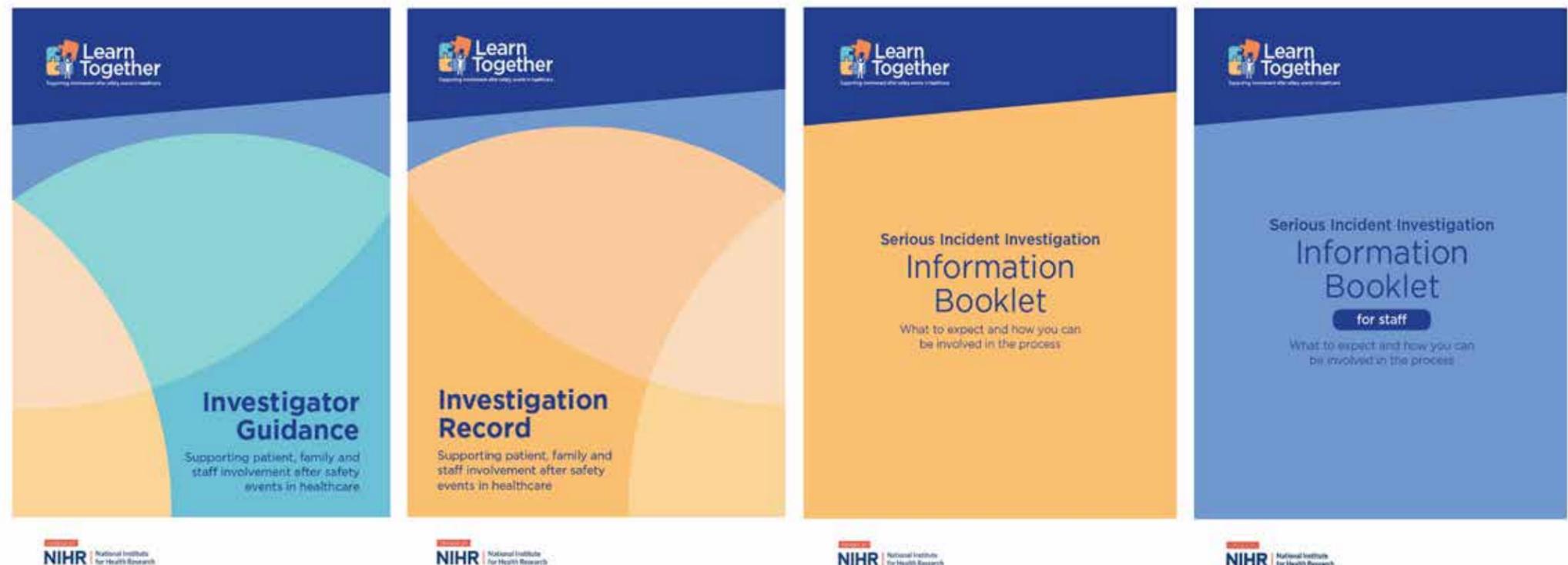
This research programme, running October 2019 to June 2023, has involved an interview study to understand from patients and families, healthcare staff and investigators, what it is like to be involved in a serious incident investigation. Fifty people took part in an interview, seven of which were recruited through LYPFT. The findings show that patients and families (and indeed healthcare staff) were not routinely asked if they wanted to be involved in investigations. They often felt in the dark about what was happening and powerless, unsupported, uncared for and not very important in the process. Although some patients, families and staff found the investigation gave them some closure, others found that the way the investigation was run made them feel worse. The interviews helped us to understand that investigations are complex social processes, and that patients, families and staff have various practical and emotional needs arising after a serious incident, which investigations should try to meet wherever possible. In summary, investigations need to contribute to both learning and healing/recovery. Through detailed analysis of the interview findings, we identified 10 'common principles' to guide investigators in involving patients and families (and staff) in investigations:

1. **Make apologies meaningful**
2. **Individualise your approach**
3. **Be sensitive to timing**
4. **Treat people with compassion and respect**
5. **Strive for equity**
6. **Provide clarity and guidance**
7. **Listen**
8. **Be collaborative and open**
9. **Respect humanity**
10. **Accept subjectivity**

These 10 common principles form the backbone of the new co-designed involvement processes and "Learn Together" © resources (four A4 booklets - see below), which are being tested by trained investigators in 20 real-life investigations from January-December 2022 in four NHS Trusts, LYPFT is glad to be one of the Trusts supporting this. We are excited to say that these co-designed processes and resources are currently being adapted for national use by NHS England and Improvement to support involvement in the new Patient Safety Incident Response Framework.



**Dr Ruth Simms-Ellis, University of Leeds**  
[R.Simms-Ellis@leeds.ac.uk](mailto:R.Simms-Ellis@leeds.ac.uk)





## Compassion in staff working in eating disorder services: Impact of workplace stress factors and emotion regulation



## Investigation of patients' understanding of physical health checks for antipsychotic monitoring and barriers to their attendance

This study asked healthcare professionals working with people diagnosed with eating disorders to complete an online survey consisting of a demographic questionnaire, measure of workplace stress, measure of two ways of regulating emotions (cognitive reappraisal and expressive suppression), and a measure of compassion fatigue and compassion satisfaction.

This study was open in NHS Trust and NHS partner organisations in the North of the country, LYPFT was one of these organisations. The study found a large relationship between workload demands and compassion fatigue, and this aspect of workplace stress was the most influential predictor in the regression model. Job insecurity was the second most influential predictor of compassion fatigue in this study, with a medium association. The timing of this study is particularly interesting, as many healthcare professionals who participated may have been faced with an increase in workload demands due to the COVID-19 pandemic. Additionally, the challenges of the COVID-19 pandemic may have made job insecurity a more salient issue for healthcare professionals working in eating disorder services. Redeployment of mental health healthcare professionals working for the NHS, specifically to support inpatient and medical environments, was a real prospect when this study was conducted. These findings suggest that these particular risk factors for developing workplace stress may be an important aspect to take into account when considering capacity for compassion in healthcare professionals working with people diagnosed with eating disorders, especially when the NHS is under pressure and redeployment is likely. Organisational change is recommended to address those factors and prevent healthcare professionals from experiencing high levels of workplace stress and compassion fatigue. Eating disorder services may benefit from modelling the impact of factors such as nurse-patient

ratio and patient acuity on workload demands, thus identifying avenues for reducing demands. Eating disorder services could consider practices such as analysing and clarifying work roles or offering flexible working patterns. Furthermore, providing healthcare professionals with sufficient information regarding redeployment, keeping open channels of communication, and positive leadership strategies could impact on reducing a sense of job insecurity in eating disorder services.

Given the results of this study, it appears that cognitive reappraisal could be a helpful skill for managing compassion fatigue and compassion satisfaction in healthcare professionals working with people diagnosed with eating disorders, however it does not appear to be a key component. Although the relationship found in this study was small, expressive suppression may not be a beneficial personal resource for healthcare professionals working with people diagnosed with eating disorders, as it has no impact on compassion fatigue and is associated with a reduction in compassion satisfaction. Alternative strategies may need to be considered for healthcare professionals' management of emotions. It may be beneficial for appropriately qualified staff to enable expression of negative and positive emotions in clinical supervision with individual healthcare professionals. Facilitating reflective groups with healthcare professionals could normalise and model sharing of emotions, giving a safe space to process such experiences with another.

**Emily Retkiewicz, Lancaster University**  
[e.retkiewicz@lancaster.ac.uk](mailto:e.retkiewicz@lancaster.ac.uk)

### Supervised by:

Dr Ian Fletcher, Lancaster University and Dr Nicola Pilkington, Lancashire and South Cumbria NHS Foundation Trust.

### Introduction

Antipsychotic medications are associated with a wide range of side-effects, including metabolic derangements. These side-effects contribute to morbidity of the population with severe mental illness (SMI). The National Institute for Clinical Excellence (NICE) recommends routine physical health monitoring to identify co-morbidities and hence facilitate early intervention and treatment. However, rates of monitoring are poor, and from a literature search, no studies have examined why rates are poor from the perspective of service users.

### Methodology

26 participants recruited from the Leeds West Community Mental Health Team (CMHT), outpatient clinic were interviewed using a standardised questionnaire. Data captured included patient demographics, and participants' understanding of, and attitude to, physical health checks. Barriers to attendance were explored using a matrix-style and open questions. Themes were identified from the answers given.

### Results

General understanding of health checks was good but knowledge regarding tests and frequency of health checks was poor. 61.5% of participants reported a barrier to attendance – barriers related to anxiety (either travel- or appointment-related), COVID-19 restrictions or health concerns, mental health issues and transport issues were most common.

### Conclusions

This investigation suggests that greater education about physical health checks, particularly regarding testing and frequency, could benefit the cohort. The barriers to attendance that were reported could potentially be addressed by straightforward measures, for example, facilitating access to transport, increased flexibility of appointments, improved booking arrangements, and addressing patients' anxieties, for example, worries about Covid-19 and venepuncture. However, a limitation of this service evaluation was the relatively small sample size; a deeper understanding of the issues would be gained by recruiting more participants from a wider geographical area and changing the methodology to capture more non-attenders.

The project was completed as part of an Extended Student-Led Research or Service Evaluation Project (ESREP).

**Bethany Chander and Joseph Friel, University of Leeds**  
[um16jhf@leeds.ac.uk](mailto:um16jhf@leeds.ac.uk)

### Supervised by:

Dr Rachel McKie and Dr Pippa Mason, LYPFT.

# A narrative that needs to be heard: supporting people with severe and complex needs to participate in research

This blog was first published by Centre for Mental Health at <https://www.centreformentalhealth.org.uk/blogs/narrative-needs-be-heard-supporting-people-severe-and-complex-needs-participate-research>

“He’s not in, mate. I don’t know who you are but you should help him. He was up all night shouting again. He really needs help”. On a balcony ten floors up, buffeted by the biting wind, we’re standing at the door to Jimmy’s flat. There’s no reply and the unutterable graffiti emblazoned on the chipboard covering his smashed kitchen window tells us in no uncertain terms that the world is not welcome here. A benevolent maintenance man had let us into his tower block in as Jimmy didn’t answer his intercom, he rarely does. He was supposed to attend a research workshop yesterday but the taxi driver we’d arranged said there was no sign of him. We’re here to check that he’s ok.

I am, and have always been, a frontline psychiatrist. That’s not to say that I don’t I admire my academic colleagues – I’m in awe of their big analytical brains and I am grateful for the evidence base that they provide the rest of us with. But over the years the realisation has dawned on me that the particular group with severe mental illness whom I support don’t figure much in what they write.

So, in March 2021 I was excited to be asked to be the local principal investigator for an innovative project called Co-PACT. Its ambitious aim was to draw upon the lived experience of those who had been detained to co-produce novel approaches to reduce the use of the Mental Health Act, particularly for those from racialised communities. In our Assertive Outreach team I see a group who, without exception, have been detained many times and unsurprisingly, many are from racialised communities. Finally, I thought to myself,

here is an opportunity to get involved in some research which might positively influence future policy...

awareness of severe mental illness remains poor... some face a struggle, day after day, with severely disabling symptoms and some are never far away from the next significant relapse.

It was exhilarating spreading the word about this project to potential recruits and it felt so promising that at last their voices would be heard. The project involved a series of paid workshops and several people were keen to sign up to share their (mostly negative) experiences of detention under the Mental Health Act. But as the weeks passed by and the date for the first workshop approached my new-found evangelism began to evaporate.

Whilst it is positive that mental health is no longer as taboo a subject as it once was, my impression is that the awareness of severe mental illness remains poor and the narrative presented is often one of conditions which are episodic in nature. That might be true for some, but others face a struggle, day after day, with severely disabling symptoms and some are never far away from the next significant relapse. Sadly, this was true for several people I had hoped might take part in the project.

As they became unwell, some lost the capacity to consent to participation in the study and others refused, their change of heart fuelled at times by resurgent paranoia or an increasingly unbridled mania with the chaos and hostility that sometimes accompany it. They became too ill to tolerate the workshops or too risky as a consequence

of their deteriorating mental state to be around the others taking part. And for some, their hospital admissions were followed, as is often the case, by a dark period during which they were left feeling lost and lonely, once more defeated and trying to make sense of what had just happened to them. Although lifesaving at times, being admitted to hospital can be traumatic and the last thing they needed now was to re-live the trauma of their treatment.

There is meaning in their psychosis if we care to look for it, and who better than these people to open our eyes to the inconvenient truths of racial inequity and disproportionate detention by mental health services?

But their journeys are rich with a narrative that really needs to be heard. Could we not learn lessons from the African asylum seeker who fled his war-torn homeland and is now tormented by flashbacks which he struggles to explain in a language that isn’t his mother tongue? He lives hand to mouth on a paltry government allowance as he tries his best to navigate this new hostile environment with no guarantee that he will even sleep in the same bed tonight. Or how about the self-anointed Indian prince whose grandiosity and suspicions about services are so obviously rooted in the unpalatable legacy of empire and a repeated exposure to institutional racism? There is meaning in their psychosis if we care to look for it, and who better than these people to open our eyes to the inconvenient truths of racial inequity and disproportionate detention by mental health services?

I take for granted the efforts we make in our Assertive Outreach Team staff as we endeavour to engage with people like Jimmy whose lives are chaotic or who have poor motivation as a consequence of their illness (or occasionally its treatment). It’s second nature for us to work flexibly and creatively, determined to stay in touch

with the homeless, digitally excluded and people for whom night replaces day due to interminable insomnia, making it near impossible to keep vital appointments. Even in the absence of prohibitive relapse and risks, all of these factors pose practical barriers to the involvement of people in all activities (including research) which might help shape mental health services to better meet their needs.

Maybe it is time for... us to challenge our apathy towards this marginalisation

Our broader efforts were rewarded with a good turnout at the Co-PACT workshops in Leeds but I was somewhat sad that not a single person from my caseload made it there in the end. Their contribution was as minimal as it had been to the Independent Review of the Mental Health Act. I have no doubt that those who were able to contribute to the review of Mental Health Act detention will have a positive impact on this work, but I am left wondering how the lived experience of these others can be harnessed.

Maybe it is time for a rebalancing of our conversation about mental illness and for us to challenge our apathy towards this marginalisation. And maybe it is time that I, as a frontline clinician, made a commitment to engage with my new researcher friends, about what we can collectively do to better include those whose voices are never heard because, to quote the late Desmond Tutu, “Exclusion is never the way forward on our shared paths to freedom and justice”.

**Dr Nuwan Dissanayaka, LYPFT**  
[n.dissanayaka@nhs.net](mailto:n.dissanayaka@nhs.net)

Jimmy is a pseudonym for an amalgam of people Nuwan sees.

This project is funded by the National Institute for Health Research (NIHR) Policy Research Programme. The views expressed are those of the author and not necessarily those of the NIHR or the Department of Health and Social Care.

The Library and Knowledge services team are currently delivering information skills training courses remotely. The team are delivering one-to-one training to request this you will be required to complete a training request form <https://www.leedslibraries.nhs.uk/courses/one-on-one-request.php>

## The following courses are free to all Trust staff:

**Cochrane library training** - This course focuses on the skills required to search the Cochrane Library effectively to retrieve high quality evidence to support work and study.

**Critical appraisal** - This course focuses on why it is important to appraise journal articles, how to go about doing this, and how to get further help.

**Current awareness** - Aimed at staff who wish to set up and use email and RSS alerts and feeds to support their practice or professional development.

**E-journals and e-books** - Aimed at staff who wish to use e-journals and e-books to support their practice or professional development.

**Google and beyond** - Aimed at staff who wish to gain skills in searching Google for information to support their work, practice or professional development.

**Healthcare databases** - This course focuses on searching healthcare databases.

**NHS OpenAthens account** - Aimed at staff who wish to better understand their Athens account and learn about the e-resources that are available to them.

## You may also be interested in accessing the introduction \*videos below:

- Critical Appraisal
- Literature Searching
- BMJ Best Practice
- Royal Marsden Manual
- Anatomy Resources
- Journals A-Z
- Browzine
- Kortext
- Registering for an NHS OpenAthens Account
- TRIP Database

These videos can be found here: <https://www.leedslibraries.nhs.uk/training/training-videos>

\*Please note Library and Knowledge services do not accept the responsibility for the content of these videos which have been produced by suppliers and external organisations.

For more information about any of our library courses; visit [www.leedslibraries.nhs.uk/home/](http://www.leedslibraries.nhs.uk/home/)

The NIHR Clinical Research Network Portfolio is a database of studies that shows national clinical research study activity. Clinical trials and other well-designed studies involving the NHS, funded by the NIHR, other areas of government and non-commercial partners are automatically eligible for portfolio adoption. Studies that are adopted on to the portfolio can access infrastructure support and NHS service support costs to help with study promotion, set-up, recruitment, and follow-up.

The Research Design Service (<https://www.rds-yh.nihr.ac.uk/>) provides guidance and support that you will need to access when making an application for NIHR funding. They also provide funding to enable service users, carers and the public to contribute to the development of your research bid.



Funding stream	Deadline
HTA	Commissioned (Stage 1) 1pm, 19 July 2022
PHR	Commissioned (Stage 1) 1pm, 16 August 2022

## Funding streams:

- 1. Efficacy and Mechanism Evaluation (EME):** Researcher-led and aims to improve health/patient care. Its remit includes clinical trials and evaluative studies.
- 2. Health Services and Delivery Research (HS&DR):** Funding research to improve the quality, effectiveness and accessibility of the NHS, including evaluations of how the NHS might improve delivery of services. It has two work streams, researcher-led and commissioned.
- 3. Health Technology Assessment (HTA):** Funds research to ensure that health professionals, NHS managers, the public, and patients have the best and up-to-date information on the costs, effectiveness, and impacts of developments in health technology.
- 4. Invention for innovation (i4i):** Funds research into advanced healthcare technologies and interventions for increased patient benefit in areas of existing or emerging clinical need.
- 5. Programme Grants for Applied Research:** To produce independent research findings that will have practical application for the benefit of patients and the NHS in the relatively near future.
- 6. Public Health Research (PHR) Programme:** Funds research to evaluate non-NHS interventions intended to improve the health of the public and reduce inequalities in health.
- 7. Research for Patient Benefit (RfPB):** Generates research evidence to improve, expand and strengthen the way that healthcare is delivered for patients, the public and the NHS.

For further details about funding opportunities through the NIHR, visit: [www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/](http://www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/)

# Contact us R&D

Innovation is a newsletter for sharing and learning about health research. This includes information about projects being carried out in your area. As such we welcome any articles or suggestions for future editions.

## For more information please contact:

### Zara Brining

Research Administrator / PA  
Leeds and York Partnership NHS Foundation Trust  
Main House  
St Mary's House  
St Mary's Road  
Leeds  
LS7 3JX

@LYPFTRResearch

T: 0113 85 52387

E: zara.brining@nhs.net

### Sarah Cooper

Head of Research & Development  
Leeds & York Partnership NHS Foundation Trust  
Main House  
St Mary's House  
St Mary's Road  
Leeds  
LS7 3JX

T: 0113 85 52360

E: sarah.cooper85@nhs.net