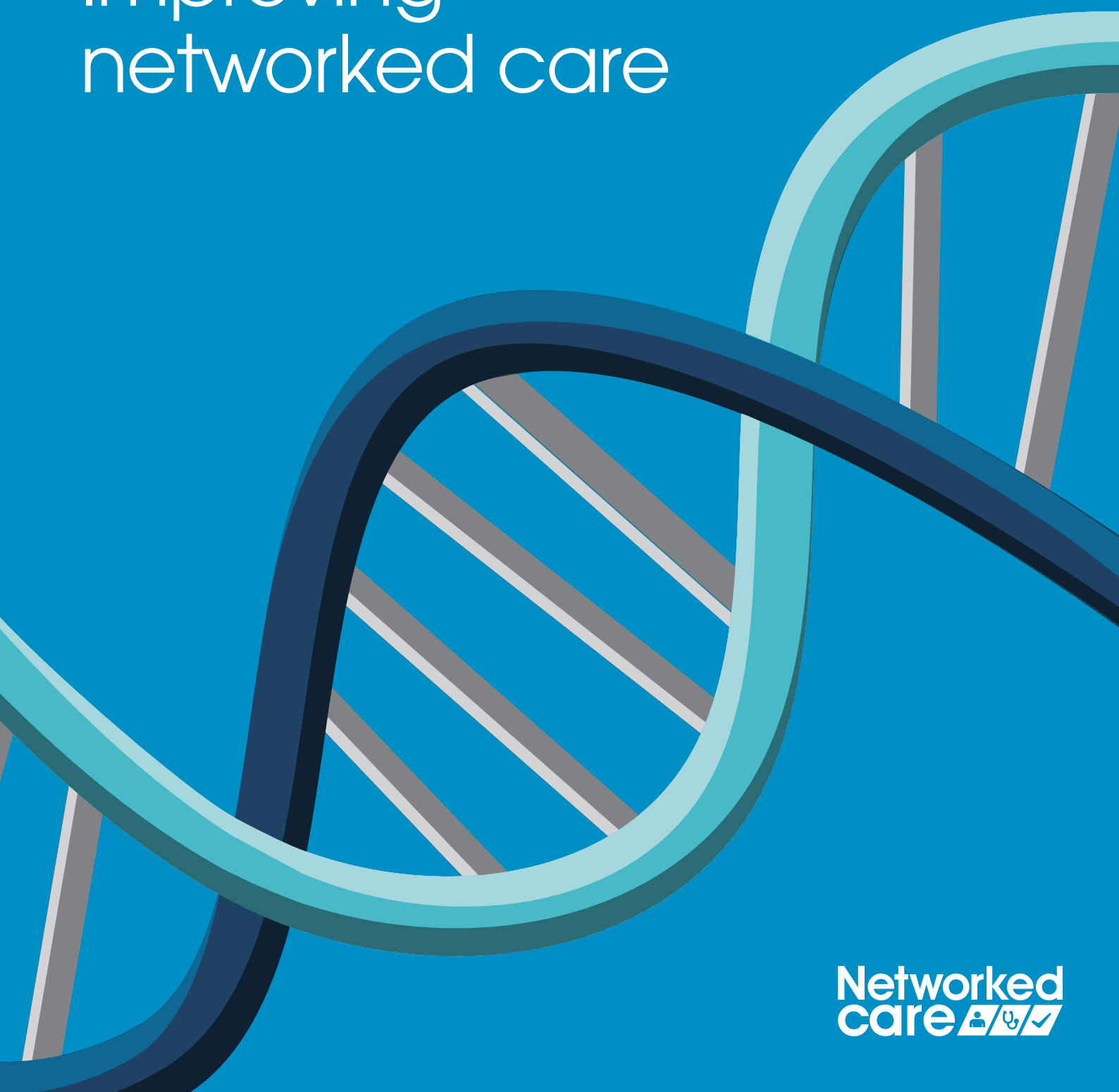
NHS

# Staff and patients
# Improving networked care



Networked care

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# Biographies

## Bev Fitzsimons

Bev is responsible for development, design and oversight of patient-centred quality improvement initiatives at the Point of Care Foundation (POCF – for more information see back cover). From 2009 to 2014, Bev was a fellow in health policy at the King's Fund, leading patient-centred quality improvement programmes in the POCF team. A social scientist by background, Bev spent 12 years working in healthcare audit and regulation at the Healthcare Commission, the Commission for Healthcare Improvement and the Audit Commission, with particular interest in the patients' and service users' experiences of care. Bev is a member of the founding cohort of the Health Foundation's Q initiative, a community of practice for quality improvement.

## Elaine Hide

Elaine works with the POCF to help train and coach in the use of the experience-based co-design method (EBCD). She was the service improvement lead involved in testing EBCD in its first use in a hospital setting. A nurse by background, Elaine spent time working in the acute sector before moving into nurse education and then to quality and service improvement, leading and managing a number of improvement projects and programmes and continuing to use EBCD. As well as working in NHS acute hospitals, Elaine has worked at the NHS Institute for Innovation and Improvement, in the independent sector and with primary care in a variety of roles including director of quality.

## Tim Withers

Tim is a nurse specialising in ophthalmic accident and emergency and has worked in various places in the UK and abroad. He joined Moorfields in 2001 and was the nursing lead at one of its largest networked sites before moving to Moorfields Eye Hospital, City Road, in 2008 to undertake several nursing projects. He completed his MSc in health management in 2010 and in the same year was appointed as the trust's head of patient experience. In 2014 he took on oversight of the complaints service and will take over the patient information service in 2018. He has recently been supporting the vanguard team's work with POCF helping to roll out the experience-based co-design project across several network sites and will continue to support this work across the network after the vanguard programme ends.

**Vanguard programme editorial team:**

**Johanna Moss** Programme executive lead
**Karen Reeves** Programme director
**Philippa Hutchinson** Programme content manager
**Brian Donnelly** Programme communications lead

# Background

## In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the NHS England Five Year Forward View strategy supporting the improvement, standardisation and integration of services.

Moorfields Eye Hospital (Moorfields) was successful in bidding to become one of 13 acute care collaborative programmes.

In April 2017 the Moorfields vanguard team published a unique e-toolkit **www.networkedcaretoolkit.org.uk** sharing findings from our research into best practice for single specialty networked care.

During 2016/17 the vanguard team worked with experts in citizen innovation and participation (see the 'patient participation' report in the resources section of the toolkit) to understand how patients can best be involved in the delivery of networked care in order to improve outcomes.

We wanted to understand how patients were participating across the Moorfields network, what we could learn from this and how best to involve patients and service users in helping to ensure that the network remained resilient and responsive to the needs of our patients and their carers. We came to understand that this needed to be through staff and patients designing services together. This early work is described in the toolkit and associated resources.

In 2017/18 we have been working with the independent charity, the POCF, to understand the best methods and tools we can use to embed staff and patient co-design of services across the Moorfields network. This report describes the progress during year two and how the work will continue after March 2018, when the vanguard funding ends.

Moorfields Eye Hospital was successful in bidding to become one of

**13**

acute care collaborative vanguard programmes

# Approach

## The vanguard programme commissioned the POCF to develop team skills in using the technique of experience-based co-design (EBCD).

EBCD involves gathering experiences from patients and staff through in-depth interviews, observations and group discussions, identifying emotionally significant points and assigning them as positive or negative. A short film, showing how patients experience the service, is created from the interviews and shown to staff and patients separately. They are then brought together to explore the findings and work in small groups to identify and implement activities that will improve the service or care pathway. This approach was designed to help the NHS develop simple ways to offer patients a better experience of treatment and care. Similar user-centric design techniques have been used by leading global companies for years.

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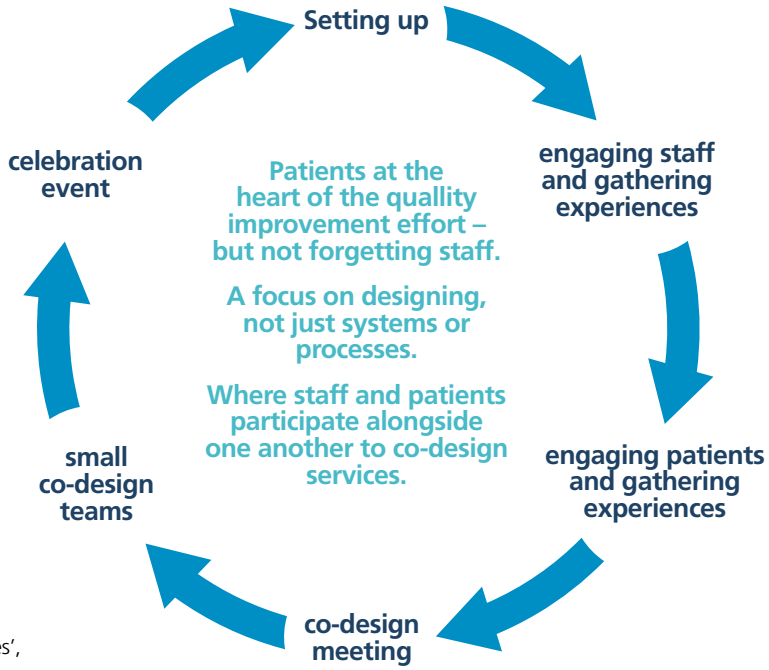
The POCF worked with five teams across the Moorfields network to pilot the tools and techniques.

The training curriculum included:

- setting up a co-design project.
- engaging staff and patients in co-design and gathering their experiences.
- staff events, patient events and joint patient-staff events.
- co-designing working groups, testing and making improvements.
- completing projects and celebrating.




Robert G, Cornwell J, Locock L, Purushotham A, Sturmey G and Gager M. (2015) 'Patients and staff as co-designers of health care services', British Medical Journal, 350:g7714

# Process

## The POCF worked with Moorfields' head of patient experience to engage with teams at the sites involved, delivering several workshops from September to November 2017.

An experienced co-design practitioner used a mentoring and coaching model to support all the teams to learn the co-design approach and overcome obstacles.

This involved repeated visits to boost training in short bursts, attending steering groups and meetings of team leaders and providing phone support and additional guidance as needed. Most of the teams focused on the outpatient setting or on a particular care pathway. Although not all teams arrived at training with a specific focus for their projects in mind, most decided on their projects soon afterwards.

The training was well received, evidenced through regular participant evaluation feedback. Key success factors were getting the right people to do the training, particularly at times of service pressure, and ensuring that a range of people in different roles attended. Some participants commented that when doctors attended it lent gravitas and a sense of urgency to the co-design projects.

It was important that people understood why they were attending training and what part they would be expected to play in the co-design process. Some people attended out of interest but did not intend to get involved in a co-design project.

# Critical success factors

## The POCF has identified a number of features of the most successful projects and teams.

It is important that teams are clear about the following:

- The 'strategic fit' of their project in the wider organisation's purpose.
- Whether co-design projects are standalone or integrated with other work.
- What is targeted for improvement. Whether that is solely patients' experience or includes efficiency, safety and wider improvement issues.
- The care pathway, department, area, specialty or particular group of patients which are to be the focus.
- The strategy for leading the projects, including organisational sponsorship.
- How, and to whom, they are accountable.

It is crucial that organisations and managers understand that it takes time for projects to become established and to build the relationships needed to embed an enduring culture of co-design. Teams also need to appreciate that EBCD is essentially exploratory in nature: goals emerge as part of the process and it is not possible to clearly describe the anticipated outcomes at the outset.

It is natural for staff to find change unsettling. Successful project leaders overcome this by:

- taking time to clarify the vision, aims and change strategy.
- connecting the project to existing organisational structures and systems.
- building consensus and understanding around goals and methodology.

Project leaders need to build alliances at both organisational level and within departments.

Project leaders need to build alliances at both organisational level and within departments, including with people who might be seen as 'informal leaders' and opinion formers, as well as people who are regarded as leaders because of their hierarchical position. The co-design process connects people with their motivation for working with patients and, in time, people who use the method move from being allies and supporters to being strong advocates and champions for it. The speed of this process depends on the strength of these relationships at the outset (see case study, page 5).

The POCF training emphasises the importance of identifying and engaging with key stakeholders from the outset, understanding their interest in the co-design work and designing engagement and communication strategies accordingly. It also emphasises the importance of strong project management, establishing governance structures for projects, a clear plan, timeline and milestones.

# Case study: Improving clinic flow

**When clinics overrun it is frustrating for patients and staff. The staff working in this clinic have wanted to improve flow to reduce late running clinics for sometime. The EBCD project work is helping to accelerate progress. The clinic has very little space and sees a 30% increase in patient numbers each year, but there is optimism and confidence that improvements are possible when staff and patients work on solutions together.**

Strong project management and staff engagement characterise the approach at this site. Members of the stakeholder group were selected to include staff at every level, including some who had not been involved in anything like this before. It was no surprise to find that receptionists and care assistants could describe what it was like to work in the clinic and had brilliant ideas about what could be changed to make improvements. Seeing their ideas implemented convinced staff that they had the power to make a difference.

Some of the stakeholder group had training in the use of the EBCD tools and helped those team members who had not. The lead manager had used the method before and was able to build understanding about the principles and benefits of working this way. Although the stakeholder group could not meet face to face as often as they would have liked, the lead manager and others ensured that all the staff were kept updated.

This combination of leadership and involvement is a recipe for success even though the service is busy and the improvement work is being done as part of the day job.

Key steps in the co-design process used by the team are shown in the diagram below.

Patients were recruited for interviews (part of step 1) and for the patient feedback and joint staff/patient event (steps 2 and 4) with a conversation in clinic with a member of staff they already knew and a follow-up phone call with more explanation. The work is continuing to complete all six steps of experience-based co-design for the benefit of patients and staff.

## Experience based co-design – six steps to improving patient care

1. • Interview staff.
   • Interview patients.
   • Staff to 'shadow' patient visits.
   • Observations of care.
2. Bring the patients together to discuss what the priorities for improvement should be.
3. Bring the staff together, not to identify solutions, but to identify priorities for improvement.
4. Bring staff and patients together to jointly decide what the priorities for improvement should be.
5. From smaller working groups of staff and patients to address the issues both groups think are the priorities.
6. Bring staff and patients back together to celebrate success.

# Adapting to local needs

## The quality improvement literature shows that having a clear, easily explained methodology is key to co-design, as is the ability to tailor approaches to local circumstances.

Teams adopted the EBCD methodology taught in the training. One of the teams adapted the methodology to reflect its already-established working relationships with a patient group. They chose to start working with these patient representatives to prioritise key areas for improvement that had already been identified, then set about the process of co-design during the POCF training session. They continue this work with the aim of co-producing outputs and improvements in a relatively short time.

# Challenges

## In settings that do not already have a culture of patient participation, the idea of patient involvement can initially be seen as a challenge.

Having a trust strategy for patient participation provides a wider context for and understanding of EBCD.

What is clear is that for EBCD to succeed, obtaining commitment, oversight and expectation from senior operational managers from the very beginning is of paramount importance. This provides not only recognition of the significance of the work but also the required time and resources, making the aims more achievable.


Having strong local leadership cannot be over emphasised, but having strong members of the team who feel involved and empowered to carry on the work in the absence of the project lead, as happened at several sites as a result of long-term unplanned absence, is equally important for success.

Another challenge was the perceived lack of time available for this work, with busy clinics, difficulty in getting staff released and annual leave commitments. Though this was mitigated somewhat by the active involvement of the head of patient experience carrying out the observation and staff and patient interviews, there was a danger that this could weaken staff engagement. In future much stronger emphasis must be given to the initial planning stage so that events, activities and staff availability are fixed in advance. This would include training only those staff to be included in subsequent activities and more thought given to who these staff members are.

From the staff's perspective, there is a risk that the model appears over complicated and time consuming, requiring skills and equipment that they may not have locally. It is important to emphasise the flexibility of the tool to reassure staff that as long as the core elements of the tool are met, they can adapt it to their local circumstances.

Recruiting patients for the project was a challenge – it is not easy to explain a complicated project during a busy clinic and some teams have struggled to find enough patients willing to commit. Posters and leaflets emphasising the local nature of the work have been produced and staff from one of the teams spoke directly to regular patients. Setting up a database of patients willing to become involved would make the process of recruiting patients easier. This was a positive feature of the work by one team where interested patients had already been identified.

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Another team also decided to use this co-design approach when reviewing the environment and implementing a new outpatient pathway across the division. This shows how the experience of co-design is beginning to spread, with increasing awareness of the need to identify receptive contexts for this work.

Many of the issues identified by patients were already well documented, including waiting times and the clinic environment. Local staff can find it difficult to find solutions with the resources available and working with patients have identified other, perhaps more realistic, interim solutions. As well as working towards the long-term aim of reducing waiting times, staff have also focused on improving patient experience during clinic by providing more information, refreshments and diversions such as television and magazines. The value of these will be explored in the joint working groups.

# Organisational priorities

## For optimal progress, patient engagement must be an organisational priority, with senior leaders taking an active interest in embedding processes like EBCD across the organisation.

Co-design work needs a 'home' in its host organisations. Related to this is the importance of getting the right people involved and trained in the co-design process. This is critically important to the chances of success.

External factors can be a powerful driving force. The CQC's 'caring and responsive' requirement, for example, can be evidenced by the use of EBCD and this can be a convincing argument in favour of its adoption.

Sometimes conflicting demands delay progress. One team was in the middle of moving to allow for refurbishment and they saw the timing of the project as distracting.

# **Case study:** Improving customer care

**When patients know that you have time to listen to their experiences of services and their ideas for change, they have so much to offer. When staff are given time to listen to patients, it reminds them of their core values and reconnects them to their purpose.**

This has certainly been the experience of staff from one team and colleagues working with them. A patient survey highlighted the need for customer care training and patients and staff have started to design a suitable training programme. This will include improved training and development for clerical and reception staff which will result in a better patient experience and improve staff job satisfaction.

Having patients in the group changes and enriches the nature of the discussion. Patients bring perspectives from a range of different eye conditions, degrees of visual impairment, life experience and their experiences of other hospitals. This makes the patient voice a genuine part of the process.

Staff have found the experience motivating and refreshingly challenging. Staff recognise that they are able to be honest and transparent with each other. Barriers to change are openly discussed and understood and the team are motivated to design something which will offer an improved patient experience.

# Support for those implementing co-design

## It is important to consider how well the co-design methodology fits with the cultural norms in an organisation. EBCD works best when staff feel empowered to lead and make changes.

The best project leaders are proactive and do not wait to be given permission.

Practical support for teams who are building their confidence really helps, as do patience and encouragement. It can help to involve doctors in co-design teams as it appeared that when doctors were present the work was afforded a higher priority by the team. In this project, the work that the head of patient experience and others have done in interviewing and filming demonstrates organisational commitment and reduces the workload for frontline staff.

The best project leaders are proactive and do not wait to be given permission.

Experience of, and confidence with, the method really helps teams to make rapid progress. Identifying a project champion who is comfortable with the method at the outset helps get things started. People's initial reluctance usually stems from apprehension when they have not been involved in anything like this before. POCF trainers are used to seeing this but once the training gets underway, there is a realisation that the approach is an appreciative one, in which all progress to greater patient engagement is to be applauded, and confidence grows rapidly.

What is apparent from people who implement the co-design approach, is that it is easier to apply than people anticipate. Practical support to help start a project and the inclusion of more confident practitioners early on can have a huge impact on progress. Although the process cannot rely on a single 'heroic leader' if it is to be sustained across an organisation, an enthusiastic, confident champion is a valuable starting point.

Permission and determination to take the time to apply the method is critically important. This requires strong clinical and non-clinical leadership and a recognition that co-design is an inherent part of clinicians' and managers' everyday jobs.

Finally, support for the implementation of co-design needs to be tailored to the needs of the organisation. There is a need to carefully balance practical support for the teams implementing co-design, while on the other hand not de-skilling or disempowering those whose role it is to take ownership to make the changes and improvements.

# Case study: Reducing the wait

**The prospect of 120 booked outpatients, many having to wait a long time in the department, was the regular situation facing staff on a Monday morning. By December 2017 new nurse-led clinics for patients with a stable eye condition had been introduced enabling some patients to be seen, tested and discharged in around an hour.**

Under the new system patient results are reviewed by a consultant within three days and a message is sent to the patient to confirm the outcome and any further appointment. It has also been arranged that some patients needing long-term review can now be seen at clinics run on a Saturday, further reducing the numbers at Monday clinics.

Local medical consultant leadership has been very important. A new consultant works alongside an experienced colleague to help instigate and implement new ideas. Similarly, local leadership from department managers has been key to getting started with EBCD.

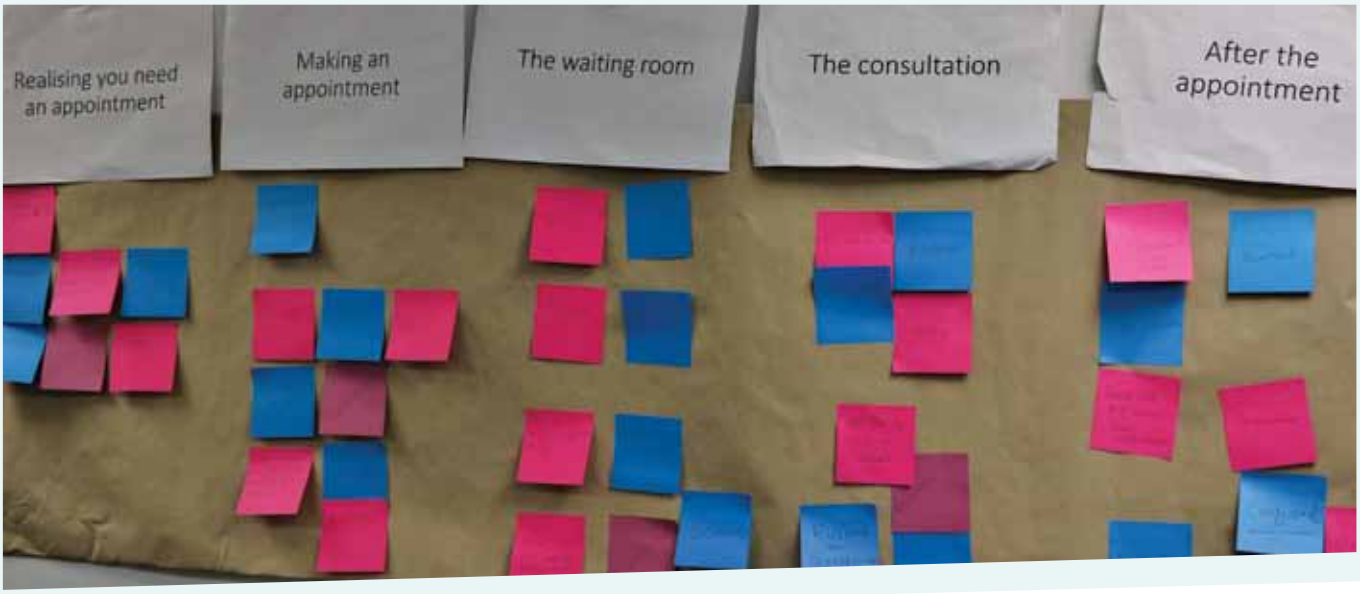
Experiences will continue to change at this site as patients, doctors, nurses, clerical staff and patients are interviewed about what it is like to deliver and receive the service.

The head of patient experience has been a trusted, credible and valuable resource to the team in helping to collect stories and make observations of care. Waiting in clinic is the top concern for patients and uppermost in the minds of staff too.

Interviews and observation are helping staff to explore what long waits feel like and to provide the foundation for involving patients and staff in designing improvements.

Some staff had training about the tools used in EBCD, while others heard about the process during interviews and because of the buzz of discussion in the department. The team have identified patients who frequently come to the Monday clinic to invite them to become involved, aiming for 10 patients to work with staff on service improvement projects.

Staff are excited that new ideas are being implemented and want to showcase the pathway changes they have made. They want patients to know they are making improvements. They don't want to miss the opportunity to get feedback from patients about their experience in clinic and gauge how successful the changes have been. They also want to find out what else can be done in time to improve the experience for staff and patients.



# Conclusion

## Several sites have made a promising start in a short period of time in implementing EBCD.

Some have moved further and faster than others. Service pressures and unplanned absence can be challenging when teams are trying to improve quality and find different ways to work with patients. Some teams manage to make progress despite these difficulties. It is important to reflect on what makes the difference.

It is clear from these case studies that some of the teams are making headway because of the confidence, enthusiasm and willingness of key practitioners, despite not yet having all the critical success factors fully in place. The learning gained from sites where progress has been slower is also contributing to building confidence and equipping teams to be in a better position for future co-design work.

What is also common across all the teams is how they value having the time to really listen to patients. Some are beginning to move from 'projects' to seeking opportunities to use co-design approaches in a wide range of service developments. This is the first step in moving EBCD from a new initiative to business as usual.

What is also common across all the teams is how they value having the time to really listen to patients.

It will not happen quickly, but if teams are given the time, resources and other support, there is plenty of evidence that the approach can be applied to its full potential across a networked care model significantly improving patient and staff experience.

## The Point of Care Foundation

The Point of Care Foundation (POCF) is an independent charity with a mission to humanise healthcare by making radical improvements in the way we care and are cared for. The POCF delivers this mission by providing evidence and resources to support health and care staff in caring for patients. It works to improve patients' experience of care and increase support for the staff who work with them. It delivers support to NHS and other organisations in the UK and abroad, to implement patient-centred approaches to improving the quality of health and care, focusing particularly on patients' experience of care.

www.pointofcarefoundation.org.uk
E-mail info@pointofcarefoundation.org.uk.

www.networkedcaretoolkit.org.uk