Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

SPSP Acute Adult Expert Reference Group Evaluation Report

Using a virtual Expert Reference Group model to co-design and co-produce improvement programmes during COVID-19 pandemic

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Background

The ihub Acute Care team remobilised the Falls and Deteriorating Patient improvement programmes in September 2020 which presented an opportunity to review and redesign both programmes. Our aim was to co-design and co-produce a revised improvement package for each programme to support clinical process improvement in acute hospitals and improve outcomes for people. The selected model was a virtual Expert Reference Group (ERG) which was convened in October 2020. Clinical and quality improvement experts from NHS Scotland boards were invited to join the ERGs and each group comprised approximately 18 members from territorial health boards.

Meetings were held monthly between October 2020 and March 2021, via MS Teams, however this excluded January and February due to pressures on the health system. A range of tools were used to create an inclusive and engaging virtual environment including: virtual break out rooms, electronic whiteboard software, recording video updates, electronic voting polls for consensus building, and resource sharing on MS Teams channels.

The driver diagrams for each programme of work were reviewed with input from Clinical Leads, members of the ERG and the ihub Acute Care team. The use of break out rooms and Google Jamboard allowed for small group discussion about each element of the driver diagram with time for feedback and wider group discussion.

An example of the Jamboard activity when co-designing the change ideas for primary driver 1 of the deteriorating patient driver diagram:

Primary Driver	Secondary Driver	Change Concepts & Ideas for PDSA Testing
Early, anticipatory planning and person centred care	Anticipatory Care planning in Community Care	Links with Primary Care
	Reliable communication across primary and acute care	Ekis/Epcs accessed at time of admission Reliable provision of information to primary care on discharge – Immediate Discharge Letter to inform eKIS
	Assessment of functional ability and health trajectory and detection of limited reversibility when assessing patients in primary and secondary care	Implement a process to identify limited reversibility (for example, SPICT)
	Reliable implementation of national DNACPR policy	Consider use of DNACPR measurement framework to support improvement http://www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Acute%20Adult%20Care/Tools%20and%20resources/201608%20DNACPR_MeasurementFramework.pdf

ReSPECT

If we could create a national way of communicating DNACPR electronically rather than on paper – it would make a huge improvement.

Implement a process to identify limited reversibility (for example, SPICT): Need to consider this in the post covid world particularly as we are now all using Rockwood frailty score.

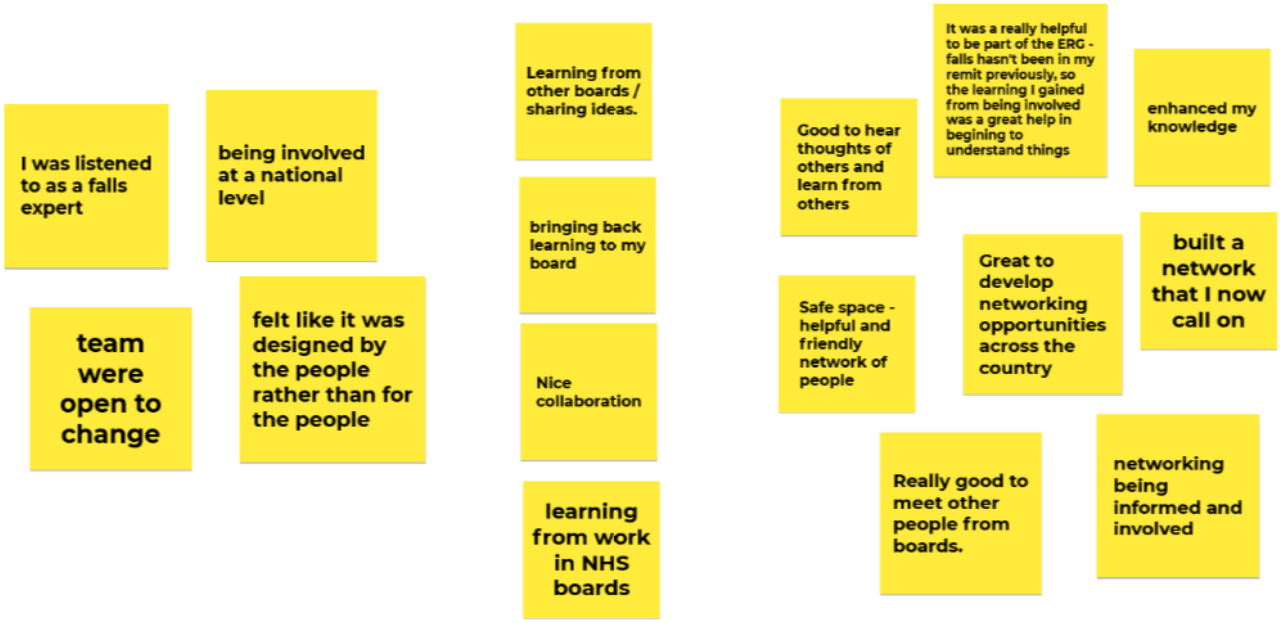
Need to also consider introduction of either a national quality standard for a TEP or a national TEP.

Voting polls were also used to support consensus building for each section of the driver diagram.

The ERGs co-designed the driver diagrams and change packages between October 2020 and March 2021. Following this, nine NHS boards tested the driver diagrams, change packages and measures in May and June 2021.

Methods

Three metrics were used to evaluate the ERGs: attendance, meeting feedback, and two focus groups following conclusion of the ERGs. The questions used to guide the focus group were provided on a Jamboard (Appendix A). The Jamboard allowed people to either discuss verbally or contribute anonymously, depending on their preference. Here is an example of contributions on the Jamboard for the first question: 'What was valuable to you personally about being part of the ERG?'



A participant information sheet (Appendix B) was circulated to ERG members a week prior to the focus group, with an opportunity to ask questions. Although this was service evaluation, informed consent was gained using the MS Teams polling function (Appendix C). The data from the focus groups were anonymised at point of collection and the data held securely on an NHS server. The quantitative data were analysed using descriptive statistics and qualitative data underwent framework analysis.

Findings

Attendance over time

Throughout the co-design and co-production process there was contribution from 50 staff from 15 NHS boards and despite unprecedented system pressures, attendance at all ERG meetings was consistently above 70%.

Feedback from each meeting

The average rating for each ERG meeting was 9 out of 10 with 98% of responses (n=49) scoring 8 or more.

Qualitative feedback through comments in the MS Teams chat box was overwhelmingly positive. The use of a digital approach to the co-design facilitated virtual connection, even during the height of the pandemic, which was important to the ERG members, who reflected:

"Highlight is sharing work nationally and working towards national solutions for Falls and other key work streams." (Falls ERG member)

"MS Teams content easy to use even with shielding at home it keeps me included. Thank you." (Deteriorating Patient ERG member)

"Very much enjoyed being part of this. Exciting times ahead." (Falls ERG member)

Focus Groups

Two focus groups were conducted with ERG members via MS Teams in November 2021. Five members from the Falls ERG participated in their focus group and three members from the Deteriorating Patient ERG participated in their focus group. The discussion focused on the following 3 questions:

1. **What was valuable to you personally about being part of the ERG?**
   A key theme was the value in networking with colleagues across the country and having an opportunity to meet with others from different NHS boards. Members particularly valued the learning and sharing of ideas they experienced as part of the ERG. A quote which highlights the value in being part of the ERG and influencing national patient safety work:

"It was designed by the people for the people"

The shared learning between colleagues will support improvement work for the falls prevention and deteriorating patient work streams and help teams improve outcomes for people in acute care settings.

2. **What did you find valuable about using the ERG as a mechanism to develop the Driver Diagram, Change Package and Measures?**
   ERG members described being part of something and having the same common purpose which enabled the groups to work well together and agree on elements of the driver diagram. Members reflected that their involvement in the ERG enabled them to explain the work clearly to their colleagues. The ERGs achieved their aims through an inclusive and collaborative approach which was valued by the participants:

> *"A really good way to develop national work with all NHS boards rather than by non-clinicians. Co-production where everyone's thoughts and views were listened to"* (Falls ERG member)

> *"Inclusion. A voice. I felt listened to. I felt included."* (Falls ERG member)

3. **If we were running another ERG in the future, what should we consider doing differently?**
   Overall the members described a positive experience. A suggested 'even better if' in relation to timeframes for task completion between meetings was captured in the following quote:

> *"More time – timelines were tight at times but this needed to be".*

The option of face to face meetings was highlighted but it was acknowledged that due to circumstances with COVID-19 this wasn't possible at this time. Indeed one member noted that the virtual nature of the ERG had allowed them to come to meetings that they otherwise would have had to miss due to clinical commitments. Feedback from one member encouraged the value of celebrating success, and shared:

> *"The people involved did a great job."*

Recommendations

In the future we would be mindful to consider and review timeframes in partnership with the ERG members. To capitalise on the advantages of the virtual approach we would also explore using a hybrid model for future ERGs to accommodate those who wished to meet in person and those who prefer to contribute virtually.

Comprehensive planning is essential when programme design is virtual. Colleagues can have varying IT skills and technical difficulties can occur when navigating between software platforms. Our message is to 'keep it simple'. Dedicated Microsoft Teams channels and video recordings can provide value by allowing members to participate and contribute as clinical pressures allow.

Conclusions

The ERGs successfully co-designed the resources which are now the cornerstone of the newly launched SPSP Acute Adult Collaborative which aims to improve the experience and outcomes for patients in acute care.

Members of the ERGs particularly valued the inclusivity of virtual methods and opportunity for enhanced engagement with colleagues in remote and rural areas. It was so successful that the ERGs have transitioned into networks which support ongoing collaboration with colleagues across NHS Scotland and provide an opportunity for shared learning and sharing best practice.

Our experience demonstrates that it is possible to co-design national patient safety improvement programmes with frontline teams, using digital methods when traditional face to face methods are infeasible.

Appendix A – Questions for focus group

- What was valuable to you personally about being part of the Expert Reference Group (ERG)?

- What did you find valuable about using the ERG as a mechanism to develop the Driver Diagram, Change Package and Measures?

- If we were running another ERG in the future, what should we consider doing differently?

Appendix B – ERG Evaluation

We would like to invite you to take part in an evaluation of the Expert Reference Group (ERG) you were part of, which co-designed the SPSP Acute Adult Collaborative. Before you decide whether or not to take part it is important for you to understand why the work is being done and what it will involve. Please take the time to read the information below and get in touch if you have any questions. You have been invited to take part because you were a member of the ERG.

What is the purpose of this evaluation?

We are interested in evaluating the ERG in order to understand its value and to inform design and conduct of future ERGs in other programmes.

What will I have to do if I agreed to take part?

If you decide to take part you will be invited to take part in a breakout room at the next Network meeting with 7-10 other members of the ERG. The breakout will form part of the total meeting time and last a maximum of 20 minutes. In the breakout room jam board will be used to explore three questions relating to:

- what was valuable to you personally about being part of the ERG,
- what you think about the value of the ERG as a mechanism to develop the Collaborative, and
- if we were running another ERG in the future, what we could consider doing differently.

The breakout rooms will not be recorded but the jam board, chat box and field notes of the discussion will be collected. These will be stored electronically for three years from the date of publication of findings and then destroyed.

Will my taking part in this evaluation be kept confidential?

If you decide to take part this will be kept strictly confidential. Your participation will only be known to the other members of the breakout room and the Acute Care team. Although direct quotes from you may be used in writing up the findings, your name and the identity of any individuals or organisations named within the breakout will be kept anonymous. The data will be stored in a locked area of our password protected server and will only be accessible to the Acute Care team.

Do I have to take part?

It is entirely up to you whether or not you decide to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw would not affect your rights or relationships with SPSP.

What happens if I don't want to take part?

If you do not want to take part there will be an opportunity before the evaluation starts for you to leave the network meeting at the point where breakout rooms are formed.

What if something goes wrong?

If you have a concern about any aspect of this evaluation please contact Claire Mavin, Portfolio Lead, Acute Care Portfolio, ihub at claire.mavin@nhs.scot.

What will happen to the findings of this evaluation?

The findings of this evaluation will written up in the SPSP Acute Adult Collaborative evaluation report and may also be presented at conferences. The findings will be shared with participants directly and at a future network meeting.

Thank you for considering taking part in this evaluation.

V1.0 25/10/2021

Appendix C - Consent

1 - I have read and understood the information sheet and had an opportunity to ask questions:

- Yes, I agree
- No, I don't agree

2 - I understand I can withdraw at any time without having to give an explanation:

- Yes, I agree
- No, I don't agree

3 - I understand that the findings from the evaluation may be used in publications or presentations including direct quotes but that the identity of any individuals or organisations will be removed and confidentiality will be respected during project reporting:

- Yes, I agree
- No, I don't agree

4 - I agree to the anonymised notes from this session being stored securely for a period of three years:

- Yes, I agree
- No, I don't agree

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