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Real-time and Right-time Care Experience Improvement Models

Evaluation Report

May 2018

Person-Centred Health and Care Programme

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Appendices

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And special thanks to all of the care teams who implemented and tested these models and all others who contributed to the content, ideas and themes contained in this report.

Foreword

Christine Jess and Susan Siegel
Public Partners working with Healthcare Improvement Scotland

As Public Partners[i], we have welcomed the opportunity to work as members of both the operational and advisory groups that support the Person-Centred Health and Care Programme. What has become clear in our work with this programme, is the strong commitment to ensuring that the views of people who receive care and services are used as drivers for improvement. We welcomed the opportunities we were given to meet with frontline staff who are involved in obtaining feedback and also service users to find out first-hand the impact of this programme.

In this evaluation report, you will read about the challenges and positive impacts of the methodologies being tested. Several key themes have emerged as well as benefits for people receiving care and for the staff and volunteers involved. Many commented on their feelings of increased value and self-worth. This has promoted further commitment and ownership of future improvement-driven service changes.

In addition, critical success factors have been identified, including the co-ordination required, the essential role of facilitation to support care teams to reflect and identify improvements, and the need to embed quality improvement as 'business as usual' rather than having it seen as a separate entity. This requires buy-in from all levels of staff to ensure ownership of change is effectively communicated, understood and embraced.

We present this evaluation report of the four demonstrator sites across NHSScotland as they implemented the Real-time and Right-time care experience improvement models. We are mindful and pleased that across each site there was significant interaction with those people receiving care or support and their families.

[i] Public partners support Healthcare Improvement Scotland on a voluntary basis and provide a public perspective and constructive challenge on our work to ensure it is person-centred and high quality.

Executive summary

Purpose

The purpose of this evaluation is to capture and report learning from the Person-Centred Health and Care Programme's demonstrator sites testing Real-time and Right-time care experience improvement models.

This evaluation has been informed by a mixed methods approach to understanding the outcomes and impact of these two improvement models. Quantitative analysis was used to understand the processes and outcomes in relation to implementation of the models and a thematic analysis was undertaken to explore their impact and how the models worked in practice.

Background

"Previously although services were collecting patient feedback there was little evidence of the feedback being used to inform improvements, celebrate success or being fed-back widely to staff."

(Programme lead, NHS Tayside)

In order to help address a recognised lack of connection between care experience feedback and improvement within healthcare organisations, Healthcare Improvement Scotland's Person-Centred Health and Care Programme has worked with four NHS boards in Scotland since October 2015 to prototype, test and evaluate two improvement models. These models attempt to create the process, environment and culture for care teams to effectively identify and make meaningful improvements directly related to feedback from the people who use their services in a reliable and person-centred way.

Both models ask care teams to take a conversational approach to gathering narrative (or qualitative) experience feedback from people receiving care or support. In the Real-time model the feedback is gathered close to or during an episode of care and in the Right-time model this is gathered two to three weeks following the episode of care (or following discharge). Both of these models require care teams to review the feedback routinely within a reflective improvement meeting and take an improvement approach to testing and implementing improvements identified from feedback.

This report outlines the evaluation findings of this programme which has been led by the overarching question:

Does combining an improvement approach with conversational methods of asking for and receiving feedback from service users help care teams to make improvements directly related to what matters to them?

Findings

"It is good to know that we are doing well, and compared to how it was months ago it is a hundred times better now. I think getting the feedback from patients helped and talking about and sharing it with staff is valuable and made a difference. Bringing it up on safety briefs as well got staff to think about it and have it in their thinking for the day."

(Senior charge nurse, Monklands Hospital)

Both Real-time and Right-time care experience improvement models have demonstrated potential to effectively support care team level improvements directly attributable to service user feedback.

Across both models, care teams identified improvement opportunities in 17% of all the feedback conversations held as part of the Real-time approach and 21% of feedback conversations held as part of the Right-time approach. This meant that care teams were able to identify one improvement opportunity for every six care experience conversations held (ratio 1:6). From these opportunities almost 50% (n=163) were implemented.

There was improvement in care experience scores noted for some participating organisations, although overall care experience scores did not improve as a combined total across all organisations. Improvements in scores ranged from 2% to 4% across care teams in two of the organisations applying the Real-time model and over 9% across care teams in one organisation applying the Right-time model.

It was noted that in this work care teams were more likely to apply a robust improvement methodology when working with the Real-time care experience improvement model than the right-time model.

Over the evaluation period care teams reported increasing perceptions of value for the processes and outcomes achieved in embedding the model(s), and in the care team's motivation to be involved and make improvements based on feedback from service users.

Key learning

"In the early days we didn't understand how powerful and compelling it would be… in terms of the emotion, it generates an energy to take action. Hearing the words that people use is very powerful."

(Programme lead, NHS Greater Glasgow and Clyde)

1. Both Real-time and Right-time care experience improvement models provide a framework that empowers care teams to effectively identify and implement meaningful improvements directly attributable to service user feedback.
2. A conversational approach and gathering narrative feedback provides the context and depth to effectively support care team reflection and identification of improvement opportunities.
3. A good level of conversational skills and training in how to collect and record narrative feedback data is required to provide the depth and context to support improvement.
4. Embedding the reflective improvement meeting as a routine activity is vital to maintain the engagement of the care team and regular improvement activity.
5. Providing facilitation and coaching support for care teams initially supports them to embed and take ownership of their approach to the care experience improvement model.
6. There was no evidence of more gratitude[ii] or social desirability[iii] bias in the Real-time model (at the point of care) than in the Right-time model (following an episode of care).
7. The Real-time care experience improvement model was quicker to set up and easier to sustain than the Right-time care experience improvement model.
8. The Real-time care experience improvement model generates a marked sense of urgency in care teams to make improvements that is not noted as visibly in the Right-time care experience model.
9. Care teams working with the Right-time care experience improvement model were less likely to use the recommended improvement approach to testing and developing improvements (PDSA cycles) prior to implementing them.

[ii] Gratitude bias: Where positive attribution is given in response to feelings of gratitude.

[iii] Social desirability bias: where responses are given that will be viewed favourably by others. It can take the form of over-reporting good behaviour or under-reporting poor or undesirable behaviour.

Conclusions

In this evaluation we saw that both the Real-time and Right-time care experience improvement models can effectively support an improvement culture within care teams. It was essential to the success of either model that:

- conversations are held with those receiving care rather than taking a survey approach
- care experience is gathered as narrative feedback
- regular facilitated reflective improvement meetings are held to agree and take forward improvement opportunities, and
- initially care teams are supported to embed the approach by experienced facilitators who understand both qualitative data and the quality improvement methodology.

Due to the improvement infrastructure embedded in both these models both care experience improvement models were able to deliver similar outcomes and support a person-centred and improvement culture within the participating care teams. In addition, combining this improvement approach with conversational methods of asking for and receiving in-depth narrative feedback from service users has increased the ability of care teams to make improvements directly related to what matters to them.

Both of these care experience improvement approaches offer a robust diagnostic mechanism to support identification, testing and implementation of meaningful improvements.

A number of recommendations from this evaluation are included at the end of this report.

Introduction

People who receive health and social care services have the right to expect high quality care that is person-centred, compassionate and respectful, as well as safe and effective. Care experience is a key component of how we define quality care and is acknowledged as a priority in both the Scottish Government's 2020 Vision[1] and the Healthcare Quality Strategy for Scotland.[2]

Health and social care organisations in Scotland have a legislated duty to involve people in designing, developing and delivering the care services they provide for them.[3, 4, 5, 6, 7] Therefore, involving people in continuously improving their experiences of care is a priority.

It is clear that to do this, people who receive care services can and should be involved in evaluating and shaping them. However, studies[8, 9,10] carried out across different healthcare organisations show that there is significant variation in how NHS organisations collect, analyse and use patient, family and carer feedback for improvement purposes, which predominantly focus on surveys and satisfaction scores.

In order to help address the apparent lack of connection between care experience feedback and improvement within healthcare organisations, Healthcare Improvement Scotland's Person-Centred Health and Care Programme has worked with four NHS boards in Scotland since October 2015 to prototype, test and evaluate two improvement models that attempt to create the process, environment and culture for care teams to effectively identify and make meaningful improvements directly related to feedback from the people who use their services in a reliable and person-centred way.

This report outlines the evaluation findings of this programme which has been led by the overarching question:

Does combining an improvement approach with conversational methods of asking for and receiving feedback from service users help care teams to make improvements directly related to what matters to them?

Overview of the care experience improvement programme

Healthcare Improvement Scotland began a care experience improvement programme in April 2015. By the end of October that year four NHS boards from across Scotland had been selected to participate in implementing and evaluating two new improvement approaches guided by service user feedback (see Figures 1 and 2).

Each organisation applied one or both models across a range of care settings (see Appendix 1). Initially, they spent several months in set-up phase, during which they planned their local approach to working with the new model(s), identified existing care teams to participate, and recruited their local programme support staff. All organisations had begun their local approach to one or both of these models by January 2016.

The four organisations participating in this programme were:

- NHS Greater Glasgow and Clyde
- NHS Lanarkshire
- NHS Tayside, and
- NHS Western Isles.

The designing of local programmes of testing was co-ordinated through dedicated organisational programme leads who were already working in person-centred care, patient and community relations or practice improvement teams within their organisations. Programme care teams (see Appendix 1) were recruited locally by programme leads to implement the models and test improvements.

The specialties of participating care teams included:

- maternity
- medical
- orthopaedic
- surgical
- older peoples services
- community nursing, and
- integrated health and social care.

The approach to implementing these improvement models was focused mainly in individual acute care and community teams. However NHS Greater Glasgow and Clyde chose to trial an approach to gathering care experience feedback across two clinical pathways, with the intention of holding improvement discussion meetings within clusters of care teams (Appendix 1).

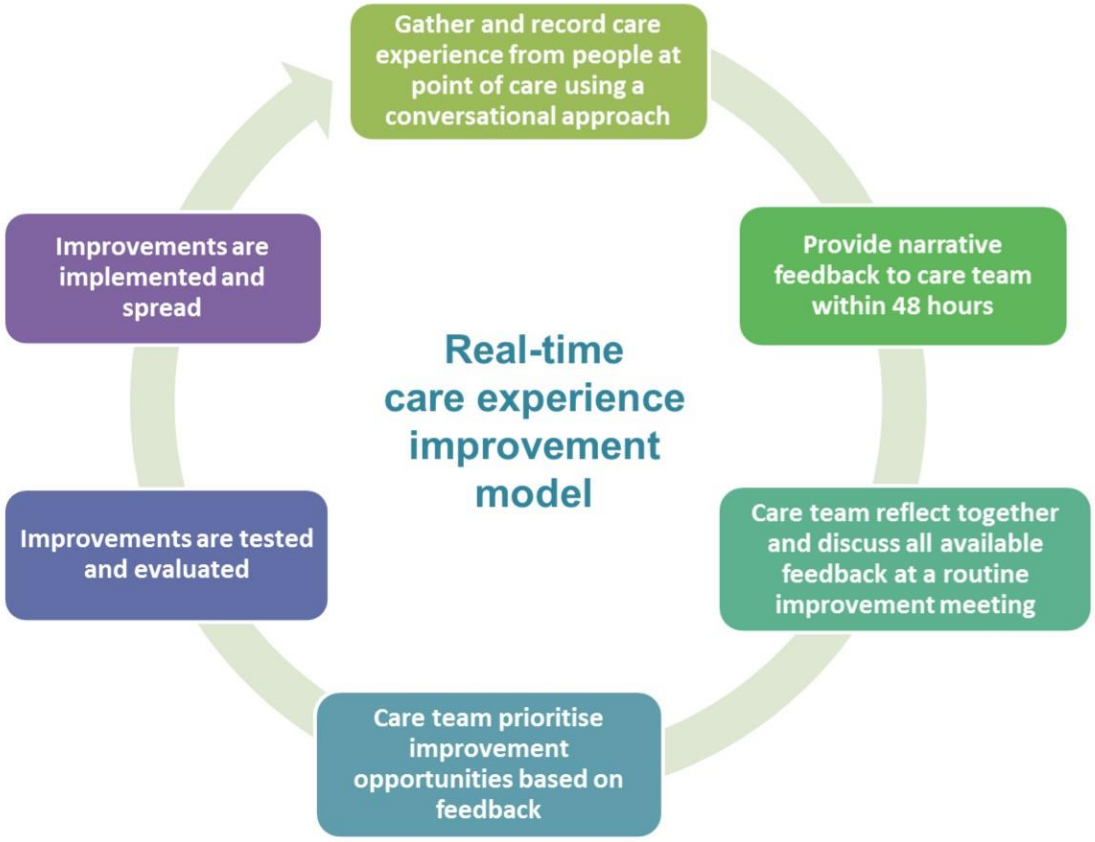
The two improvement models implemented by care teams are described below.

Real-time care experience improvement model (Figure 1)

Using evidence that suggests narrative feedback can effectively support service improvement, [11, 12] this model asks care teams to take a conversational approach to gathering narrative (or qualitative) experience feedback from people receiving care or support in real time, that is close to or during the episode of care.[13] It recommends a convenience sample of a minimum of five conversations[14] be carried out each month, although more can be held.

The feedback should then be provided rapidly[15] to the care team, within 48 hours of collection where possible. The care team then reflects on all of the feedback with as many members of the multidisciplinary care team as possible, followed by an improvement discussion. Improvement opportunities will be identified during this discussion and then prioritised and progressed as quality improvement activities by the care team using the Institute for Healthcare Improvement's 'Model for Improvement'[16] (see Figure 3).

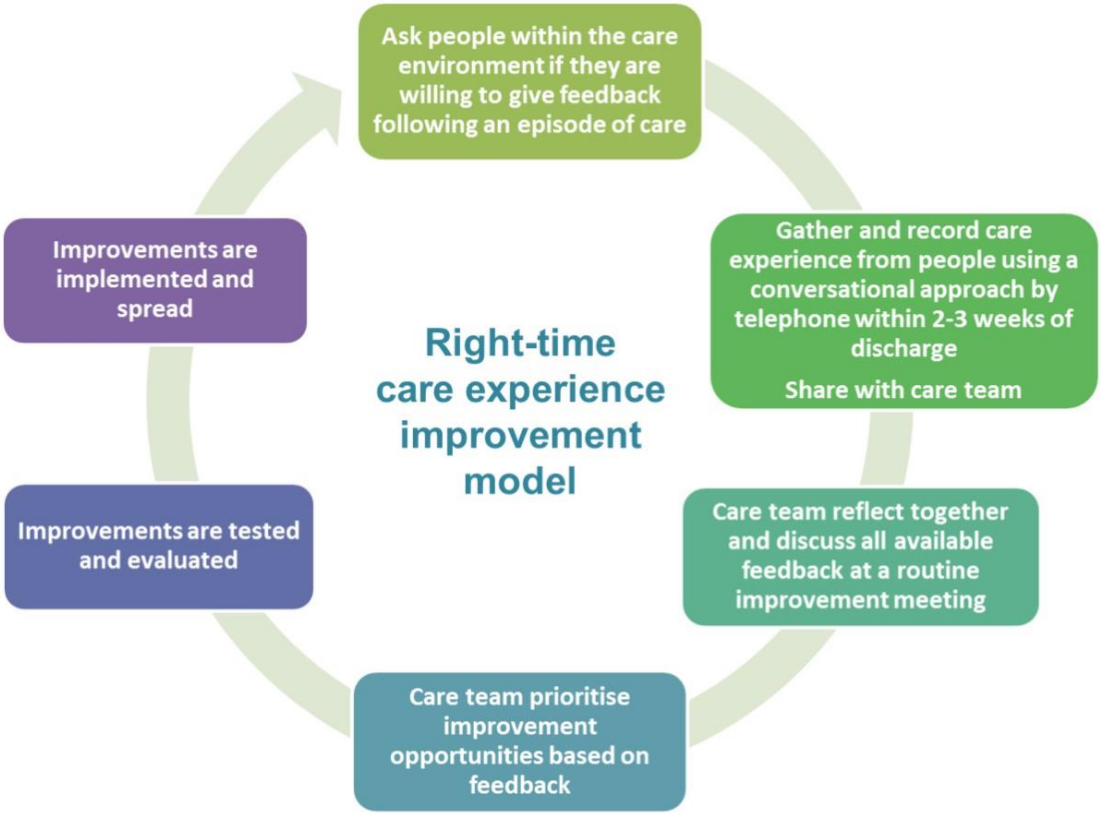
Figure 1: Real-time care experience improvement model



Right-time care experience improvement model (Figure 2)

This model has most of the same characteristics as the Real-time model, however rather than gathering feedback within the care setting, this model begins with obtaining consent in the care environment to allow a telephone conversation to take place about care experiences two to three weeks following the episode of care[17] or following discharge. When using this model the feedback is provided to the care team to reflect on and hold an improvement discussion as soon as possible following collection. The team then identify and prioritise improvement opportunities to be taken forward as quality improvement activities, in the same way as in the Real-time model.

Figure 2: Right-time care experience improvement model



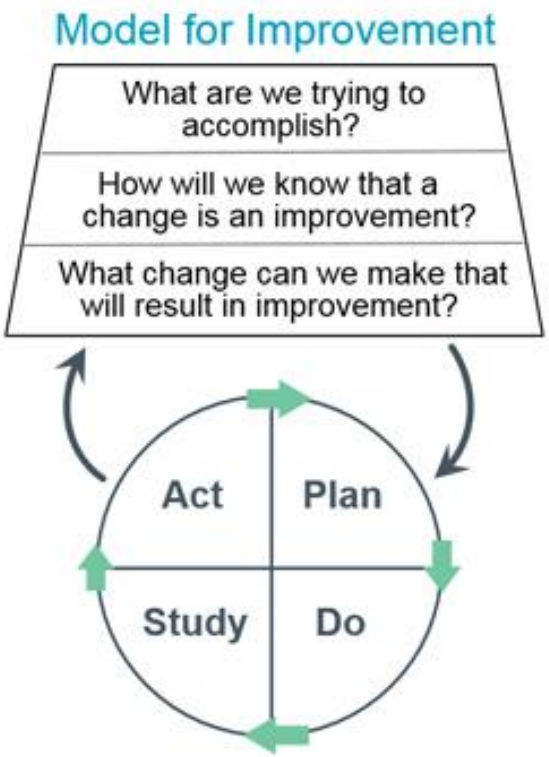
The rationale for testing a feedback model at both 'point of care' and following an episode of care was to explore the suggestion made by Sweeney, Brooks, and Leahy[17] that feedback given after an episode of care can reflect the reality of the experience more, with less positive bias, than that shared at the point of care. It also suggests that people have better recall and may give more honest feedback within a three-week window.

In this programme of work, the Model for Improvement (Figure 3) was recommended to support care teams to test and implement improvement opportunities identified from collected feedback. The Model for Improvement is a simple yet powerful tool for accelerating improvement, which has two parts:

- three fundamental questions which can be addressed in any order, and
- Plan-Do-Study-Act (PDSA)[16] cycle to test and implement changes.

The PDSA cycle guides the test of a change to determine if the change is an improvement.

Figure 3: Model for Improvement (IHI)[16]



Evaluation methodology

The purpose of this evaluation was to capture and report learning from the programme demonstrator sites. The evaluation has been informed by a mixed methods approach (Figure 4) to help understand the impact of applying both improvement models being tested (illustrated in Figures 1 and 2), as well as the differences between them.

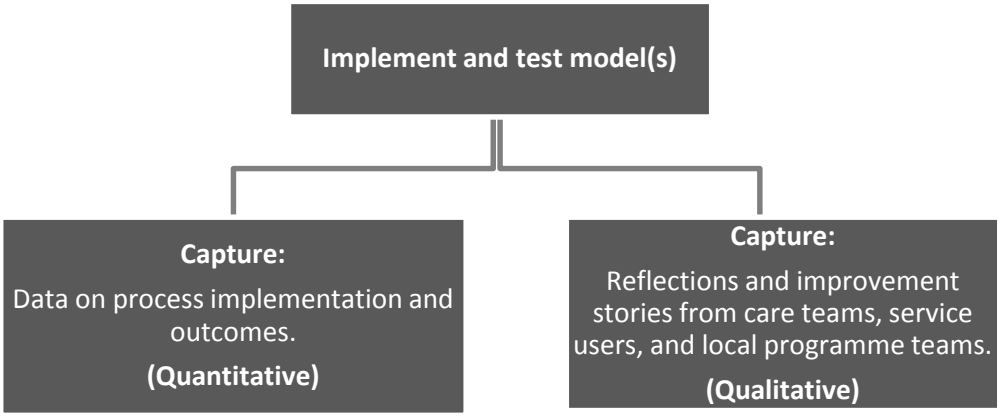
This evaluation was guided by the programme's overarching question:

Does combining an improvement approach with conversational methods of asking for and receiving feedback from service users help care teams to make improvements directly related to what matters to them?

The following approaches were used to collect insights for this evaluation:

- **Quantitative measurement and analysis** of process reliability in implementing each model.
- **Learning capture from each demonstrator site**, including reflections on how the models were locally implemented and sustained and case studies to understand what difference this has made to service users.
- **Document review and thematic analysis** of a range of qualitative data sources that captures the experiences and reflections from staff and the programme team involved in the testing of both models. The thematic analysis followed Braun and Clarke's[18] six-phase approach which allows identification of prevalent patterns in interview transcripts that explain what is common in the participants' experiences.

Figure 4: Evaluation model for capturing learning from programme demonstrator sites



Quantitative analysis was carried out to understand the processes needed to implement each model.

In order to compare and analyse the quantitative data collected on the processes needed for implementing these models the following data definitions were agreed.

- **Number of conversations:** the number of individual care experience interviews/themed conversations conducted and then discussed at the improvement meetings.
- **Improvement opportunities:** improvements identified by the care teams at the improvement meeting as a result of discussing care experience feedback.
- **Unique improvements tested:** individual improvement opportunities identified at improvement meetings that are then tested in order to determine if the opportunity would lead to an improvement. Please note that one unique improvement test may include several PDSA cycles which are not counted.
- **Implemented improvements:** improvements identified at improvement meeting that are then implemented. This is not an indicator of the number of improvements sustained.

The qualitative findings have been informed by document review and thematic analysis of the following sources:

- Transcripts from individual and group interviews with the programme leads and 30 clinical staff in total from participating care teams across all organisations[iv]. The interviews were carried out by independent external social researchers.
- Transcript from a focus group held with five participants comprising of 3 programme leads and two public partners involved in the programme to confirm and expand on the interim qualitative findings.
- Reflections from participating organisations' care teams describing the impacts of changes made and using the improvement models.

[iv] The full thematic analysis for this evaluation is available on request.

- Reflections from local programme support teams of their experience of supporting implementation of the model(s), their challenges and successes in supporting improvement.
- Reflective learning logs from a range of participants in each demonstrator site.

Evaluation limitations

Limitations identified in this evaluation methodology are detailed below.

- **Evaluation of impact on people who use the services**
  The evaluation of this work could not systematically collect service-users perspectives on the impact of care teams applying these improvement models. Only collection of perspectives on individual improvements that had been implemented using the model was possible.

  For that reason the thematic analysis and interpretations made in the findings and conclusions have focused mostly on the staff's understanding and interpretation of the impact on people. Where possible, predominantly in the case studies and learning reflections, we have attempted to include narrative from the service users' perspective, in their own words, on the difference a specific improvement intervention implemented, using one of the models, has made to their experience.

- **Staff experience**
  Whilst staff consistently reflected that their understanding of service users' perspectives increased and developed over time applying this model, this improvement was not measured systematically. Future investigation on this would further aid understanding of the potential impact on the culture of care teams.

Evaluation of process and findings

As seen in other feedback approaches, the demonstrator sites gathered a large proportion of positive and neutral feedback in addition to less positive feedback. Although it is possible to identify improvement opportunities from positive and neutral feedback, care teams were more likely to identify improvements from feedback that did not align with their perceived standards of care quality. Consequently care teams working across both models identified one improvement opportunity for every six care experience conversations held (ratio 1:6). This equates to identifying improvement opportunities in 17% of all the feedback conversations held as part of the Real-time approach and 21% of feedback conversations held in Right-time.

We also found that care teams working across both Real-time or Right-time models were able to implement almost 50% (n=163) of all the improvement opportunities (n=346) identified, which can be directly attributable to listening to and reflecting on what people said about their individual care experiences (see Tables 1 and 2).

It was noted in the process evaluation that care teams using the Right-time care experience improvement model were less likely to test and develop improvements before implementing them (see Table 4). The recommended improvement approach for both Real-time and Right-time models is the Model for Improvement, which incorporates small tests of change (PDSA cycles) to help ensure that change is an improvement and more effectively support sustainable implementation.

Some studies including Reed and Card[19] have suggested that there can be a pressure in healthcare improvement activities to move to a phase of 'doing' and 'acting' at the expense of testing what is most likely to be sustained. However, to fully understand why the care teams using the Right-time care experience improvement model specifically were less likely to use the recommended improvement approach (see Figure 4), in particular the testing phase, may require further study.

In reviewing the following process outcomes, it is helpful to note that care teams generally focused their initial efforts and capacity on improvement opportunities that they believed would have the most impact. This was due to more improvement opportunities being identified than could be tested and implemented in the period of evaluation.

In addition, not all feedback was actionable directly by the care team receiving it. At times, improvement opportunities had to be shared with other individuals or services outside the immediate care team, or escalated to the managerial team for their attention and action. This was out of scope of this programme, and therefore is not reflected in the number of improvements implemented by the participating care teams.

Real-time model process outcomes

The Real-time care experience improvement model was tested by three NHS organisations (see Appendix 2). Data collection for this model began in January 2016 following a period of set-up and concluded in November 2017.

Over the evaluation period, 1,627 Real-time conversations were held with service users about their individual care experience across 32 care teams. This resulted in 255 improvement opportunities being identified from feedback during 230 care team reflective improvement meetings. In turn, this led to 139 unique tests of improvement ideas which have resulted in 119 improvements being implemented (see Figure 5 and Table 1). We are unable to say how many improvements have been sustained over time with the data currently available.

Figure 5: Combined process outcomes across sites testing the Real-time care experience improvement model (January 2016–November 2017)

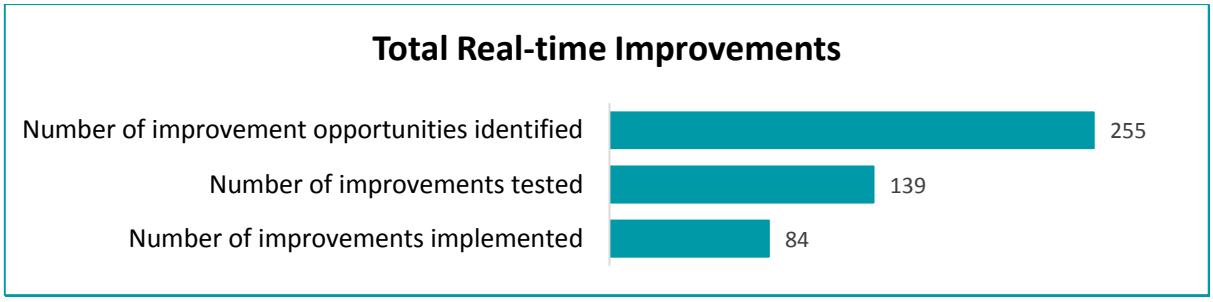


Table 1: Results for organisations testing the Real-time care experience improvement model (January 2016–November 2017)

Demonstrator site	Total care teams	Number of conversations	Improvement opportunities	Unique improvements tested	Improvements implemented
NHS Greater Glasgow and Clyde	20 (8 clusters)	979	143	87	56
NHS Western Isles	3	85	15	12	4
NHS Lanarkshire	9	563	97	40	59
Total	**32**	**1627**	**255**	**139**	**119**

Right-time model process outcomes

The Right-time care experience improvement model was tested by two NHS organisations (see Appendix 2). Data collection for this model began in June 2016 following a period of set-up and concluded in November 2017.

Over the evaluation period, 432 telephone conversations were held with people following their episode of care. This resulted in 91 improvement opportunities being identified across nine participating care teams during 87 care team reflective improvement meetings. This led to 10 unique tests of improvement ideas that have resulted in 44 improvements being implemented (see Figure 6 and Table 2). We are unable to say how many improvements have been sustained over time with the data currently available.

Figure 6: Combined process outcomes across sites testing the Right-time care experience improvement model (June 2016–November 2017)

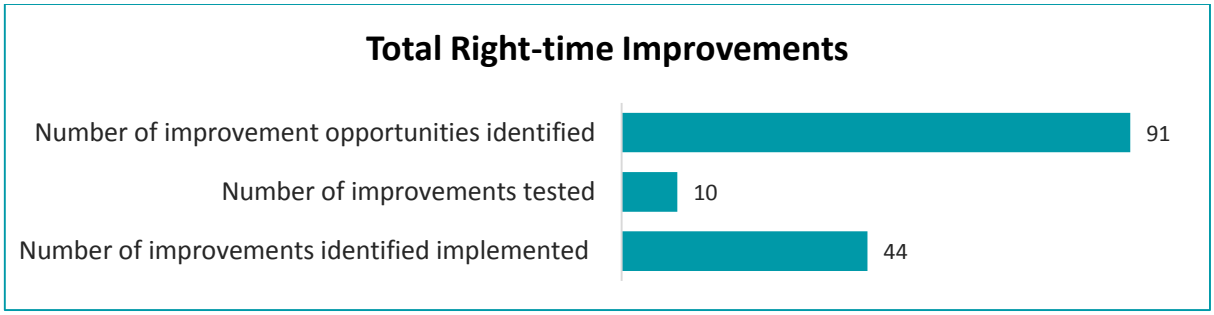


Table 2: Results for organisations testing the Right-time care experience improvement model (June 2016–November 2017)

Demonstrator site	Care teams	Conversations	Improvement opportunities	Unique improvements tested	Improvements implemented
NHS Lanarkshire	7	241	70	4	39
NHS Tayside	2	191	21	6	5
Total	**9**	**432**	**91**	**10**	**44**

Comparison of Real-time and Right-time models

The ability to make a direct comparison between the outcomes of each participating organisation is limited due to some variation in how each participating organisation adapted their approach to implementing these models.

These variations include:

- the format and structure of the care experience conversation, which in most cases was developed from a pre-existing approach or discussion framework
- how narrative feedback was presented to the care team, and
- the participants invited to join in the care team reflective improvement discussion, which on occasions did not involve the whole care team or include multi-professional representation.

However, we have looked at two comparative outcome rates that could most robustly demonstrate the overall differences in how the Real-time and Right-time care experience improvement models performed cumulatively across all participating organisations. These are as follows:

Testing rate - number improvements tested divided by the number of improvement opportunities identified by the care teams, and

Implementation rate - number improvements implemented divided by the number of opportunities identified by the care teams.

We can see from the conversion rates outlined in Table 3 that both models have converted almost 50% of improvement opportunities identified into implemented improvements.

Table 3: Overall conversion rates for Real-time and Right-time care experience improvement models

Model	Improvement opportunities identified	Testing rate	Implementation rate
Real-time	255	0.54	0.47
Right-time	91	0.11	0.48

A direct comparison of outcomes in these conversion rates can be seen in the one participating organisation (NHS Lanarkshire) that used both Real-time and Right-time models and applied the same discussion tools and improvement approach. We see for this organisation the improvement implementation rate was higher (around 60% for both models) than the overall implementation rate seen in Table 3. We also see a similar low level of testing before implementing improvements within care teams applying the Right-time care experience improvement model.

Table 4: Overall conversion rates for Real-time and Right-time in NHS Lanarkshire

Model	Improvement opportunities identified	Testing rate	Implementation rate
Real-time	**97**	**0.41**	**0.61**
Right-time	**70**	**0.06**	**0.56**

Whilst we cannot be conclusive about the overall best value of one improvement model over the other from these results, programme leads and care teams have shared that they feel motivated by the current relevance and immediacy of feedback received when using the Real-time care experience improvement model especially. This model appears to generate a level of urgency to make improvements and to resolve issues 'in the moment' for individuals that is not replicated in teams applying the Right-time model.

Specific examples of improvements undertaken in each area can be found in Appendix 3.

Care experience

This work was not specifically focused on improving care experience scores, rather the mechanisms within care teams to hear and respond to care experience feedback more effectively. However, it was important to record and track how this programme of work impacted on overall care experience within the 32 participating care teams.

Care experience scores were already collected routinely by most participating organisations and so were provided for each of the involved care teams during the period of evaluation. Each organisation calculated these scores in one of two ways, either as a quantitative aggregated score of positive responses across a range of care experience domain questions, or by one single question asking the person to rate their experience on a numbered scale.

As care experience scoring is commonly interpreted from satisfaction ratings, it was anticipated that care experience scores within this work would align with the baseline set by the national inpatient care experience surveys for Scotland[v]. These have remained between 80% and 95% positive, on average, across acute health settings for a number of years.

It is useful to note that responses to satisfaction questions do not necessarily reflect the full experience of care. 'Satisfaction' being how positive someone feels about an encounter or interaction, whereas 'experience' is largely based on emotion, is the lasting story, and is defined in all that is perceived, understood and remembered. Martin et al[9] explain that focusing on experience allows care teams to explore more effectively how care is being experienced and what is effecting that experience.

For some participating organisations there was improvement noted in care experience scores, although overall care experience scores did not improve as a combined total across all organisations. Improvements in scores ranged from 2–4% across care teams in two of the organisations applying the Real-time model and over 9% across care teams in one organisation applying the Right-time model.

The following outlines the overall care experience scores that were provided by each participating organisation during the period of evaluation.

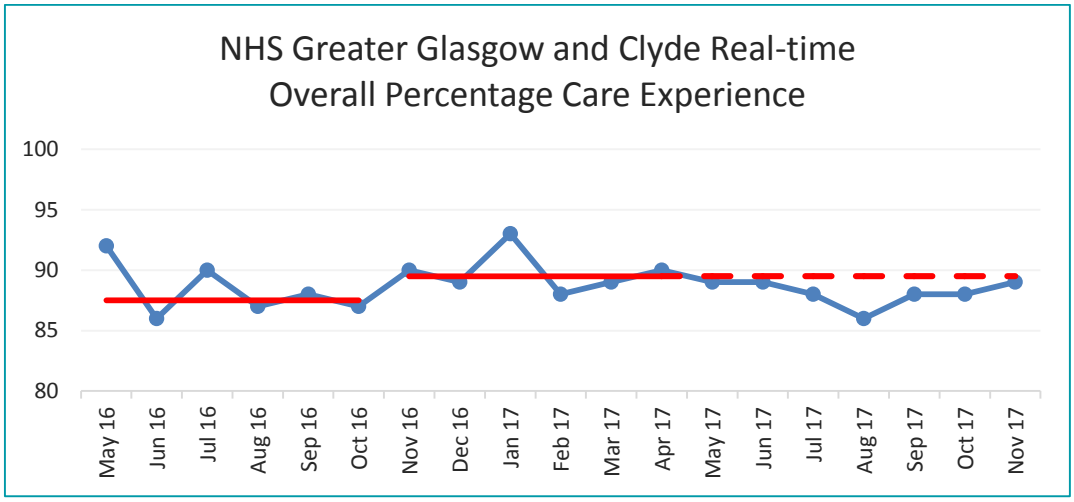
[v] NHSScotland Inpatient Experience Surveys: http://www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey

NHS Greater Glasgow and Clyde (Real-time model)

The overall care experience score in this organisation was based on a percentage of positive responses to all enquiry questions aggregated from all conversations held each month.

Over this programme of work NHS Greater Glasgow and Clyde saw a small improvement (+2%) in the overall care experience within the care teams participating (Figure 7).

Figure 7: Overall Real-time Care Experience in NHS Greater Glasgow and Clyde



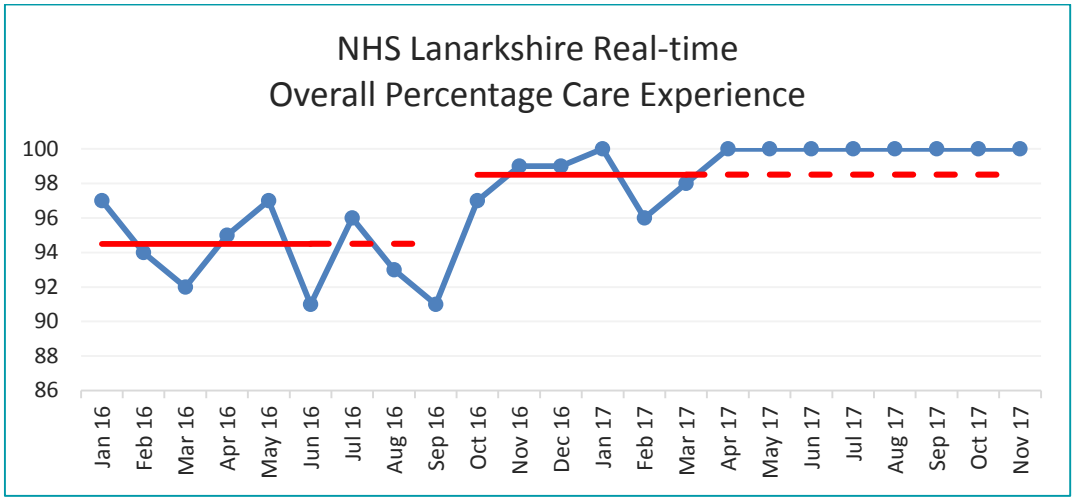
As can be seen in Figure 7, there was a sustained improvement after 6 months of testing the Real-time model, with the median increasing from 87.5% to 89.5%. However, this was followed by a number of consecutive months where the care experience score wasn't maintained at this new level.

NHS Lanarkshire (Real-time model)

The overall care experience scores in this organisation were based on responses to a single question: 'How happy are you with the care and support received?'

In NHS Lanarkshire their work with the Real-time model led to an overall sustained improvement (+4%) in care experience in their participating care teams.

Figure 8: Overall Real-time care experience in NHS Lanarkshire



The data in Figure 8 shows that an improvement took place after October 2016 which is when all of the care teams involved had fully embedded the Real-time model process. From April 2017, there was further improvement and care experience scores were showing at 100% for eight consecutive months.

NHS Lanarkshire (Right-time model)

Again scores were based on responses to the individual question: 'How happy are you with the care and support received?'

NHS Lanarkshire's care teams working with the Right-time model saw an overall sustained improvement (+9.5%) in care experience.

Figure 9: Overall Right-time care experience in NHS Lanarkshire

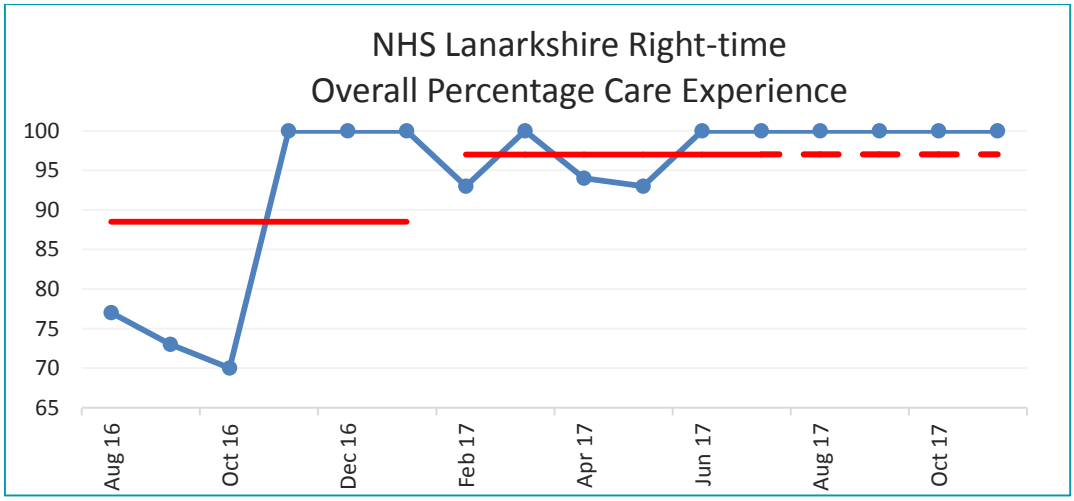
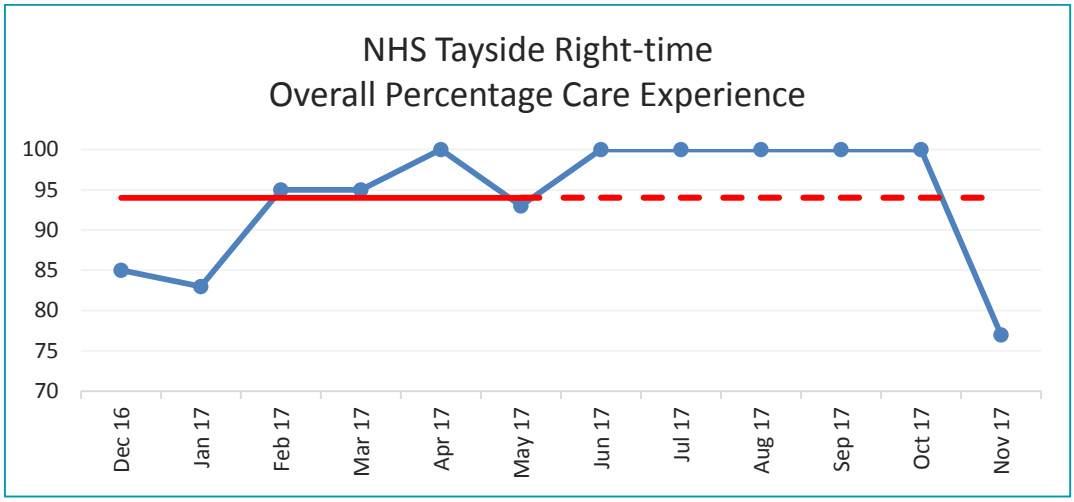


Figure 9 shows the later starting point of August 2016 for the Right-time process in NHS Lanarkshire. Following initial set-up, care experience scores improved from February 2017 once the Right-time model process was embedded within care teams and this improvement was maintained throughout the programme, with six consecutive months having a score of 100%.

NHS Tayside (Right-time model)

The overall care experience scores in this organisation were based on an aggregated percentage of people who scored their overall care as either 4 (very good) or 5 (excellent) each month.

Figure 10: Overall Right-time Percentage Care Experience in NHS Tayside

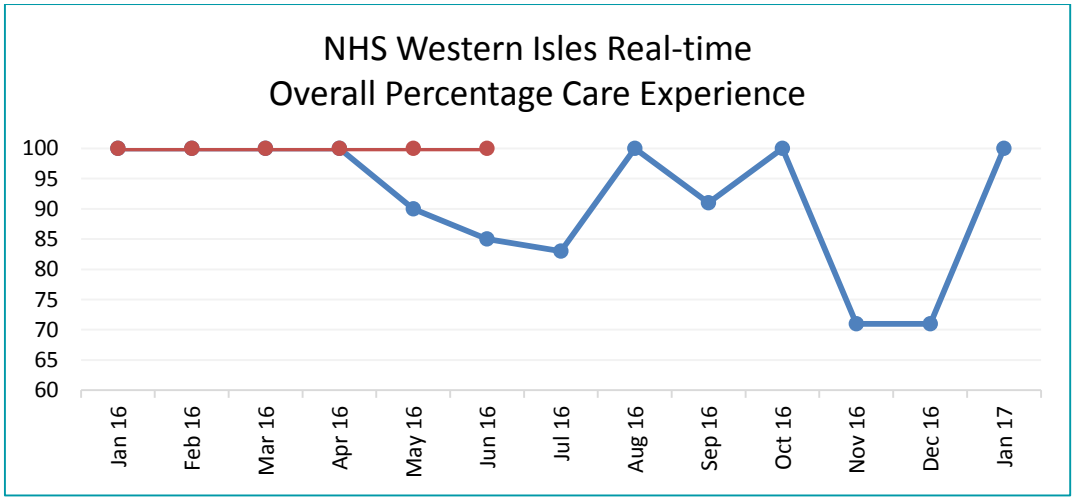


NHS Tayside had 12 months of care experience data, which included a period of five months with the score of 100%. The results did not demonstrate an improvement as scores required to be above the median of 94% for 9 months to demonstrate improvement rather than normal variation.

NHS Western Isles (Real-time model)

The overall care experience scores in this organisation were based on the percentage of overall positive comments aggregated over a number of care experience questions.

Figure 11: Overall Real-time Care Experience in NHS Western Isles



NHS Western Isles had a baseline of 100%, therefore, it was not possible to demonstrate change (see Figure 11). On average, seven interviews were carried out each month across the three care teams - in some months only one interview was achieved due to a range of service challenges.

Participant reflections

To understand more about the successes, challenges and impacts of implementing the care experience improvement models each participating organisation shared their approach and learning reflections.

NHS Greater Glasgow and Clyde

Ann McLinton
Person-Centred Health and Care Programme Manager

Bridget Reade

Joanne Campbell

Noreen Robinson

Sukhinder Singh

Alison Anderson

Clinical Improvement Co-ordinators

NHS Greater Glasgow and Clyde tested the Real-time care experience improvement model. This was supported by the pre-existing and established Person-centred Health and Care Programme Manager and a team of clinical improvement co-ordinators, external to the care teams, employed to capture experiences and support care teams to apply the model across two clinical 'pathways'.

The main method used for gathering and listening to the care experience of service users, relatives and carers is through a locally-developed approach described as a 'themed conversation'. This enquiry concentrates predominantly on gathering and developing feedback on the experience of the person-centred principles of care giving. Both quantitative and qualitative feedback is gathered over consecutive monthly cycles and is reported directly back to clinical teams and their managers. This cycle of feedback helps the clinical teams to evaluate the impact and outcome of the improvement interventions and actions they have implemented over time.

NHS Greater Glasgow and Clyde used their existing enquiry approach to test the Real-time care experience improvement model with two service user pathways. This approach was designed specifically to listen to people's care experience at a variety of different points in a person's care pathway to explore whether a greater insight and understanding of their whole experience would be gained.

The pathway approach was intended to provide the opportunity to engage with a wider range of multi-professional and multidisciplinary staff that come into contact with people using health and care services and the local managerial and leadership structures, and to involve them in the improvement process.

The following two pathways of care that were included in the project are:

- acute medical pathway at Glasgow Royal Infirmary, and
- maternity pathways at the Queen Elizabeth University Hospital and the Royal Alexandra Hospital.

The intention of holding improvement discussion meetings within clusters of care teams proved challenging to co-ordinate with care team staff and other disciplines due to competing workloads and priorities. The alternative approach was to hold individual care team meetings across the pathways rather than hold cluster care team meetings.

There were a total of 20 individual care teams who held improvement meetings across eight clusters: five clusters in the medical pathway and three clusters in maternity (see Table 5 and Appendix 1).

Table 5: NHS Greater Glasgow and Clyde care pathway clusters

Medical clusters	Maternity clusters
• Acute Assessment Unit • Acute Medical Receiving • General Medical • Older People's Service • Rehabilitation	• Antenatal • Labour and Birth • Post-natal Pathways

Reflections from the programme lead

How our work has made a difference and what has been the personal impact for people

We have found that people invited to provide Real-time feedback on their care experience welcomed and relished the opportunity to provide feedback in this way. Many people commented that they would have been unable to articulate their feedback in the same detail if writing a letter or thank you card themselves. Others expressed their gratitude for helping them to reflect on their care experience and how this could help to put their thoughts and feelings into perspective.

Having a one-to-one conversation with someone who is not a direct member of the care team can help to provide a neutral space for people to express issues and concerns that they are either unsure about how to discuss with the care team or unable to articulate independently. Involving relatives, carers and the interpreting service has also enabled feedback from people where they have communication impairment or where English is not their first language.

Real-time feedback has been a morale booster for the care teams involved. Many staff reported that they were initially sceptical about the approach and were anxious about what the feedback

would tell them because they are so used to only receiving negative feedback and hearing about what they get wrong. Once care teams became more familiar with the process and realised that the positive feedback far outweighed the negative feedback, they became more optimistic and embraced the opportunity to be involved in taking improvements forward.

"They [care team] are now interested to know the feedback and what we can do about it. It [the feedback] belongs to them. They all want to read it. A lot of times, they agree with it but they did not know how to change it."

(Clinical improvement co-ordinator, Medical Pathway, Glasgow Royal Infirmary)

Empowering staff to take responsibility for the improvements which are within their control helps to create a sense of ownership and develops a 'can do' attitude when they see what difference can be achieved from involving or interacting with people in a different way.

The care teams and their management and leadership structures, for a variety of reasons, value Real-time feedback. Firstly, Real-time conversations with people helps to develop a deeper level of enquiry and insight into people's care experience and helps to focus on what matters most to them at that time.

Gathering feedback in real time allows the opportunity for early resolution of issues. Secondly, whilst it is difficult to evidence that this mitigates complaints being raised at a later stage, many of the care teams report a reduction in the number of complaints or a change in the nature of complaints they receive.

"It has changed my own practice. I am much more open about asking women about what matters to them rather than ticking all the boxes; that comes from just listening to women's stories… Stories can be so powerful; we need to capture them and use them."

(Clinical improvement co-ordinator, Maternity Pathway, Royal Alexandra Hospital)

Gathering feedback across a pathway of care allows for change and improvement to be concentrated at the right points in the care process either at an earlier or later interval of care. Whilst time consuming, it is possible to extract feedback which is not directly related to the care team and out with their sphere of influence and redirect this to other staff, disciplines or services.

Through analysis and theming of the care experience feedback collected and the improvement meetings and conversations held with care team staff, a number of improvement projects identified in both pathways of care are being progressed. Quantitative and qualitative data generated from the feedback is used as the main measurement and monitoring approach to evaluate if improvement is achieved.

"We are working hard to help the care teams take ownership of the feedback. It is hard to avoid emotions surfacing when reading the feedback about your care team. Concentrating on the themes emerging from the feedback helps to focus the discussion on improvements. People do take it [the feedback] personally."

(Clinical improvement co-ordinator, Medical Pathway, Glasgow Royal Infirmary)

Key learning for my organisation

Gathering Real-time feedback across pathways of care can be time and resource intensive. Whilst it is not a model that is scalable to the whole organisation without substantial investment, it is possible to achieve a volume of improvement activity with a small investment of resource. Working with a core group of care teams to nurture and support improvement development can help to share and spread this across other teams and services.

In comparison to other forms of feedback they receive, with the exception of complaints, care teams and their leadership and management like the amount of detail that the Real-time feedback provides.

The depth of enquiry achieved by the clinical improvement co-ordinators provides additional detail about the context of the feedback they gather. This depth and detail of feedback assists the care teams to tailor the change ideas and improvements more specifically and in the right context of care.

Collating feedback over consecutive months helps to establish if there are patterns and themes arising from what people have said about their care experience and when improvements have been put in place.

"You need to know what you are doing right and things that need to be improved. You can trundle along thinking you are doing a great job and you are not..."

(Senior charge nurse, Acute Assessment Unit, Glasgow Royal Infirmary)

Continuity of support between who gathers the feedback and who supports the improvement meetings and conversations with care team staff is invaluable to developing good working relationships and to supporting a sense of involvement and ownership of the whole process.

NHS Greater Glasgow and Clyde Real-time case study

Improving communication

The Acute Assessment Unit in Glasgow Royal Infirmary cares for people who have been referred by their GP for further tests to assess their health. Staff asked the people who used the service about their care experience and identified several improvement opportunities including information flow (people understand what is happening to them and when) and then started testing ways to improve.

How information flow was improved?

- Introduction of a 'communication round' by named nurse to update people about what is happening in their care.
- Developed an information leaflet to inform people of the process of assessment and planning of the care process, and advised of what is happening and when by the nurse before leaving the cubicle.

What difference did it make?

"On arrival I felt the staff were aware that I was coming and had everything prepared for me. This made me feel that I would have a good experience and that staff knew what they were doing. Staff kept me up to date at every opportunity and I knew what was to happen next and by whom."

(Service user attending acute assessment unit at Glasgow Royal Infirmary)

See Appendix 3 for summary examples of improvements undertaken in NHS Greater Glasgow and Clyde.

NHS Lanarkshire

Rick Edwards
Programme Manager

Denisa Lorincova
Practice Development Person-Centred Care Facilitator

With additional support for the Right-time telephone interviews from Jean MacDonald and Fiona Watson, Patient Focus and Public Involvement Facilitators.

NHS Lanarkshire undertook testing of both the Real-time and Right-time care experience improvement models. The work was supported by a programme manager and a practice development facilitator who assisted care teams applying the improvement models to gather and reflect on service user experience feedback, to identify good practice as well as improvement opportunities and support teams to act on them. Additional staff were employed on a part-time basis to undertake telephone interview follow-up calls for care teams applying the Right-time model.

The NHS Lanarkshire Public Reference Forum helped to shape the local approach and telephone interviewing. The forum also helped develop an information and consent card for distribution to people sharing their feedback.

For both models a conversational approach was developed from a pre-existing care experience enquiry approach used by NHS Lanarkshire.

As NHS Lanarkshire tested both models, the Real-time and Right-time reflections are presented first, followed by the overall learning from both models.

Reflections from the programme lead

Real-time model: How our work has made a difference and what has been the personal impact for people

Narrative about how people felt and experienced care in the care teams applying the Real-time model has improved and become more helpful over time. Some returning patients noted that their care experience had been far better and superior than on previous admissions to the same clinical area. They shared noticeable changes in staff attitude, staff morale and how this approach of gathering and listening to their views is making a difference for them in the care environment.

"In terms of giving feedback I thought this was a sign of openness to improvement and should be more routine without being tokenisation. You were clearly listening. If I can do something to support the NHS and the team that got me through this I would and all I can offer is an honest critique."

(Service user, University Hospital Wishaw)

"Staff made my experience really good in the ward this time. I had a fantastic care, support provided by staff, caring about me as a person who matters. Most of the staff nurses behaviour has gone up and beyond this time round in the ward. The care, empathy has been exceptionally good."

(Service user, Monklands Hospital)

"At first it was uncomfortable for me to see and hear from this lady that she felt we were not listening to her when we were out visiting her the first time. I wouldn't think that we would do that, but talking through this lady's experience and looking at what happened that could have contributed to her feeling this way, helped me to look at her experience differently."

(Healthcare support worker, Hairmyres Hospital)

Right-time model: How our work has made a difference and what has been the personal impact for people

Similar to the Real-time care experience improvement model, feedback collected using the Right-time model has helped healthcare staff and the care teams better understand and interpret people's experiences, which seem to have improved.

Looking beyond the subjective thoughts and feelings about the care experience in the reflective team discussion has helped staff develop a broader perspective. Their understanding of the person's experience was balanced by the collective reflection in the improvement meetings, so how they respond to what is being said is making a difference in service users' care or experience.

Many of the staff involved in testing the Right-time model have expressed that having this feedback has improved team cohesion and outputs. Those who had not previously been involved

in care experience feedback have told us they found this approach interesting, challenging and rewarding.

"It was great as a student nurse to see person-centred care as taught in university is happening at this level in hospital wards."

(Student nurse, Monklands Hospital)

"Good to have meeting's to increase role in the team, as AHP's move around a lot – helps us drive what everyone else is doing."

(Allied health professional, Hairmyres Hospital)

We ask service users and carers what they think of the feedback process during our Right-time follow-up calls and they have said they appreciate the opportunity to provide feedback. Quite often they said that they had not expected anyone to contact them and felt valued knowing that their shared experience will provide learning opportunities for staff. They also tell us it is good to have a different approach to asking for feedback as they had been thinking about their experience since leaving hospital in preparation for the call, and so felt more prepared for a conversation. People told us:

"It's good to know that you're asking my opinion and I'm glad the staff will be listening."

(Service user, University Hospital Wishaw)

"It's good to know my opinion matters."

(Service user, Monklands Hospital)

It is worth considering though how Right-time feedback works from an organisational perspective. Whilst it is a valuable approach, it is also more difficult to undertake. There are additional administrative processes to consider such as providing written information to explain the process and gaining consent for telephone calls. In order to generate at least five interviews for each care team each month, staff need to recruit and get consent from 3-4 times that number to achieve the targeted amount of conversations.

The Right-time interviewers also reflected that it can be more challenging to keep people focused on feedback for a particular care team on the telephone as they tend to reflect on their whole experience, including after return home if they are continuing to receive other services.

Key learning for my organisation

Intentionally creating the opportunity for front-line staff to learn from service user feedback, allocating time once a month to collect feedback, recording it on our electronic system, and having a facilitator at the improvement meeting who supports care teams to review people's feedback using either the Real-time or Right-time model is important.

Supporting front line staff in learning about quality improvement and reflective practice and allowing staff protected time to participate in meetings has promoted a learning culture where high quality, safe, effective and person-centred care is the standard, with staff feeling supported to be creative in their thinking of solutions they can test that can improve care experiences and clinical practice.

NHS Lanarkshire Real-time case study

Bedside handover

Ward 6 in University Hospital Wishaw is a busy general medical ward caring for both males and females. When the staff asked people about what it felt like to be in their ward they were told that it was not always clear what was happening to them each day and sometimes they did not feel as involved in decisions as much as they would like.

How did they improve?

At the improvement meeting, staff discussed this feedback and identified that the wards handover system needed to be improved between shifts and a better approach to personalised conversations with people about their care was needed.

Staff tested various different approaches and refined and developed a bespoke bedside handover process based on what worked for service users, family members and staff.

What difference did it make?

"I feel that staff consider what is important for me in hospital. I have been given all the information about care and treatment and the opportunity to ask questions which were then well answered. Staff make me feel involved in my care and treatment."

(Service user, University Hospital Wishaw)

See Appendix 3 for summary examples of improvements undertaken in NHS Lanarkshire.

NHS Lanarkshire Right-time case study

Discharge process

Ward 6 in Monklands Hospitals used Right-time telephone interviews to gather peoples care experience. Whilst the feedback received was generally positive, some service users indicated they had not received a discharge letter and the information provided on discharge could have been better.

How did they improve?

The care team used the Model for Improvement to test and develop a new discharge process involving nursing, medical, pharmacy and ward clerk staff. This process involved a 'discharge diary' which includes information on people receiving a discharge letter, medication information and supporting verbal information when they left the ward. The process includes alternative steps to communicate if people chose to leave without this information.

What difference did it make?

Service users are reassured that they have information about their care and treatment available for their GP and community staff to enable continuity of care and follow-up.

Staff have benefitted as discharge information is also available at the nurses station which enables easy and accurate communication with the bed manager as well as service users and GPs who contact the ward with enquiries within a few days of discharge. There has also been a reduction in medicine returns to the pharmacy and phone calls to the ward from GPs.

See Appendix 3 for summary examples of improvements undertaken in NHS Lanarkshire.

NHS Tayside

Stephanie Stewart
Patient Feedback Co-ordinator

Dr Deborah Baldie
Senior Nurse, Practice Development / Research Fellow

NHS Tayside worked on applying the Right-time care experience improvement model. This was led by the Practice Development and Research Fellow, and was supported by a patient feedback co-ordinator. To guide Right-time follow-up conversations with people at two to three weeks following an episode of care, the team chose to use a validated tool called the Picker Patient Experience 15 (PPE15) questionnaire developed by Jenkinson, Coulter & Bruster [20].

Two care teams from Ninewells Hospital, Dundee, were recruited to test the Right-time model and the University of Dundee Medical School recruited volunteers to carry out the post-discharge telephone calls. The volunteers received training to enable them to confidently carry out post-discharge telephone calls and to deal with distress should it occur. The team also worked with their local clinical governance team and business unit to develop electronic forms and dashboards that would help them record the information collected, assist with analysis and outputs of care experience feedback data.

Every month, the team ran facilitated improvement meeting sessions with the participating wards to help them consider and act on the feedback. During these sessions, practice development principles and methods were used.

Reflections from the programme lead

How our work has made a difference and what has been the personal impact for people

People are asked at the end of the follow-up calls how this method and tool has felt for them to give their feedback. We have found people are responding positively to this, although a small number of service users reported they would have preferred to feedback online or by email.

With regards to the questions asked, people are rating overall care and treatment received positively alongside receiving good emotional support and receiving care that is dignified and respectful.

There has been a positive impact on staff involved with this process of receiving and acting on care experience feedback, particularly in relation to how they are communicating with service users and their families.

Staff have told us that using volunteers is reducing the burden of clinical staff gathering feedback and gives more objectivity to feedback received.

Medical student volunteers are reporting very positive experiences of asking for feedback from service users. This is allowing them to develop and improve their communication skills and gain a greater understanding of what is important to people, helping them to appreciate how developing skills in asking about care experience and listening will to be of benefit to them in the delivery of care and in their future careers.

Key learning for my organisation

Although services were gathering care experience feedback previously, there was little evidence of the feedback being used to inform improvements, celebrate success or being fed-back widely to the staff. The programme team has now been facilitating meetings every month with staff to consider their feedback data using practice development principles.

The PPE15 questionnaire is only appropriate for certain service user populations (over 18 years old, people who have had an overnight stay, those able to undertake a post discharge telephone conversation). It is necessary, therefore, to identify other tools and methods for other service user groups, for example those with cognitive impairment, dementia, communication difficulties or mental health problems.

Gathering narrative (qualitative) comments and stories from people has been most useful for care teams to identify where improvements are required. It is important to ensure this qualitative data is presented in its raw format to teams in a user friendly and easy to interpret format. It is also important that teams are supported through facilitation to consider the feedback and work through it to action. We have found the numerical data from the PPE15 tool is only useful for assurance and we had to adapt it to collect narrative data to support improvement.

"We're realising that patient expectations are not the same as our assumptions. For example, in dialysis they said there's not enough blankets, or an elderly patient couldn't change his TV channel. These are easy fixes, that are meaningful to the patients, but we don't necessarily see them."

(Nurse, Renal ward, Ninewells Hospital)

We feel that some changes do not require any testing as they are around staff behaviour and in particular communication with service users. For example, both our test wards identified issues that came down to communication between staff and service users. The teams have been making efforts to ensure they check with the person to establish what they know already about their condition and treatment plan, if it has changed and why the information they are receiving now is different. Overall, staff have reported taking a more enquiry-based approach rather than an instructive approach.

Using our approach to testing this model has shown that dedicated resources are required to ensure effective set-up of the process and ongoing recruitment and training of volunteers is

required. It is also critical for individuals to be identified to support and co-ordinate the work of the volunteers to ensure we implement and sustain this process at scale.

NHS Tayside Right-time case study.

Information on discharge

Ward 38 in Ninewells Hospital is a post-natal inpatient ward caring for women after they have had their baby. When women were called after they had left the ward, they mentioned that they sometimes lacked enough information and the opportunity to ask questions before their discharge.

How did they improve?

The staff agreed to work on ensuring women felt informed on discharge and were provided with the opportunity to ask any questions and have these answered satisfactorily before discharge. This involved sharing the discharge information pack with women earlier and allowing more time for any questions the women had before they left the hospital.

What difference did it make?

"Before I was discharged the midwife sat down and explained about feeding, co-sleeping, who to contact if I was concerned, etc. I was given very clear instructions."

(Service user, Maternity ward, Ninewells Hospital)

See Appendix 3 for summary examples of improvements undertaken in NHS Tayside.

NHS Western Isles

Lillian Crichton
Improvement Co-ordinator

NHS Western Isles appointed an improvement co-ordinator to lead the local programme of testing the Real-time care experience improvement model between October 2015 and March 2016. The programme began with the recruitment of three care teams across two hospital sites:

- Surgical care team, Western Isles Hospital, Stornoway
- Medical 2, Western Isles Hospital, Stornoway, and
- Uist and Barra Hospital, Benbecula.

A locally-developed tool was used to guide the conversations with people receiving care about their experience. These conversations were carried out independently of the care team in the Western Isles Hospital by the hospital chaplain and the improvement co-ordinator, who then provided this feedback to the care team for reflection and improvement discussion. In Uist and Barra Hospital the senior charge nurse held the conversations with service users and led the team discussions.

Reflections from the programme lead

How our work has made a difference and what has been the personal impact for people

Staff have found the project a good learning experience. Understanding that you can lead change in your team even without having perceived authority has helped to build resilient staff champions for this quality improvement approach.

Implementing small changes with key groups of staff has been rewarding and helps teams to acknowledge positive improvements and make the areas for improvement more visible.

Taking ownership of care experience feedback and involvement takes a leap of faith and teams respond well to being given permission and encouragement to ‘just do it!’ – trying out small scale tests of change to see if your predictions are correct can be challenging but the benefits are worth it.

"When we receive feedback from someone about a negative process or outcome we are quite often aware of it and it is frustrating to read".

(Senior charge nurse, Western Isles Hospital)

People receiving care and their families say they are appreciative of the opportunity to talk about their experience of care in hospital.

"I'm glad to be able to talk to someone about everything. I hope that what I've told you goes to help make the process easier for someone else."

(Service user, Western Isles Hospital)

Key learning for my organisation

Within NHS Western Isles, this work identified a gap in using care experience feedback for improvement. There is a real opportunity for staff to learn from people receiving care and families about what it is really like from the users' perspective and most importantly to make changes and improvement based on what people tell you.

Staff appreciated the feedback from service users and their families as it gave them an insight into how the care was being perceived. The vast majority of feedback was very positive and staff found it useful to know about the small things that might have made someone's day.

However, when the programme began, the staff focused on how to capture and share the information to staff individually, rather than consider how they reflected on it together. This made it harder for the staff to identify potential improvements together and seemed to stall identifying potential improvement opportunities and tests of change. Over time, the care teams realised that they could only progress improvements when they met together, discussed the experience feedback and prioritised actions.

When this part of the Real-time model was developed, it resulted in identifying more improvement opportunities and evidenced the need for improvement to come from the care team motivation rather than governance reporting systems. There needs to be visible momentum around quality improvement driven by leaders at all levels in the organisation. Ownership for quality improvement and sharing learning works where a multidisciplinary care team involved and there are tangible results for the person receiving care.

NHS Western Isles Real-time case study

Nickel allergy

Due to the significant issues with travel between the Western Isles surgical services, pre-operative assessment can be undertaken on one island and the surgery completed on another. This is followed by recovery and rehabilitation as near to home as possible. This means that people needing surgery have to be flown from one island to the other.

At a meeting of all three Western Isles test teams, the charge nurse from one team (Uist and Barra) shared some feedback from a person who had told them about their experience of hip surgery in the Western Isles Hospital. Unfortunately they had a nickel allergy and as a result had a series of infections due to their body reacting to the nickel in the hip replacement joint. This had not been identified at the pre-operative assessment and meant significant delay in their recovery. When the teams discussed this they realised that 2 additional surgeries had recently been cancelled as a result of metal allergies.

It was estimated that the cost for each cancellation was almost £3,407 taking into account bed days, surgery and travel costs.

How did they improve?

This feedback led the staff to review both the pre-operative processes to ensure metal allergies were discussed at an earlier stage to reduce cancellations and improve the experience for other people in the future. They also developed a warning system in patient case notes to ensure that staff were aware of the issue.

What difference did it make?

Changing the pre-operative assessment process across the hospitals resulted in a reduction in both surgical cancellations due to allergies and in unnecessary travel for people living on outlying islands from the main hospital.

See Appendix 3 for summary examples of improvements undertaken in NHS Western Isles.

Key learning

Both Real-time and Right-time care experience improvement models have demonstrated potential to effectively support care team level improvements directly attributable to service user feedback as seen in the evaluation of process findings and outcomes.

Over the evaluation period, care teams reported increasing perceptions of value for the processes and outcomes achieved in embedding the model(s), and in the care team's motivation to be involved and make improvements based on feedback from service users.

The key learning points from the evaluation of Real-time and Right-time care experience improvement models are presented below.

1. Both Real-time and Right-time care experience improvement models provide a framework that empowers care teams to effectively identify and implement meaningful improvements directly attributable to service user feedback.

Where all elements of either improvement model were reliably adhered to by care teams, they were more able to reflect on feedback and carry out improvement activities monthly than if a step was omitted. We also found that applying the Real-time model across a pathway of care delivers similar outcomes as applying to a single care team where there has been investment in adequate co-ordination and facilitation support.

Care teams working with both care experience improvement models were able to implement almost 50% of improvement opportunities identified during the evaluation period (see Table 3). The number of improvements implemented using either model demonstrates the potential of this approach to deliver meaningful improvements that can potentially be tracked and sustained over time using an improvement approach.

"Previously although services were collecting patient feedback there was little evidence of the feedback being used to inform improvements, celebrate success or being fed-back widely to staff."

(Programme lead, NHS Tayside)

2. A conversational approach and gathering narrative feedback provides the context and depth to effectively support care team reflection and identification of improvement opportunities.

Proposing the introduction of a conversational approach and gathering narrative feedback initially felt uncomfortable and challenging to all participating care teams as this was a different approach to the norm of asking for feedback through questionnaires. However, the value of a conversational approach became apparent as teams started to work with it.

"In the early days we didn't understand how powerful and compelling it would be…. in terms of the emotion, generates an energy to take action. Hearing the words that people use is very powerful."

(Programme lead, NHS Greater Glasgow and Clyde)

"Many staff report that they are initially sceptical about the approach and are anxious about what the feedback will tell them because they are so used to only receiving negative feedback and hearing about what they get wrong."

(Programme lead, NHS Greater Glasgow and Clyde)

As expected, these care experience improvement models produced a large proportion of positive and neutral feedback. However, on conclusion of the evaluation period, care teams had identified improvement opportunities from 17% of all the feedback conversations held using the Real-time model (Table 1) and 21% of feedback conversations using the Right-time model (Table 2).

"We are getting more detailed [feedback] so that you have something to work with. Much more detailed and useful than the universal feedback forms."

(Senior charge nurse, NHS Greater Glasgow and Clyde)

"It has changed my own practice. I am much more open about asking women about what matters to them rather than ticking the boxes – that comes from just listening to women's stories… stories can be so powerful – we need to capture them and use them."

(Clinical improvement co-ordinator, NHS Greater Glasgow and Clyde)

Care teams working with these models told us that the resulting feedback collected offered more useful insight and understanding of the issues than some of the traditional types of quantitative feedback they receive.

"Suggestions from the patients have helped us come together as a team to see what we can do for a particular individual. We can often do something about it straight away."

(Senior charge nurse, NHS Western Isles)

3. A good level of conversational skills and training in how to collect and record narrative feedback data is required to provide the depth and context to support improvement.

The skills identified to hold and record good conversations with people about their care experience was key to productive reflective improvement meetings. During these meetings, the care teams were able to effectively identify improvement opportunities that could be taken forward as an improvement activity.

To collect the quality of narrative data necessary, interviewers required the skills to identify and follow opportunities for deeper enquiry that could support the improvement discussions more effectively. Whilst there were differences in the conversation approaches and tools used in participating organisations and how feedback was gathered, the ability of interviewers to flex the conversation around an individual's disclosed experience became important for gathering meaningful and actionable feedback.

"Gathering feedback is much more complex [than survey approaches]. Takes a certain type of person to undertake that role – need to have particular qualities and communication / interpersonal skills and ability to build rapport."

(Clinical improvement co-ordinator, NHS Greater Glasgow and Clyde)

"New volunteer is not so experienced at delving into the interviews – we would have liked to know more about some things – but the moment is passed."

(Senior charge nurse, NHS Western Isles)

4. Embedding the reflective improvement meeting as a routine activity is vital to maintain the engagement of the care team and regular improvement activity.

Holding reflective care team improvement meetings is a vital component of both care experience improvement models, and was central to building team engagement and embedding the improvement process and culture.

"It's powerful to wait for the collective conversation – the solutions lie within the clinical team (and might be better ideas, also more likely to be implemented…)"

(Programme lead, NHS Greater Glasgow and Clyde)

"It is good to know that we are doing well, and compared to how it was months ago it is a hundred times better now. I think getting the feedback from patients helped and talking about and sharing it with staff is valuable and made a difference. I think we managed to raise more awareness about their [service user's] experiences and what is important from it. Bringing it up on safety briefs as well got staff to think about it and have it in their thinking for the day."

(Senior charge nurse, Monklands Hospital)

Where care teams were not able to meet and reflect on feedback during the month, teams found it difficult to sustain improvement activities in the interim and the benefits of rapid feedback was lost. Only when care teams established a reliable process for all aspects of the model did regular improvement activity occur.

"Without the motivation, there is a risk that team reflection meetings on care experience will fizzle out. There needs to be visible momentum around quality improvement driven by leaders at all levels in the organisation."

(Programme lead, NHS Western Isles)

Multidisciplinary reflection on narrative feedback, although sometimes difficult to co-ordinate, can more effectively assist care teams to recognise and respond to improvement opportunities and identify from within the team who is best placed to lead the improvement activity.

"They've enjoyed hearing the feedback, some have never been involved before. Some feedback mentions staff by name or role. That's a real morale booster. With negative feedback, we've tried not to be defensive – it's not about blaming. In the beginning we were slipping into that, but at the beginning of every session, we remind ourselves that it's about learning."

(Senior charge nurse, NHS Lanarkshire)

"Good to have meeting's to increase role in the team, as AHP's move around a lot – helps us drive what everyone else is doing."

(Allied health professional, Hairmyres Hospital)

Leadership commitment and protected time for staff participation in improvement meetings also determined whether care team improvement meetings were happening on a regular basis.

"Allowing staff to have protected time to participate in these meetings, and learn away from the clinical area can help both individuals and teams to be creative in their thinking and solutions and testing, innovating and improving care experience."

(Practice development facilitator, NHS Lanarkshire)

The level of improvement activity reduced considerably at times of increased workload pressures or staff shortage. Being viewed as a 'good to do' activity rather than a 'must do' activity resulted in both the care team improvement meeting and improvement activities being suspended at times due to prioritisation of capacity. The impact was seen most in the levels of improvement activity being undertaken during pressure point times, such as during the winter.

"There have been lots of vacancies and staff sickness. This presents issues both of continuity and not having the time."

(Senior charge nurse, NHS Lanarkshire)

5. Providing facilitation and coaching support for care teams initially supports them to embed and take ownership of their approach to the care experience improvement model.

All of the participating organisations identified the facilitation of care team improvement meetings and quality improvement coaching support as an enabler to embedding these models. This also helped care teams to more effectively explore and understand the potential improvements found within this type of data. It was generally agreed by care teams that they found working with this type of data for improvement difficult at times and may not otherwise have identified meaningful improvements on their own.

All care teams involved reflected that they benefited from their local project team's support to collect data, facilitate reflective discussions, and coach them around improvement. Their learning reflections commented on the importance of effective facilitation, especially at the early stages of applying these models, to help the care team reflect on qualitative feedback and view this in the context of improvement.

"I think it is the skill set that underpins facilitation, when you are in the relationship with the team, where you are facilitating them and trying to get them to analyse the feedback in more depth that's a much richer experience than if you just sat down with the team and read the feedback and they just take everything at face value."

(Programme lead, NHS Greater Glasgow and Clyde)

Most care teams noted that they initially found the improvement meetings challenging to focus discussions appropriately on improvement and avoid defensiveness. Setting these meetings as an action-focused reflective space has, over time, resulted in participants involved describing this activity as valuable, purposeful and blame-free. This has been seen most in those teams who were initially supported to set up and run the improvement meetings by external facilitators who had skills in both quality improvement approaches and working with qualitative data.

It was noted that when feedback is reviewed independently rather than within a multidisciplinary team improvement discussion, even if subsequently shared in other ways such as posting feedback in team areas, the level of team engagement, identification of potential solutions and improvement activity was considerably less. It was the opportunity to discuss and reflect on what it means to the care team that made the difference.

"Being flexible and open to ideas from patients and care staff creates a sense of safety for people to speak out and openly share their views on what could work or what wouldn't work in their clinical area."

(Practice development facilitator, NHS Lanarkshire)

6. There was no evidence of more gratitude or social desirability bias in the Real-time model (at the point of care) than in the Right-time model (following an episode of care).

The rationale for testing a feedback model at both 'point of care' and following an episode of care was to explore the suggestion made by Sweeney, Brooks, and Leahy [17] that feedback given after an episode of care reflects the reality of the experience more, with less bias, than that shared at the point of care.

Most participating organisations expressed initial concerns about potential bias in gathering feedback during an episode of care. However, we found no patterns emerging to suggest less bias in feedback obtained when an enquiry was made two to three weeks following an episode of care but rather, similar themes and tone of feedback were received at both point of care (Real-time) and following the episode of care (Right-time).

"At first we did think that if we collected the data there would be a bias. That people wouldn't be honest with us. But we've done things in a progressively different way. [The co-ordinator external to team] saw the same people, used the same questions and it didn't make any difference, she got the same data. She also asked their experience of being interviewed by staff – they said they didn't mind."

(Community nurse, Kenilworth Medical Centre, NHS Lanarkshire)

"We didn't fully appreciate that people would be so open. Thought they might hold back a bit."

(Programme lead, NHS Greater Glasgow and Clyde)

An assumption around the reason for this is that the conversational explorative approaches used in these models are intended to produce qualitative (narrative) feedback data. This type of care experience feedback is the person's experience or story, which remains much the same regardless of timeframe, whereas a quantitative (survey type) measure is asking people to make a decision on how satisfied they were, which may be more likely to change over time. This is an assumption that would require further study.

7. The Real-time care experience improvement model was quicker to set up and easier to sustain than the Right-time care experience improvement model.

The Right-time care experience improvement model took longer for participating organisations to establish a delivery process. Most challenges were in establishing an approach to gathering feedback within three weeks of discharge, which included:

- recruiting and appointing staff to conduct telephone interviews
- establishing ongoing processes for gaining consent in the care environment to contact people following discharge, and

- co-ordinating the interviews and the care team receiving the feedback in a format that supported care team reflection.

"There's learning around recruitment of volunteers – they need a volume of calls to be viable, we wanted 10 patients a month. It's been very hard work –the time needed to encourage the staff to do the recruitment."

(Feedback co-ordinator, NHS Tayside)

"When we are thinking about sustainability and spread, we have tried to keep the impact on staff workload to a minimum but we still have a fair bit of going along and checking that they have identified patients that are willing to be contacted post-discharge, it is the fault line in the model."

(Programme lead, NHS Tayside)

Participants involved expressed a perception that although everyone involved had developed their skills in holding conversations with service users, the development of enquiry skills was greater for those staff involved in holding conversations in using the Real-time model.

"[attending the care team meetings] helps them [interviewer] learn how the narrative feedback they have collected is received and perceived by the care team and helps them to identify gaps and details they may have missed when gathering or recording feedback. The continuity helps to develop a working relationship based on trust and respect where the [interviewer] are integral to the care team."

(Programme lead, NHS Greater Glasgow and Clyde)

The telephone method of enquiry in the Right-time model appears to have some inherent limitations due to the 'arms-length' nature which can sometimes prevent the depth of exploration and probing that would provide a full understanding of an individual's care experience in the same way as it would be possible when being in the room with a person.

In addition, the people carrying out Right-time telephone interviews were generally not included in the reflective improvement meetings. When the person conducting the conversation with the person was not directly involved in the care team improvement meeting, it sometimes resulted in the care team finding it more difficult to clarify the detail or context of experiences shared. This was identified as a potential drawback to being able to drill into the issues and identify appropriate improvement opportunities.

"In the Real-time stuff, if there are things coming out of it, and you think that doesn't stack up or that seems unusual then you can go back and ask the person but we can't do that in the Right-time as they are anonymised."

(Programme lead, NHS Tayside)

8. The Real-time care experience improvement model generates a marked sense of urgency in care teams to make improvements that is not noted as visibly in the Right-time care experience model.

The care experience feedback being provided to the care team rapidly when using the Real-time model appears to generate an urgency in the care team to respond. This is not as evident in those teams using the Right-time care experience improvement model.

This sense of urgency to improve seems to be engendered by a range of things including:

- the awareness of feedback conversations happening in the care environment
- the rapidness of feedback coming to the care team for review, and
- a perception that there remains the opportunity for the person giving the feedback to experience some improvement (as feedback was collected within the previous 48 hours).

The opportunity to also carry out 'in the moment' or 'quick fixes' was seen positively by the care team and the people who used the service.

"Once care teams become more familiar with the approach and realise that the positive feedback far outweighs the negative feedback they become more optimistic and embrace the opportunity to be involved in taking improvements forward."

(Programme lead, NHS Greater Glasgow and Clyde)

9. Care teams working with the Right-time care experience improvement model were less likely to use the recommended improvement approach to testing and developing improvements (PDSA cycles) prior to implementing them.

Although the improvement implementation rate was the same for both models, the overall use of the recommended improvement approach to testing and developing improvements (PDSA cycles) was considerably lower when using the Right-time model (11%) compared to the Real-time model (54%).

"Much of what they came up with doesn't get to 'test phase' – as they are no-brainers in terms of not needing a test of change."

(Programme lead, NHS Tayside)

Further work may be required to fully understand why teams using the Right-time model were less likely to use the recommended improvement approach (see Figure 4), in particular the testing phase, as this approach was recommended in both models.

Conclusions

In this evaluation we saw that both the Real-time and Right-time care experience improvement models can effectively support an improvement culture within care teams. It was essential to the success of either model that:

- conversations are held with those receiving care rather than taking a survey approach
- care experience is gathered as narrative feedback
- regular facilitated reflective improvement meetings are held to agree and take forward improvement opportunities, and
- initially care teams are supported to embed the approach by experienced facilitators who understand both qualitative data and the quality improvement methodology.

Due to the improvement infrastructure embedded in both these models both care experience improvement models were able to deliver similar outcomes and support a person-centred and improvement culture within the participating care teams. In addition, combining this improvement approach with conversational methods of asking for and receiving in-depth narrative feedback from service users has increased the ability of care teams to make improvements directly related to what matters to them.

Both of these care experience improvement approaches offer a robust diagnostic mechanism to support identification, testing and implementation of meaningful improvements.

Recommendations

For care organisations to implement and embed Real-time or Right-time care experience improvement models so that they can reliably identify and deliver improvements that are meaningful to people receiving care and staff providing care it is important to:

- increase leadership prioritisation and support for care teams to adopt and embed into routine business improvement approaches that actively respond to and value what matters to people
- focus efforts on gathering in-depth narrative feedback from service users, families and carers that will inform and empower care teams to effectively identify improvement opportunities and act on feedback to improve care provision and the experience of care, and
- invest in building skills and capabilities within care teams, and quality improvement support teams, to gather, analyse and understand qualitative care experience feedback, and to use quality improvement approaches to identify and act on what people tell them about their care experience.

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Appendix 1: Participating care teams

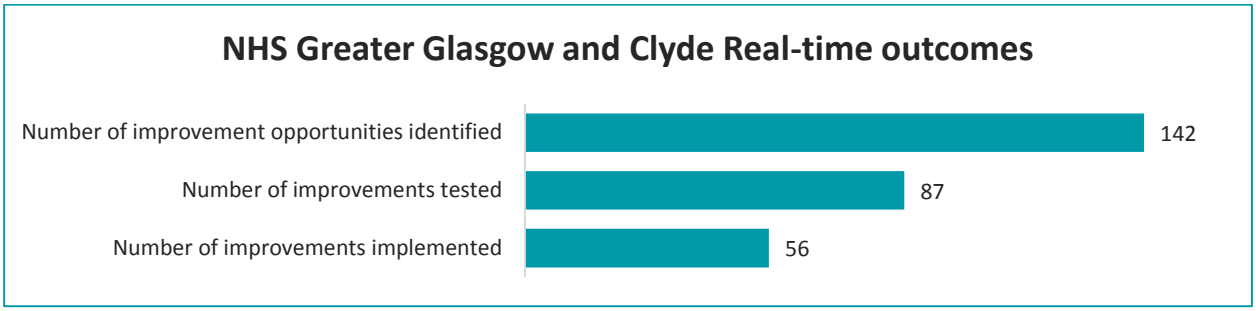
Model	Organisation	Location	Specialty	Ward/Service team
Real-time	NHS Greater Glasgow and Clyde	Glasgow Royal Infirmary	Emergency Care/Medical Care	Acute Assessment Unit
			Acute Medical Receiving	Ward 50
			Acute Medical Receiving	Ward 51
			Acute Medical Receiving	Ward 53
			Medical High Dependency Unit	Ward 52
			Downstream Medical Ward	Ward 4
			Downstream Medical Ward	Ward 15/28
			Older People's Services	Ward 30
			Older People's Services	Ward 39
		Royal Alexandria Hospital	Maternity	Antenatal Out Patients Department
			Maternity	Antenatal Day-case
			Maternity	Ward 31A
			Maternity	Ward 31B
			Maternity	Community Midwifery Team
		Queen Elizabeth University Hospital	Maternity	Antenatal OPD
			Maternity	Antenatal Day-case
			Maternity	Ward 47
			Maternity	Ward 48
			Maternity	Ward 50
			Maternity	Community Midwifery Team
	NHS Lanarkshire	Hairmyres Hospital	Surgical	Ward 6
			Medical	Ward 10
		University Hospital Wishaw	Surgical	Ward 6
			Medical	Ward 17
			Medical	Ward 16
		Monklands Hospital	Surgical	Ward 7
			Orthopaedic	Ward 11
			Mental Health	Ward 24
		Biggar	Community	Integrated Care and Support Team
		Larkhall	Community	Integrated Care and Support Team
		Cumbernauld	District Nursing	District Nursing Team
	NHS Western Isles	Western Isles Hospital	Surgical	Surgical Ward
			Medical	Medical 2
		Uist and Barra	Older People/GP referral/Maternity	Community Hospital
Right-time	NHS Lanarkshire	Monklands Hospital	Surgical	Ward 7
		Hairmyres Hospital		Critical Care Unit
				Emergency Department
	NHS Tayside	Ninewells Hospital	Renal	
			Maternity	

Appendix 2: Process outcomes by organisation

The following charts show the numbers of improvements outcomes identified, number tested and total number implemented service changes for each participating organisation.

NHS Greater Glasgow and Clyde

Figure 12: NHS Greater Glasgow and Clyde Real-time outcomes (total conversations = 966)



NHS Lanarkshire

Figure 13: Real-time Outcomes in NHS Lanarkshire (total conversations = 563)

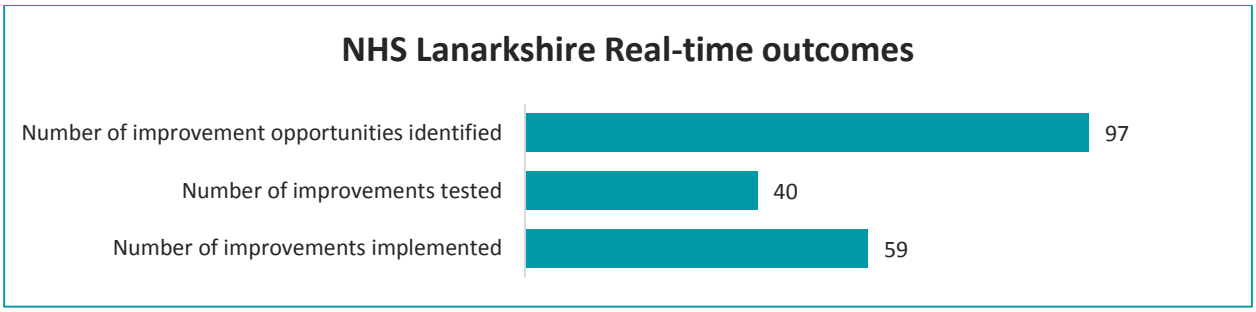
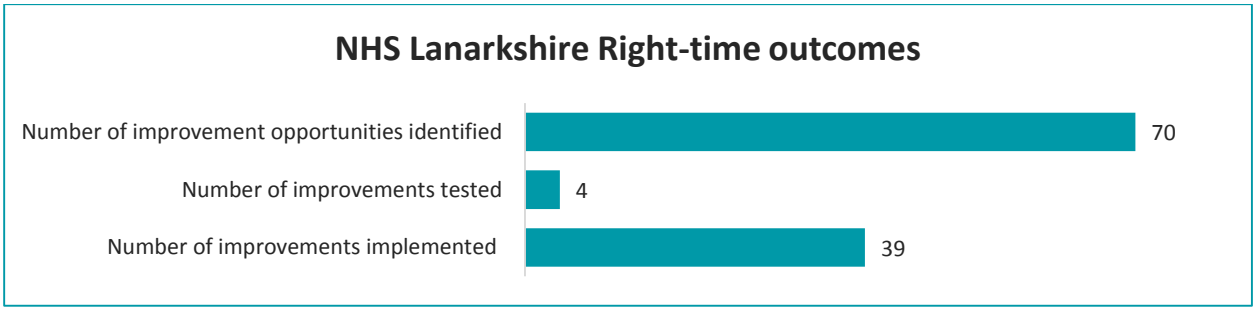
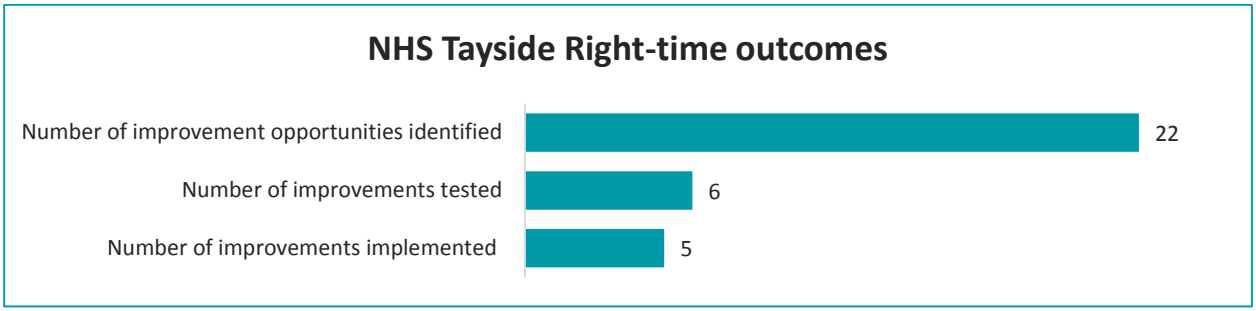


Figure 14: Right-time improvement outcomes in NHS Lanarkshire (total conversations = 242)



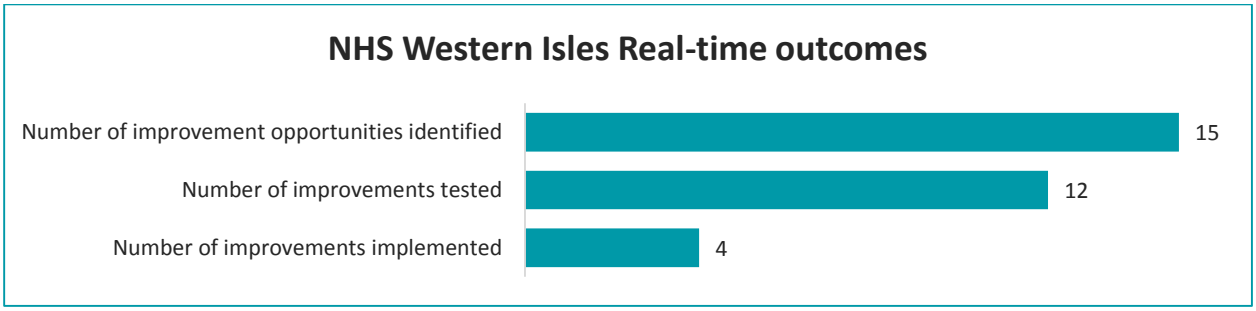
NHS Tayside

Figure 15: Right-time outcomes in NHS Tayside (total conversations = 191)



NHS Western Isles

Figure 16: Real-time outcomes in NHS Western Isles (total conversations = 85)



Appendix 3: Examples of implemented improvements

Organisation	Improvements	What difference did it make?
NHS Greater Glasgow and Clyde	Medical Pathway: Provision of sandwiches, cold snacks and drinks between meals and offer of a hot meal at designated meal times for people waiting in the Acute Assessment Unit (AAU) before they are transferred to another ward.	People are now able to eat and drink, and nutritional support is maintained for vulnerable people where appropriate. This also reduced the need for relatives to go seeking suitable food and drinks for people while they are waiting for the person to be moved.
	Medical Pathway: Introduction of a communication tool within the older people's ward to keep relatives and carers informed about what has happened throughout the day. This was intended to help stimulate conversations when people are visiting and to invite any questions ahead of ward rounds the following day.	Relatives and carers have told us they find the information helpful when visiting and it has improved the communication challenges of cognitive impairment. This has helped relatives to learn about the social interaction and stimulation from staff that has occurred, encourages a two-way flow of communication, information sharing and enquiry between staff, patients and relatives.
	Medical Pathway: Relatives and carers are contacted by clerical staff or nursing staff in the acute medical receiving unit (AMRU) to inform them when people are transferred to a downstream ward. This is intended to support relatives and carers in going directly to the correct ward at time of visiting.	The approach has minimised the number of relatives and carers arriving at the AMRU to then find out their family member has been transferred and having to then negotiate their way across the hospital site to find the correct ward.
	Maternity Pathway: changed process for identifying and giving Anti D immunoglobin injections (to prevent Rhesus Disease) to new mothers. This had previously been identified as causing delays in their discharge.	Women who require Anti D immunoglobin injections are now identified earlier. This has minimised delays experienced in the discharge process and has improved the flow of women waiting on transfer from the labour ward.

Organisation	Improvements	What difference did it make?
NHS Greater Glasgow and Clyde	Maternity Pathway: Promotion of a relaxing environment and privacy when women are in early labour within the antenatal ward. Partners are now invited to stay in the ward. When a single room is available this is offered or they are moved to an empty shared room where possible. Electric candles and a blue-tooth music system have been introduced into the bathrooms.	Women now experience enhanced privacy and dignity when in early labour which is vital to establishing a feeling of safety and security and important for their hormonal response. Enhancements to the environment have promoted relaxation and reduced anxiety. This also supports the involvement of partners in early labour.
	Maternity Pathway: Promotion of the birthing pool and birthing aids for women in labour.	This has increased staff's knowledge and confidence in supporting women using the birthing pool and different birthing aids. It has enhanced the birthing experience for woman by promoting these as a normal part of labour.
NHS Lanarkshire	Surgical team: Staff used the 'see something, say something, do something' model to challenge other staff when they observe any 'unacceptable behaviour/attitude.'	Staff are now more aware of their behaviours and attitudes and this is no longer being raised in feedback from people receiving care.
	Surgical team: Feeling involved in discussion and decisions - staff used 'teach back' during interactions with patients on the ward round to ensure involvement and understanding.	Patients are now reporting that they feel involved in discussions and decisions, and better understand their treatment and care plan.
	Medical team: Some patients' relatives work shifts and were unable to make visiting times. We have now moved from timed visiting to open visiting.	We are now receiving positive feedback about open visiting from patients, families and carers.
	Medical team: Introduction of a bloods communication folder at nursing station which indicates if nursing staff can advise patients of their results without the need for the patient to wait to speak to a doctor.	Feedback from people now indicates that the bloods communication folder has allowed them to be informed of their results in a timelier manner and has reduced anxiety.

Organisation	Improvements	What difference did it make?
NHS Lanarkshire	Integrated care team: Developed a resource for patients and staff describing all care professionals in the integrated care team, the team's role and the support and care they provide.	People receiving care have reported that using this resource has better informed them and they now understand what services they will receive and who would be providing their care and support.
NHS Tayside	Renal care team: Staff implemented a 'check-in' with patients and their families before they are discharged in an attempt to address any information needs related to their condition, treatment or discharge.	People now say that their understanding of important information has improved. Results from the PPE 15 tool used in subsequent telephone calls has shown that this is improving (from 60% up to 100% when last measured)
	Maternity ward: Midwives initiated a discharge process that ensured discharge information was provided to women the day before or at the very latest, 12:00 noon of their discharge. They also ask women if they have any concerns or queries about going home on the afternoon of their discharge and through this are able to ensure sufficient information is provided to all women being discharged from the unit.	In the six months following the initiation of this approach women reported being better informed before discharge of the danger signals to watch out for at home.
NHS Western Isles	Surgical team: A pre-operative information resource was developed by the care team as part of a wider allergies management approach.	This resource now helps to inform people more effectively about their operations and stimulates a discussion to help reduce anxieties about the surgery.
	Medical team: As a result of feedback, staff implemented 'What matters to me' boards into the ward area and developed daily 'What matters to you today?' conversations with people.	Staff now report they feel more informed about the people they are caring for and the people in the ward have also said that they were better understood by the staff.

Glossary

care experience	The experience of a range of interactions, processes, or environment within a health or social care system. This involves understanding how a person's behaviours, attitudes, and emotions are impacted by these. This includes the practical, experiential, affective, meaningful and valuable aspects of human interaction.
care team	The range of staff working directly in the care setting who are responsible for the delivery of care.
narrative	Qualitative feedback provided and recorded verbatim as experience stories.
person-centred care	A term used to describe a standard of care delivery. It is generally agreed that person-centred care is delivered when health and social care professionals work together with people who use services, tailoring them to the needs of the individual and what matters to them.
person-centredness	Behaviours and attitudes that support people to develop the knowledge, skills and confidence they need to more effectively make informed decisions and be involved in their own health, care and support. It ensures that care is personalised, co-ordinated and enabling so that people can make choices, manage their own health and live independent lives, where possible.
public partners	Public partners are volunteers who support Healthcare Improvement Scotland and provide a public perspective and constructive challenge on our work to ensure it is person-centred and high quality. Three public partners have been supporting the Person-Centred Health and Care Programme since 2016.
Real-time	Solicited feedback gathered in person close to or during an episode of care or support (optimally reporting back to care team within 48 hours).
Right-time	Solicited feedback gathered by telephone following an episode of care or support (optimally collected within two to three weeks of discharge).

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