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Care experience reflective improvement meetings guide

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The Care Experience Improvement Model

Improvement Hub

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NHS SCOTLAND

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About this guide

This guide describes the method used for holding care experience reflective improvement meetings[1] within the Care Experience Improvement Model (CEIM) approach (figure 1).

Terms used in this guide

Care experience	How human and service interactions, processes or environments within a health or social care system affect the thoughts, feelings, and well-being of people receiving care or support.
Care or support team	A range of people who work together directly or indirectly to provide care or support.
Multi-disciplinary	A diverse group of people who work in health or social care services. This includes health or social care staff that are involved in delivering or supporting the delivery of a service. For example it could include, care workers, doctors, nurses, healthcare support workers, social workers, allied health professionals, administration staff, portering staff, and other types of support staff who are directly involved with the care or support team.
Qualitative	Descriptive data that cannot be measured, and is concerned more with quality than quantity. Qualitative data is often used to understand concepts, opinions, or experiences.
Narrative	A story or account of events or experiences.
Reflective practice	Looking back at actions or occurrences to make meaning from it to generate insights and translate this into practical improvement ideas.
Reflective improvement meeting	Non-judgemental, non-defensive, solution focused meeting space that supports information sharing, prioritisation and collaboration in reviewing care experience narratives in order to identify improvement opportunities and take action.
Values Based Reflective Practice (VBRP®)	Values Based Reflective Practice, otherwise known as VBRP®, is a registered approach developed by the Spiritual Care and Chaplaincy Programme at NHS Education for Scotland (NES) that promotes regular inter-disciplinary group reflection.

1. It is acknowledged that there are other approaches to reflective improvement meetings that are available and could be used for this purpose.

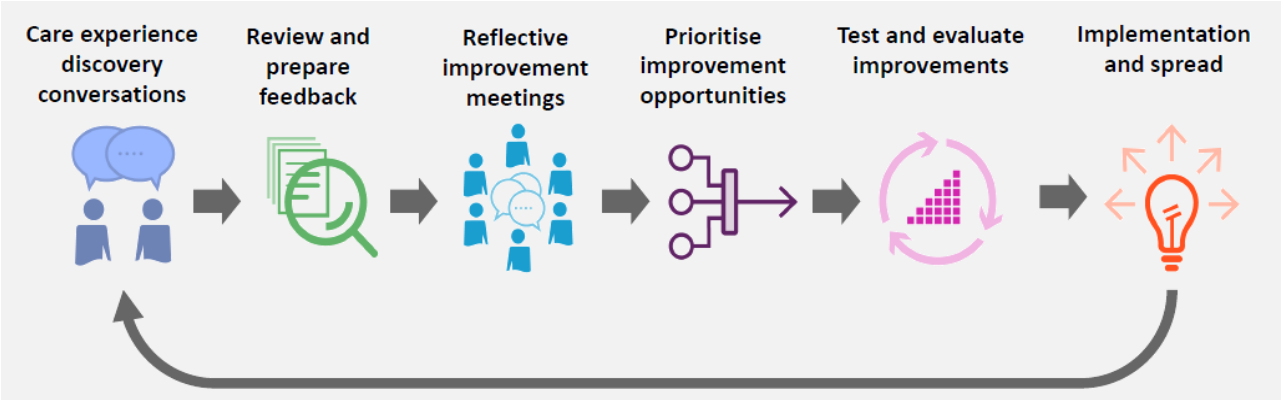
The Care Experience Improvement Model (CEIM)

Care Experience Reflective Improvement Meetings are a key concept in the Care Experience Improvement Model (CEIM)[2]. CEIM is a simple framework (figure 1) that guides health and social care teams to reliably develop, embed and maintain a process and the conditions to help them effectively identify and make meaningful improvements directly related to feedback in a person-centred way.

This model supports health and social care teams to:

- **Take a conversational approach** to gathering qualitative care experience feedback from people for whom they provide care and support
- **use a discovery approach** to these conversations, so that care experience is central to the feedback
- **hold at least six conversations monthly**, focusing these across a specific care or support journey or pathway
- **establish a routine multi-disciplinary (where possible) team reflective improvement meeting** that supports a review of the care experience feedback and identification of improvement opportunities, so that acting on feedback becomes the responsibility of everyone rather than only one or two individuals in a team
- **develop pragmatic Quality Improvement (QI) skills** within the team, using a recognised quality improvement approach[3] in order to effectively focus on and respond to the issues identified through feedback, and to
- **identify and try out change ideas**, then implement and embed those that make a positive difference.

Figure 1 – The Care Experience Improvement Model



[2] Find out more about the Care Experience Improvement Model at: https://ihub.scot/ceim

[3] The Model for Improvement: https://learn.nes.nhs.scot/2959/quality-improvement-zone/qi-tools/model-for-improvement

Improving care experience

Ensuring positive experience of care, treatment and support is an essential component of delivering good person-centred health or social care services, alongside effectiveness and safety.

Improving care experiences at care or support delivery level is not simple and requires effective leadership and a person-centred culture and values. It also requires health and social care delivery teams to have a systematic approach to meaningfully collecting, analysing, learning from and acting on feedback to support quality improvement activities.

This resource sets out some of the key factors required for health and social care teams to embed a robust continuous improvement approach by establishing monthly Reflective Improvement Meetings. This is a structured space where teams, using people's experiences of care or support, can effectively identify improvement opportunities and act on them.

Reflective improvement meetings

A reflective improvement meeting, when used to consider qualitative feedback information, should be a non-judgemental, non-defensive, improvement focused meeting space that supports information sharing, prioritisation and collaboration. This approach to reflecting on feedback supports teams to fully embrace being open and honest about what they hear in feedback and to explore how they feel about it. It allows them to be creative and innovative in developing ideas to solve issues that have been raised and in identifying how good practice can be reliably applied across the team.

Reflective improvement meetings should be multi-disciplinary (where possible) so that acting on care or support experience feedback becomes the responsibility of everyone rather than only one or two individuals in a team.

Project management tools to support an improvement meeting can be found at NHS Education for Scotland's Quality Improvement Zone.

Setting up a reflective improvement team meeting

Protect time

Teams should plan enough time to hear and discuss feedback. This works best when a monthly meeting is scheduled in advance and everyone in the team knows when and where the reflective improvement meeting will be held.

It is possible to incorporate this reflective time in pre-existing meetings, although if doing this it is essential that time in the meeting is allocated routinely to allow focused discussion of the narratives and to make decisions about next steps.

In many cases it has been shown that incorporating this discussion on feedback into an already established meeting is less successful than creating a new space for this. This is because often the reflection on feedback isn't prioritised and can become diluted or overshadowed by the already established focus or purpose of the group. Although if this is the only option, it is advisable to schedule discussions around feedback early in the meeting rather than simply tacking it on at the end when participants are tired and already thinking about moving on to start work or going to their next meeting.

Build a safe space

Creating the conditions for reflection on the quality of care or support being delivered by a team can require some thought and preparation in advance to generate psychological safety within the meeting space. Predominantly this requires 4 ground rules to be consistently applied to all discussions, and these are:

- Be kind
- listen to understand,
- avoid judgement or defence, and
- maintain an improvement and action focus.

Although care experience feedback can often be positive, when it isn't it is important that the team is supported with their emotions around this and encouraged not to jump to defending or explaining why something might have happened in a particular way. Rather, to reflect on understanding why people might have felt the way they did (as shown in their feedback). This can help to remove some of the tendency to blame and can keep the team focused instead on what might be done differently.

Agree meeting structure

There is no single meeting structure recommended for a reflective improvement meeting. The structure should be designed around what works best for the team and the approaches they can most easily engage with routinely. There are however some key elements that should always be incorporated to ensure effective reflection on experience feedback is at its centre, these include:

- **Time** for everyone to read the feedback narratives or for them to be read out to the team,
- **reflective discussion** on what the team have learned from the narratives (individually and/or from small group review),
- **group consideration** of the improvement opportunities and prioritisation of improvement ideas, and
- allocation within the team of **improvement ideas for small scale testing**

An example of core tasks in a reflective improvement meeting that includes these elements is shown in figure 2.

Reflective improvement meetings should be held on a routine monthly cycle that follows the collection of narrative feedback from people receiving care or support, their families or carers. Find out more about gathering care experience feedback in the 'Guide to using a discovery approach for care experience conversations' at: https://ihub.scot/ceim

Clarify roles

All those involved in a reflective improvement meeting should be assigned a role (see figure 3). It is important that everyone is clear about their role before a meeting commences. Individuals may also take on different or multiple roles at each meeting depending on what is required or their skills.

It is important to ensure that a senior leader is involved in the reflective improvement meeting who can quickly give permission for improvement activities, such as testing, and who can unblock obstacles or access more senior support when required for change.

It can also be helpful to involve others who can support the reflection, idea generation or in planning and making improvements, such as subject matter experts in the area you are aiming to improve or support staff such as quality improvement or a person-centred care advisors.

Figure 2 – Core tasks within a simple reflective improvement meeting structure

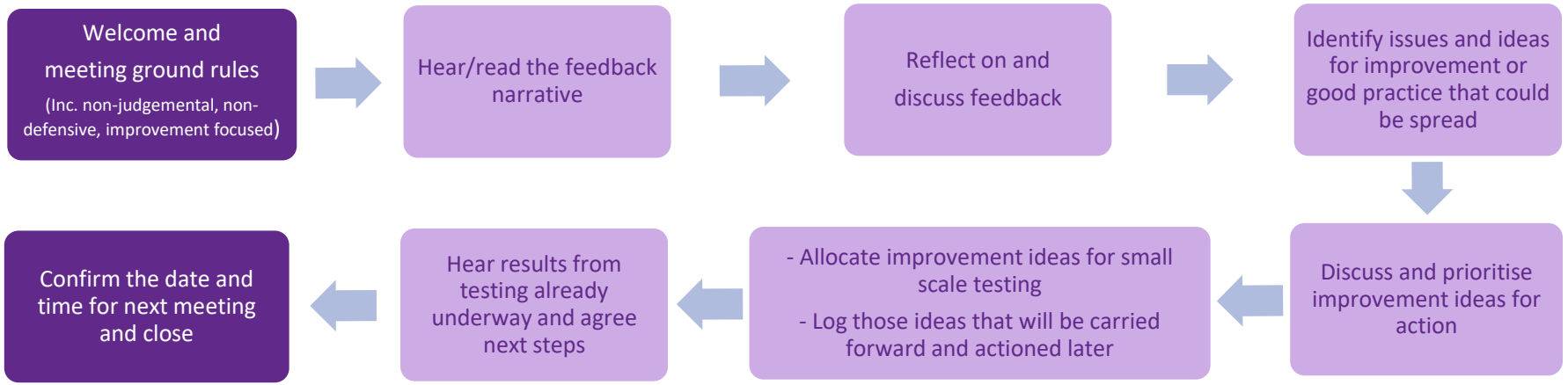


Figure 3 – Reflective Improvement meeting roles

Facilitator	Facilitation is needed during these meetings to keep the focus on improvement and to ensure a non-judgemental and non-defensive approach. The person taking on this role will be responsible for: • guiding the team on how to use/review the feedback during the meeting • supporting colleagues to reflect together on what the feedback means for the quality of care or support delivered by the team • leading the quality improvement focused discussion, and • considering the emotional impact of hearing feedback on team members
Conversation lead(s)	These persons have gathered the experience feedback being considered at the meeting and will either present it directly to the team during the meeting or will have provided it in writing in advance. As they held the conversation(s) that generated the feedback they can often also provide some insight into any context or circumstance that the team attending may have questions about.
Note taker	This person records the insights that surface from the team reflection on feedback, records all improvement ideas, notes those that have been prioritised for action during the meeting, and records progress made on any testing that was undertaken in the previous month.
Improvement team members	These are participants in the improvement meeting from the wider multi-disciplinary team. Their role is to reflect on the feedback, share their thoughts and feelings about what they have heard, contribute to ideas for improvement and help the group prioritise these for action.
Improvers	These are improvement team members who have been allocated improvement ideas to take forward for small scale testing and are responsible for feeding back to the team if these change ideas have successfully made a difference to the experiences that generated them.

Team reflection

Using reflection to capture new knowledge or feelings about hearing care experience feedback (positive or negative) can help a team to continuously learn and improve. Building reflection into an improvement meeting is a big part of being an effective improvement team, as it gives those involved the ability to learn and adapt quickly.

Doing this can be challenging because when work is busy it can be difficult to find and justify the time to reflect on what feedback means for the quality of care and support delivered by the team, but it is important to find time and ways to put what is learned from feedback into action.

Important questions to help teams reflect on experience feedback include:

- What do you notice?
- What are you curious or wonder about?
- How does this make you feel?
- What improvement opportunities does this present?
- What improvement ideas could you try?

Three levels of seeing (VBRP®)

It can also be helpful to use tools such as those used in Values Based Reflective Practice[5] to support team reflection on narrative feedback. The 'three levels of seeing' tool works well when used immediately following the team hearing or reading feedback.

The first level of seeing focuses on what team members see or notice (the obvious). The second level of seeing is concerned with the kind of seeing that arouses curiosity, makes team members wonder about something. The third level of seeing follows a time of processing the noticing and wondering, and is a moment when they realise or perceive something.

So, restricting team responses initially to what they notice (I notice…), wonder (I wonder…) can produce some positive reflections that enable the penny to drop and the team to realise or perceive something new (I realise…) that will help them to explore the feedback together and also help them to step away from some of the emotional impact experienced from direct feedback. Facilitating this within a meeting can at first be challenging and may take a bit of practice.

[5] VBRP® is a registered, national initiative created and led by the Spiritual Care and Chaplaincy Programme at NHS Education for Scotland (NES). Through the use of trained and registered facilitators, VBRP® groups facilitate staff to reconnect their professional role with their personal motivation, vision and soul. To find out more about Values Based Reflective Practice visit : https://learn.nes.nhs.scot/21027/person-centred-care-zone/spiritual-care-and-healthcare-chaplaincy/values-based-reflective-practice-vbrp

The NAVVY tool (VBRP®)[5]

When faced with feedback from people who receive care or support, teams can often jump from the issue that has arisen straight to looking for solutions, without pausing to thoroughly explore what might lie within an 'issue', or to critically consider factors that might surface from the proposed 'solution'. The purpose of the NAVVY tool is to create a space between the 'issue' and any proposed 'solution'.

The NAVVY Tool asks questions of any situation across five themes (needs, abilities, voices, values and you), although not all questions in the tool might apply to the feedback being considered. Without testing out which questions do apply to the feedback and require attention, the reflective practice cannot be values-based.

N	**Needs** • Whose needs are being met? • Whose needs are left unmet? • Whose needs have not been considered in a particular situation or line of action?
A	**Abilities** To what abilities or capabilities does the situation draw attention?
V	**Voices** Who/what has a voice in the situation and who/what is silent or silenced?
V	**Values** • What is being valued here? • What is being overvalued or undervalued in this situation? • Where is value being placed e.g. where it does not belong etc.? • If there are competing values at work in the situation, how are these being managed?
Y	**You** • What does the situation say about you, the individual worker? • What does the situation say about you, the team? • What does the situation say about the wider context in which the team find themselves (the collective 'you' of the health or care organisation)?

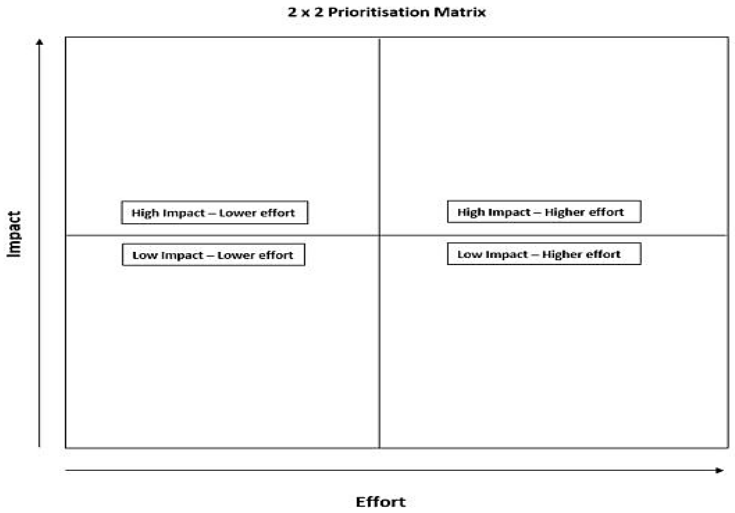
Prioritise improvement ideas

The improvement team will be able to identify and prioritise opportunities for improvement highlighted through their reflection on the feedback. This may also be assisted by generating criteria or questions that help to prioritise what the team should work on first. For example, the team may ask questions like:

- Is this improvement idea a quick win (easy to test with high impact potential)?
- Is it more complex but would have a big impact for service users and/or staff?
- Is it of high importance to service users, patients, families or carers?
- Will it support staff in their work to deliver person-centred care?

A prioritisation matrix can also be a useful visual tool to help the team to decide which improvement ideas to test first and how to focus their activity and energy. It works best when carried out collaboratively within the reflective improvement team. It can help to build broad buy-in and communicate why the team have chosen to test certain ideas before others. A simple form of this is the 2x2 matrix as shown in figure 4. Find out more about using a 2x2 matrix at the Quality Improvement Zone in NHS Education for Scotland's 'TURAS | Learn'.

Figure 4 – The Quality Improvement Journey



Using quality Improvement (QI) approaches

It is recognised that not everyone working in health and social care has experience of using quality improvement (QI) methods. Where this is the case for those involved in a care experience reflective improvement meeting, it is important to seek support from others in the team or from the wider organisation, such as qualified Improvement Advisors, to help robustly plan and take forward testing and implementation of change ideas.

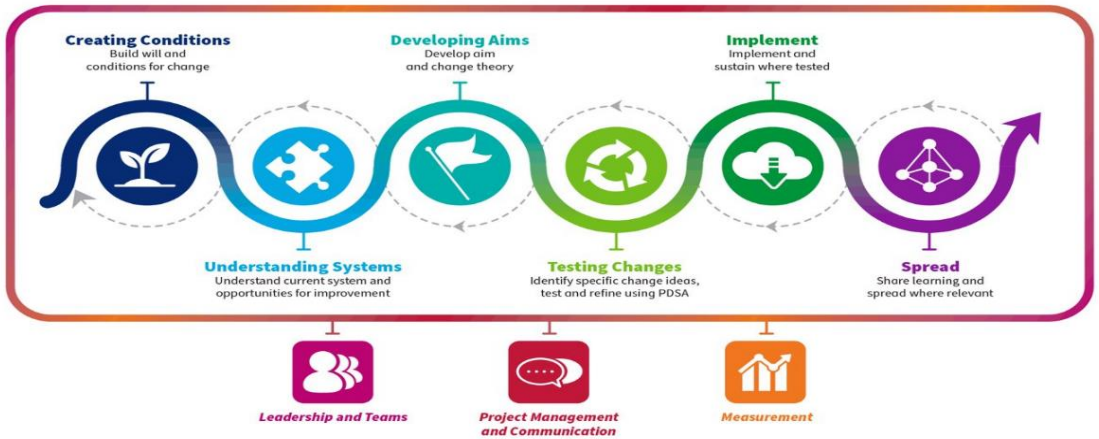
The team can also develop their knowledge and pragmatic skills in using quality improvement approaches by utilising the online resources and personal development tools available at NHS Education for Scotland's Quality Improvement Zone in 'TURAS | Learn'.

The quality improvement journey

The Quality Improvement Journey shown in figure 5 illustrates the stages of an improvement initiative or project.

The Care Experience Improvement Model recommends using this approach to help develop a quality improvement infrastructure for the Reflective Improvement Meeting. It can help team members visualise how their work on gathering feedback can support them to 'understand the current systems' from the perspectives of people who receive care or support, their families or carers. This assists in moving care experience feedback into improvement action by using the last four stages of the model shown in figure 5 to guide the activities of the improvement team. Find out more about the quality improvement journey at the Quality Improvement Zone.

Figure 5 – The Quality Improvement Journey



Person-centred vision statement

Taking time out to create an improvement team vision statement[6] that helps to describe the quality of person-centred care or support that the team want for people who interact with their service can be helpful for a new Reflective Improvement Group (see appendix 1 – Creating an improvement team vision statement).

This activity can be used as a way of involving the whole group in shaping the future of person-centred care or support in their service. This can also help to keep the group focused, support ownership and commitment to the success of the group, and frame group discussions to ensure that people who use the service are at the center of all decisions and changes.

Feedback trends

Once the Care Experience Improvement Model is embedded into team practice and Reflective Improvement Meetings are established on a monthly cycle, the team may start to see trends in the data gathered from feedback over time[7]. This can also at times result in less positive feedback re-emerging about changes the team thought were 'quick wins' early on. Seeing this in the data should be viewed as a positive aspect of the process now established, as it helps to provide assurance when changes are making a difference and enables the team pick up on any changes that may need to be reviewed by the team again.

Bringing these issues back to the reflective improvement team can be hard but it is important to focus on continuous improvement and maintaining the non-judgemental, non-defensive maxim of the improvement team.

Collaborative improvement partnerships

Once the Reflective Improvement Meeting is established the team should consider inviting people who use the service or those that support or advocate for these individuals to participate as improvement partners[8]. The value of involving people who have a service user perspective in the improvement team can be immense as they can offer unique insights into 'what really matters' and they can help focus the team's attention on improvement ideas that are most meaningful for the people they care for or support.

[6] The Scottish Government, The 3-step improvement framework for Scotland's public services: https://bit.ly/3vpkTrB

[7] The Health Foundation, Measuring patient experience: https://www.health.org.uk/sites/default/files/MeasuringPatientExperience.pdf

[8] The Kings Fund, Patients as Partners (2016): https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Patients_as_partners.pdf

What people have said about using this approach

> What you can't underestimate is the importance of the reflective meeting to identify the improvement opportunities.
>
> *CEIM learning programme participant, NHS Highland*

> Staff feel empowered to progress improvements relating to what really matters to people there and then.
>
> *CEIM learning programme participant, NHS Grampian*

> Don't start with something in mind that you think needs changed. Let the conversations identify the need and shape the change.
>
> *CEIM learning programme participant, NHS Highland*

> I was particularly struck by hearing the voice of the person, in their words and their emotion. Then seeing how the improvement ideas just popped out...it was very powerful!
>
> *CEIM learning programme participant, NHS Grampian*

> This has changed the way I would plan to implement any new changes or adapt an existing process. It provided the inclusion of patients and families who are most important, as they utilise and benefit from our services.
>
> *CEIM learning programme participant, NHS Fife*

> It increases awareness of patient experience, allows systematic improvements to be made, and makes the patients feel valued.
>
> *CEIM learning programme participant, Angus Health and Social care partnership*

Acknowledgements

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Suggested reading

1. Institute of Healthcare Improvement. **How to Improve. Science of Improvement: Forming the Team**. Available from: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx [accessed 1st March 2021]
2. NHS Education for Scotland. TURAS Learn. Person-centred Care Zone. **Values Based Reflective Practice**. Available from: https://learn.nes.nhs.scot/21027/person-centred-care-zone/spiritual-care-and-healthcare-chaplaincy/values-based-reflective-practice-vbrp [accessed 1st March 2021]
3. NHS Education for Scotland. TURAS Learn. **The Quality Improvement Zone**. Available from: https://learn.nes.nhs.scot/741/quality-improvement-zone [accessed 1st March 2021]

Appendix 1 – Creating an improvement team vision statement

Creating an improvement team vision statement can help keep the team grounded and focused on what they hope to achieve. It is a way to explain clearly to others what their quality and improvement aspirations are and helps the team to remain focused on what's important.

The difference between a mission statement and a vision statement is that a mission statement is about what you do now (your approach and objectives) whereas a vision statement is firmly based on a desired future. There are many approaches to developing a vision statement, one example is shown in figures 5 and 6.

Figure 5 – Vision statement framework

Output	• Describe what you will do as an output for the people who receive your service - **the product, impact, or outcome that results from what you do**
Unique factor	• Define the unique factor your team will deliver that other teams may not - **what you do to deliver your output**
Who are you serving	• Outline your key service user(s)/stakeholders - **those that will benefit from the output**
Real-world, human impact	• Describe how the people who receive your service will perceive the future in real-world or human terms - **what they will see hear or feel**

Figure 6 – Example vision statement

Our team will lead continuous improvement in person-centred end of life care that ensures everyone affected by dying, death and bereavement has the best possible experience that meets their needs and reflects what matters to them.

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