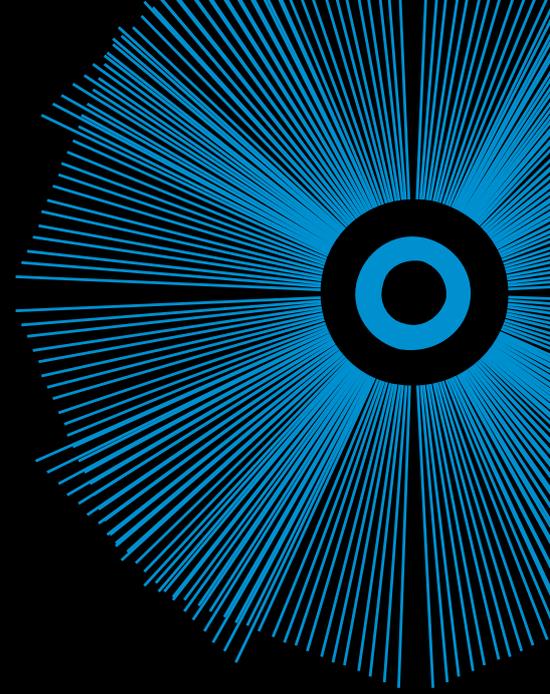




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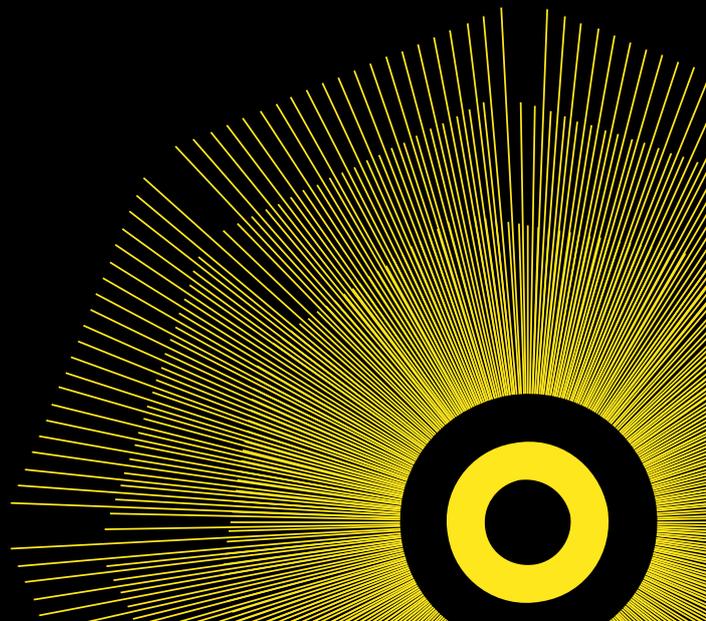
Shine 2012 final report

Project title

Organisation name Cambridge University NHS Hospitals
Foundation Trust

December 2013

The Health Foundation
Tel 020 7257 8000
www.health.org.uk



Part 1. Abstract

Project title: Supporting patients to inform clinical commissioning to achieve best outcomes – the value of planning using patient centred information.

Lead organisation: Cambridge University Hospitals Foundation Trust.

Partner organisation: Cam Health Clinical Commissioning Group

Lead Clinician: Dr Jonathan Fuld, Dr Mark Brookes

Background

COPD (Chronic Obstructive Pulmonary Disease) is a long term condition causing disabling breathlessness, leading to inactivity and worsening health status. With support quality of life can improve and hospital admissions can be reduced but we need to understand what type of support is most helpful. Importantly:

1. Patients need access to services that they perceive as relevant.
2. COPD services are commonly designed around a medical model and do not address the practical, social and emotional aspects of patients' lives.
3. The commissioning process needs to be better informed by patients' experiences, needs and aspirations. There is no local systematic means of empowering patients to inform commissioning.

Our project addressed these issues by testing a process to provide (3).

The innovation and methods

We tested an approach to co-producing change called Working Together for Change (WTfC) in which patients, commissioners and service provider's work together to determine the improvements they wish to see. WTfC generates high quality qualitative information about patients' needs and preferences, gathered systematically to support the commissioning process. It has been used successfully in social care and mental health settings. This project tested the feasibility of WTfC in the context of COPD.

The first step was to complete 40 'person centred reviews' (PCRs) with people living with COPD. In these one-to-one meetings patients were supported to explore what's working in their life with respect to COPD, what's not working, what's important to the future and the top two priorities in each area. They were invited to attend the next stage of the process, which were two one-day workshops.

Workshop invitations were extended to commissioners, health care professionals, managers, service providers and third sector organisations with responsibility for delivering COPD care and support.

The six priorities for each patient were taken forward to the workshops. These were themed and analysed by all participants working together. The aim was to understand the root causes of what was not working and to identify what success would look like if the root causes were addressed. Success statements were agreed from the perspective of patients and professionals and action plans created.

The Shine project team conducted the PCRs, and organised and facilitated the workshops with support from Helen Sanderson Associates, who devised the WTfC process. The team included the British Lung Foundation's Support and Development Manager.

The evaluation aimed to identify whether WTfC produced information of value to commissioners and whether the process was acceptable to participants. We conducted a qualitative evaluation including workshop observations and interviews with professionals and patients. There was no funding to implement solutions, but some of the ideas generated are being considered for application in health care settings.

What we achieved

Through close and informal interaction with patients and carers, professionals gained an enhanced understanding of the realities of living with COPD which was described as “humbling”. For example, realising the difficulty people have with eating and breathing at the same time was a poignant and important example of physical limitations that can prevent patients following healthcare advice.

The types of services identified as requiring action included better access to information in the community and care pathways, more holistic care, improved access to services, greater focus on dietary issues, improved access to patient information for healthcare professionals, improved customer service at GP reception desks and monitoring of projects for effectiveness, scrapping targets for targets’ sake. Ideas were categorised as ‘quick fixes’ or ‘major projects’ and professionals took away actions for their own organisations.

Patients felt their issues were fairly reflected and not “lost” even if not all included in the action plans. They understood a need to focus immediately on the most realistically achievable outcomes (some were more ambitious, e.g. longer opening hours), but felt that all information was regarded as “precious”.

The process was engaging and enjoyable. Patients in particular found the experience to be powerful and felt they were making a contribution for the future. All participants believed that everyone was committed to the process which was integral to success.

Since the project ended we have been working with commissioners to develop training for reception staff to support them in having a better understanding of COPD and to improve patients’ interactions with reception staff.

What were the challenges and how were they overcome?

Patients and professionals worked together to realise the values of co-production and this range of perspectives made the process more valuable. It would have benefited from more GPs (only one attended) and primary care nurses; however we had good representation from patients and carers, the third sector, managers and other health care professionals.

One of the main challenges for professionals was finding diary space for the two workshops. We spoke individually to all of the invitees to explain the benefits and all reported afterwards that it was time well spent.

799/800

Part 2. Quality impact: outcomes

PCRs were conducted in patients' homes, residential homes and GP practices. Workshops were in community facilities.

Data were generated through interviews and observations.

Enhancing commissioners' understanding of patient needs/aspirations

- The experience was enlightening. It was "humbling" to see the reality of life for those with COPD, e.g. realising that people had difficulty eating and breathing at the same time. Taking part drew professionals' attention to physical limitations that prevented patients following medical advice.
- It is crucial for professionals to understand patients' frustrations and help them to overcome them; the workshops were a powerful way to highlight those frustrations.
- We produced a written report for commissioners unable to attend. It covered the process well but some would also have appreciated a summary report. We presented the outcomes at the CCG board meeting and a patient forum. These were well received.

The services to which patient needs/aspirations relate

- Access to information, e.g. community navigators; community COPD co-ordinators; community information days with transport; more time at diagnosis for education/lifestyle information.
- Holistic/integrated care, e.g. health centre including social, third sector, benefits, dentist etc.; scrap organisational boundaries; named HCP to co-ordinate care.
- Access, e.g. longer opening hours, improved access to community respiratory team.
- Dietary issues, e.g. dieticians in MDT meetings; training for HCPs.
- Patient information, e.g. microchip 'bus passes'; real-time patient information available to all professionals dealing with the patient.
- Improved customer service at reception.
- Monitor new projects for effectiveness; scrap targets for targets' sake.

Were participants satisfied that the conclusions/actions reflected needs/aspirations?

- Patients felt their issues were reflected and not "lost" even if not included in final outcomes/actions. They understood that more realistically achievable outcomes needed to be focused on (some were very ambitious, e.g. longer opening hours), but felt all information was "precious".
- Carers felt their needs were taken into consideration.
- Some professionals were surprised at issues highlighted and resulting outcomes/actions – some they had not appreciated as being important to patients. There was real benefit in understanding what patients *actually* want as opposed to what professionals *imagine* they want, or what professionals want *for* the patients.

This included looking at patients holistically and not just focusing on COPD, e.g. finances, mental health, support structures.

Participant experience

- The process was engaging and conducive to speaking honestly. Participants were willing to attend a similar process again.
- There was a sense of freedom. Patients particularly found the experience to be powerful and felt they were making a contribution for the future. Some feared that outcomes could be biased by a herd mentality.
- Professionals and patients gained insight about the reality of COPD from others' perspectives.
- The facilitation and organisation contributed to the positive atmosphere. The "visual elements" were useful.
- Professionals and patients believed everyone was committed to the process and that this was integral to success.

We maximised reliability and validity by audio recording interviews, comparing observational data with interview accounts, reviewing outputs with a sample of participants.

500/500

Part 3. Cost impact

This project supported patients to be active partners in their own care and tested an innovation in mainstream health that has been used in mental health and social care. In mental health and social care, WTfC projects have realised reduced relapse rates, fewer emergency admissions, higher staff satisfaction rates and reduced complaints.

Our project tested the feasibility of the process to provide useful information for commissioners of COPD services. It did not include delivery of agreed actions. Economic analysis of any resulting service changes is outside the scope of this evaluation.

However, we can comment on the cost of implementing the process. Direct delivery costs include facilities and equipment for conducting the workshops, and training of facilitators. Indirect costs include professionals' time for attending workshops and conducting PCRs. These costs will vary by location. In our case we obtained the facilitator training at an advantageous rate because the creators of the WTfC process wished to support the testing of the process in a physical health setting. The total cost for delivering the workshops was £8,699

We now have a number of team members trained to deliver this methodology and who could support others to deliver the process. This effectively lowers the cost in the longer term for delivery in our local area.

Commissioners would need to balance the cost of the methodology against the benefits of having better quality patient centred information.

A larger scale project would be needed to conduct a full cost-benefit analysis which took into account the economic impact of service changes.

255/500

Part 4: Learning from your project

What helped?

We are very pleased with the delivery of this project and have achieved against the agreed objectives.

We had a strong team of committed individuals that enabled the delivery. It was essential that everyone who took part in the process felt they had a role to play.

Regarding professional invitees, the steering group spent considerable time during the planning stage drawing up a list of contacts from a range of commissioning organisations, service providers and third sector.

Patients were identified by staff in GP practices as well as from a previously held register of patients who had attended Pulmonary Rehabilitation in Cambridge, and existing lists of patients with whom the Centre for Self management Support had previously been in contact. We ensured a range of patient views by including those who had not previously been involved in rehab programmes or health care consultation exercises. We approached patients by explaining the process and the benefits to participants; generally patients were happy to support the process

All invitees were approached personally by phone for the workshops.

Efficient project management was vital in co-ordinating the invitations, organising venues and facilities and ensuring smooth running on the day.

The evaluation uncovered a huge enthusiasm among both patients and professionals to share experiences and learn from each other. Whilst some professionals had been hesitant about giving up two days of time to attend, they reported afterwards that it had been hugely insightful and beneficial. There was a real desire to understand patients' needs better and this process helped professionals to gain new insights. Similarly patients wanted professionals to understand their situation. The process therefore tapped into powerful existing motivations that just need the right sort of channel in order to be realised.

Patients were happy and pleased to be part of the project and we had excellent anecdotal feedback that suggested they part of the whole process and that for many they saw a benefit of "doing it this way".

Within social care the PCR is an established part of the support process. This is not the case in COPD care and so we devised a format suitable for our needs but based on the same framework in order to elicit the same information as a social care PCR. Our PCRs were completed on a one-to-one basis, whereas in social care they are completed with the individual's support team; however this was a successful adaptation.

We kept a consistent team throughout the delivery and this helped its success.

The process was robust and previously tested successfully in mental health and social care;

Both workshop venues worked well and offered different things.

The main strength to this type of event is the planning and commitment of the team to make it work. You must have a strong committed team.

Challenges

One of the main challenges was ensuring that we had sufficient numbers participating in the workshops and that we had the right mix of participants. We implemented a robust process of invitation and follow up to ensure we had the right numbers in attendance. The numbers were lower on the second workshop day; however patients' numbers remained consistent. Some professionals were unable to attend both days as time pressure is always a challenge in health care services. However, when they were able to see the benefits of the process many reported that the time spent was well worth it.

Due to the nature of their condition, patients can be ill at the last minute and unable to attend. However even though many of these patients struggled with their condition they attended and participated throughout.

What would we do differently?

In future we would invite more GPs and primary care services and also representatives from the ambulance service.

623/800

Part 5. Plans for sustainability and spread

The benefits of this implementation of WTfC will be sustained if action plans are implemented by commissioners.

Discussions were had with the commissioning team following the workshops where we looked at the quick wins. A clear deliverable was identified that could be acted on immediately – patients had been concerned about access to GPs and nurses, particularly with regard to interactions with receptionists when they are trying to make appointments. It was identified that receptionists would benefit from having a better understanding of the nature of COPD and the problems associated with living with the condition. We have worked with the CCG to develop a training session for receptionists from all Cam Health practices and this will be delivered in March 2014.

In order to spread the benefits of the WTfC to other health economies we need to publicise the value of the approach. We will look for opportunities to present at conferences and professional events as well as promote the process through our own networks. This would require funding to attend conferences.

This work will be highlighted on the team's web site describing it as a powerful way to gather patient centered information in a systematic and robust way.

The team members who delivered WTfC are now trained in the process and could support others to develop these skills.

Learning is transferable to other disease areas and the process can be applied at scale to LTC pathways.

We expect that successful implementation of WTfC will result in the commissioning of services that have been informed by patients, perceived by patients as relevant and beneficial and which have greater uptake and equality of access.

On a salutary note, the Respiratory Alliance, whose Chief Executive attended the workshops, was keen to draw up plans for a much wider consultation exercise across England to co-produce a Respiratory Manifesto with patients - using a similar approach to that used in WTfC. The aim was to build on WTfC work and to broaden the issues discussed with a wider group of respiratory patients, from different parts of the country, using the same techniques. The Alliance needed to seek funding for this project and anticipated that it would take a while for the funds to be raised. Unfortunately we have recently learned that whilst the respiratory community had expressed considerable ideas, goodwill and commitment to the vision and ethos of the Respiratory Alliance, few, if any, stakeholders were in a position to commit membership fees. In addition, the Board had given detailed consideration to potential new sources of funding including other statutory income, industry and charitable trusts, but none could be secured within the required timescale. With no identified long-term funding available the Directors sadly came to the conclusion that the Respiratory Alliance was not a going concern. This example illustrates both the aspiration for co-production in this area and the formidable funding challenges in a climate of austerity.

483/500

Appendix 2: Resources from the project

Commissioners' Report (without appendices)

Working Together for Change 2013

Background

In January 2012, Cambridge University Hospitals Foundation Trust (Addenbrooke's Hospital) partnered with the British Lung Foundation (BLF) to successfully tender for funds from the Health Foundation's Shine programme. The purpose of the Shine programme is to develop new approaches to delivering healthcare through one of the following categories:

- supporting patients to be active partners in their own care
- improving patient safety

Improving quality (as defined by the Institute of Medicine) while reducing costs. The funding enabled us to implement Working Together for Change, a process tested in social care to collate and analyse person-centred information to inform commissioning, in the context of COPD.

The project, running over 14 months, considered:

How to support patients to inform clinical commissioning to achieve best outcomes – the value of planning using patient-centred information.

The project was led by a team of specialists from across Primary and Secondary Care and included clinical leads from both the hospital and a LCG (Cam Health). The steering group included patients and representatives from the Centre for Self-Management Support in Cambridge, based at the Trust. The project involved patients who live with Chronic Respiratory Disease; however the intention was always to consider its transferability across to other long term conditions (LTCs).

COPD and its impact on the health economy

COPD (Chronic Obstructive Pulmonary Disease) is a long term condition which causes disabling breathlessness. Breathlessness and exercise incapacity lead to inactivity and worsening health status, leading to further deterioration; patients become vulnerable to exacerbations, frequently requiring hospitalisation. COPD costs the NHS £500m pa, mostly relating to hospital admissions; there are negative impacts on patient wellbeing and quality of life.

Evidence shows that if COPD is well managed and patients receive appropriate support, including self-management support, that quality of life improves and hospital admissions can be reduced. There is more work to be done to understand how best to implement support and what form is most helpful to patients.

The problem

Experience in Cambridgeshire has identified key issues relating to patients getting the right support. We believe this pattern is recognisable on a national scale.

- 1) Patients need access to services that they recognise as appropriate and relevant.
- 2) Many existing COPD services are developed around the medical model and do not fully address the practical, social and emotional aspects of patients' lives.
- 3) The commissioning process needs to be informed by patients' experiences, needs and aspirations. While patients are represented on steering groups of clinical commissioning groups there is no systematic means of empowering the wider patient community to inform commissioning so that services address patients' needs and aspirations.

The solution

The project addressed the need for high quality qualitative information about patients' needs and preferences that could be gathered through systematic means. The process tested to achieve this was based on the Working Together for Change (WTfC) framework which has been previously successful in social care and mental health settings. We wanted to see if we could use this process in mainstream health to understand what COPD patients want, what works for them, what doesn't work and what is important to them for the future.

Note that the scope of the project was to test the process of WTfC (in this setting) only and there was no funding to implement solutions; however as a result some of the ideas have been considered for application in health care settings.

This report summarises how the process was implemented (the decisions made, the ideas tried, what worked and what could be done differently next time) and the outputs (service ideas and solutions generated).

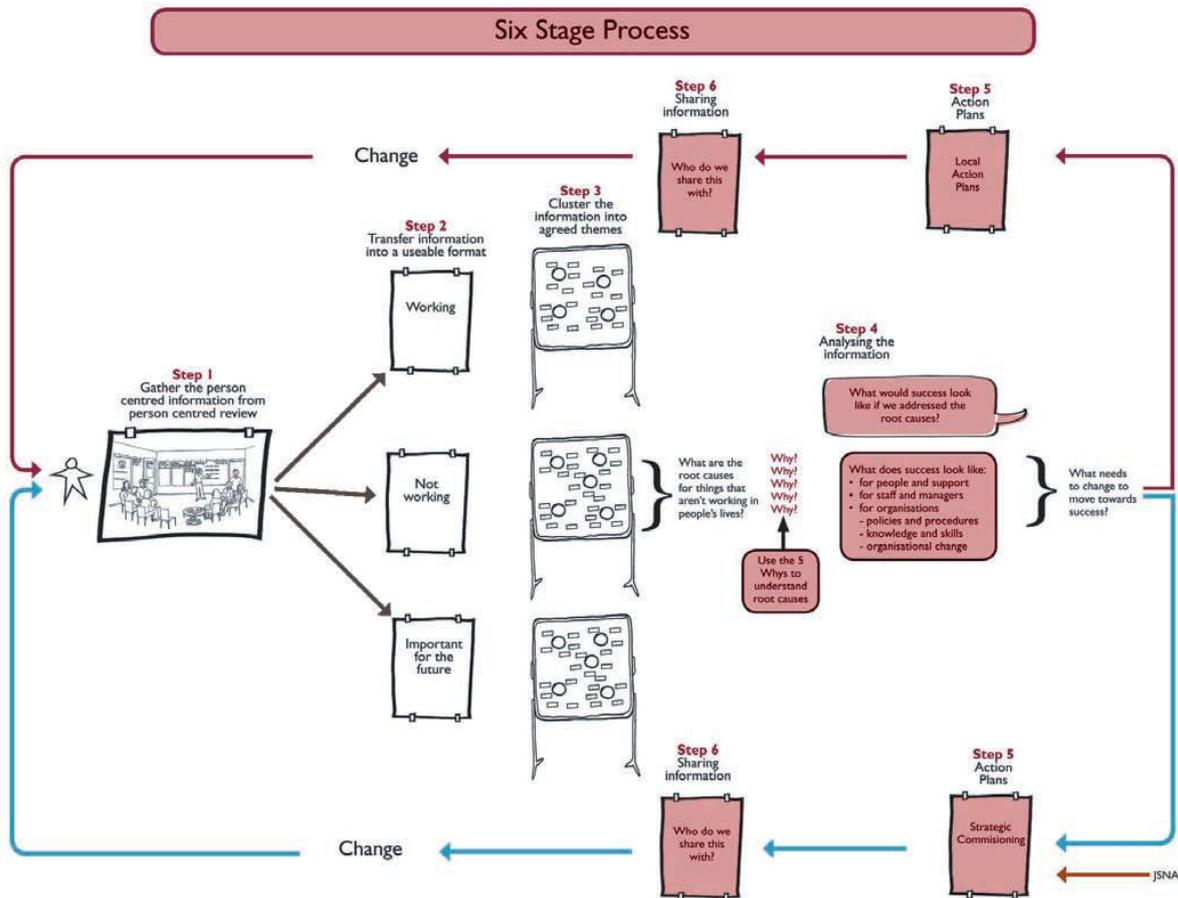
The WTfC workshops were co-designed by the SHINE project team. The team were trained in the process prior to the workshops and additional facilitation at the event was provided by Jon Ralphs for Helen Sanderson Associates who devised the original process.

THE PROCESS

Working Together for Change

As a framework for co-production of service development, Working Together for Change is a process that takes as its starting point information gathered in one-to-one reviews (Person Centred Reviews) from people who use services. In a subsequent workshop setting, participants work together to look for the big themes, narrow down their focus onto those they feel most need further examination, and build an action plan. This is done collaboratively by people who use services (this can include the people whose information forms the basis of the process, as well as others who did not take part in reviews), people who work for the service, and others such as people's families, community connections, and other interested parties (for example, commissioners of services).

Working Together for Change has an established six-stage framework:



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The information gathered for Working Together for Change reflects three areas:

- What is working,
- What is not working, and
- What is important for the future?

This information is usually gathered from Person Centred Reviews.

Person Centred Reviews

In a social services context, person centred information can be gathered from person centred plans, support plans or person centred reviews. Each of these processes typically use the questions 'what is working, what is not working' and 'what is important for the future.'

Where other information is required, the Person Centred Review process can be adapted to provide this.

We completed 40 Person Centred Reviews with people living with COPD. The individuals were identified by staff in GP practices as well as from a previously held register of patients who had attended Pulmonary Rehabilitation in Cambridge. As there was no existing Person Centred Review process to draw on we designed a framework for one-to-one interviews

which included the key questions above. Patients were asked to agree the two most important statements, in their own words, for what's working, what's not working and important to the future. These six statements were taken forward to the workshop stage. Patients were asked at the end of the review if they would like to attend the workshops. Where they agreed invitations were sent out.

Some were unable or chose not to attend, sometimes because they did not feel confident enough. A key point to note is that this process allows the voices of those not attending to still be included in the next stage. It is rare in health that we have the opportunity to listen to patients about their experiences across primary and secondary care.

See Appendix 1 for question profiles used for the Person centred reviews.

The workshops

The next stage was designing the workshop and using the information gathered to drive the process to the end.

Designing our Working Together for Change event - *decisions made in planning*

Initial discussions focused on establishing the purpose and aims of the event. We discussed the difficulties of staying true to the Working Together for Change process in the light of the understanding that for many of the people living with COPD attending a two day workshop might actually be challenging in its own right. The other consideration for us was that the scope of the project did not include the very last stage of action planning as we were only testing the process and its application in main stream health. However we intended:

- ✎ To use the spirit of the process as a framework for an inclusive event to help the whole service to understand what was working and not working about the service, and to act on this if appropriate and agreed by all.
- ✎ To use information from Person Centred Reviews.
- ✎ To use all the most important statements as defined by the patients from what's working, not working and important to the future.
- ✎ To try out a Working Together For Change event that could then be refined and used to address issues facing all patients living with long term conditions and to support commissioners to understand what is important to this cohort of patients.
- ✎ To find ways to involve people who traditionally would have been excluded from the whole process, e.g. patients with literacy problems, housebound patients and carers.

Involving professionals in workshops

We considered having a number of different groups to reflect the range of individuals that could be served by this process. Participants were:

Hennessy	Brenda	Dir of Patient Experience & Public Engagement	CUH
Rogers	Fraser	Public Engagement Manager	CUH
Murray	Gail	Commissioning Dept	CUH
Sieff	Adrian		THF

Little	Vivienne		THF
Myers	Sandra	Programme Director for Integrated Care	CUH
Harrison	Rachel	Manager	Cam Health LCG
Linehan	Geraldine	Vice Chair of Cam Health	Cam Health
Slatter	Amanda	Project Support Officer	Cam Health
Roberts	David		Hunts Health
Perrott	Susan	IRT Lead	CUHFT Integrated Respiratory Team
Sice	Christine	Respiratory Team Lead	CCS Hunts & Fenland Respiratory Team
O'Driscoll	Richard	CUHFT Complex Discharge Transformation Manager	CUH
Arnold	Lois	Discharge Planning Manager	CCS Discharge Planning Team
Clarke	Marion	CCS Reablement Service	CCS
Brown	Helen	Crossroads	Crossroads
McCallum	Ruth	Care Network	Care Network
Byrne	Lynne	Senior Ops	Age UK Cambridgeshire
McKevitt	Mike	Head of Patient Services	British Lung Foundation
Wibberley	Steven	Director of Operations & Innovations	British Lung Foundation
Armstrong	Dr Miriam	Chief Executive	Respiratory Alliance
Jongepier	Lianne	Joint Respiratory Lead for the East of England	
McNeil	Julie		Healthwatch Cambridgeshire
Fuld	Jonathan	Respiratory Consultant	CUH
Young	Jane	Respiratory Nurse Specialist	CUHFT Integrated Respiratory Team
Ahmed	Nadeem	Development Officer	Cambridge Alliance for Independent Living
Johnys	Hilary	Direct Services Manager	Care Network Cambridgeshire
Howson	Sophie	Community Matron	CCS
Thomas	Val	Consultant in Public Health	Cambridgeshire County Council
Burkin	Julie	Occupational Therapist & Lead Practitioner	Long Term Conditions Service, CUHFT
Malik	Mustafa	Project Manager	Cam Health
Greaterex	Sandra	Team Leader	Addaction, Cambridge Alcohol Service

Talbot	Susie	Cambridgeshire Safer Communities Partnership Team Lead	Cambs Drugs & Alcohol Action Team (DAAT)
O'Meara	Inger	Senior Health Improvement Specialist	Cambs County Council
Saint	Graham	Strategy Officer	Cambridge Local Health Partnership, Cambridge City Council
Bendon	Jessica	Adult Treatment Co-ordinator	Cambridgeshire Drug and Alcohol Action Team, Cambridgeshire Safer Communities Partnership Team
Cupit	Stephen	Service Manager for Inclusion Drug Treatment Services in Cambs	Cambridgeshire Drug and Alcohol Action Team, Cambridgeshire Safer Communities Partnership Team
Clissold	Beverley	Housing Officer	City Homes North
Aston	Carolyn	Benefits Adviser	East of England Ambulance Service Citizens Advice Bureau Cambridge
Gomez-Serrano	Clara		Independent Living Service, Cambridge City Homes

It was reiterated to participants at the outset that the aim was to test the process in mainstream health and that whilst there was no funding for action this did not preclude participants taking action on their own account as a result.

Workshop attendance

40 professionals and patients/carers attended, of which 22 were patients and carers.

Overall, the events were a success. Most patients managed to attend both days. Day one was better attended by the professionals than day two.

The first day overall was better-attended.

Amount of information used in the workshops

We used, as previously stated, the top two statements from each PCR on each area of what's working, not working and important to the future.

It is important to realise that some information was included in the PCR but would not have been taken to the workshop as it was not highlighted by the patient as the main priority. This information however is valuable and we decided as a team to capture this separately. This information could be available to commissioners and service providers in the future to help shape services or to use for another WTFC workshop to identify further work areas.

A process called Dot voting was used at each stage of the process, this enabled the room to decide on the priorities to work with as the workshops progressed; it kept us to time and allowed the whole room to have a say in the ideas that should be taken forward.

Planning and preparation for the workshops

The two main preparation tasks were to book a suitable venue for the patient group and to prepare the materials for the workshops.

It was challenging to find a venue that was available for two whole days, which had level access with a short distance between the car park and the room and which was economical and spacious enough for five pin-boards and for forty participants to move around freely during the WTfC process. Commercial venues are expensive and community venues are in regular use by community groups.

We chose two separate venues for the two days, mainly because of availability. Both worked well but had different benefits and pitfalls; these are summarised in the learning section.

Around 240 statements from the person centred reviews were written up on cards prior to the workshops and other materials needed preparation or ordering.

The Process

On the whole, our event followed closely the Working Together for Change process – the flow of a piece of person-centred information through theming, root cause analysis and into planning follows the established framework. The workshops were facilitated by members of our own team and supported by Jon Ralphs from Helen Sanderson Associates, the team that developed the original process.

All the information that the group was working with during the process was derived from service users.

For each of the sections, we had over eighty statements to theme. It was a challenge to finish the theming with all the information gathered; however we took a flexible approach to the first morning.

The theming sessions were very successful. As you would expect some people were more involved than others; however overall everyone contributed in some way.

Dot voting was used as previously described to focus on the priority areas.

What is theming?

Theming is an opportunity to group together the statements created in the person centred review. It is easier to work with themes rather than individual patient statements, because other workshop participants are likely to have faced some of the same types of issues.

Themes were agreed for what's working, what's not working and important for the future. This is an important element as it is an opportunity to see what we are doing well as well as where there could be improvement.

Whilst we themed all three areas and acknowledged them we then went onto work with the not's working themes for the remainder of the workshops.

An example of how a theme from the workshops was developed would be where patients have said -

"I feel like a burden and never have enough time with my GP",

"I feel like I get different information from different people"

"I feel like I am pre-judged because I am breathless"

These statements are then put together and developed as an "I statement"; the example here might be "I am not listened to"

The actual "I statements" developed from the themes were

- I can't do what I want to do
- I'm anxious and depressed
- I can't get appointments when I want them
- I'm not treated as a person
- I don't think the right hand knows what the left hand is doing

All of the "I statement" were developed from each theme by the participants.

Participants then considered the root causes of the 'I' statements. This allowed the groups to consider why there is a problem. The question 'why' is asked several times until all possible root causes have been considered and listed.

Issues such as poor training, culture, funding, and staff changes were listed in some sections as a root cause.

See appendix 2 for all of the root causes for themes.

For each root cause success statements were then formulated to represent what success would look like if the root cause were addressed.

We considered success from the point of view of:

- The Patient/service user
- The commissioner
- The Clinicians/practioners
- The Third sector

Radical, Traditional, Different? – Participants used a solution focused approach to think of solutions that were radical, traditional and different. Before we looked at this we asked the groups to consider what was already in place to ensure there was no duplication.

All of these are in Appendix 3

Radical – Something that may never be considered, this may feel impossible but at this stage everything can be considered. (A Heston Blumenthal approach)

Traditional – Something that may be happening already but a change could make it better, maybe doing more of the same, this may feel quite comfortable. (A Delia Smith approach)

Different – This is considering a more community based approach, there may be some people in the room who have experience if good community solutions that could be rolled

out of changed to make them more accessible for all. This may feel sensible but a stretch as it may feel responsibility is being shifted. (A Jamie Oliver approach).

This is an important step as it allows us to acknowledge what we already do and have in some areas; this can be shared among the groups.

It also allows the groups to come up with ideas using free thinking approaches without boundaries. These are listed in *Appendix 3*.

The outputs from this session are then used to develop the investment grid.

The Investment grid

The development of the investment grid follows. This allows us to consider all the solutions in one place and rank them against each other according to the cost-benefit involved. The definitions for the rankings are:

- Major Projects
- Thankless Tasks
- Fill in's
- Quick Wins

Dot voting was used to prioritise the areas from the theming session to be taken forward to the investment grid.

The final investment grid is in appendix 4

Next Steps

This section is about deciding what happens next and who will be responsible for taking any of the agreed actions forward.

It is important to note that this workshop was to test the process as previously stated. However some of the quick wins were allocated to individuals to action.

Evaluation

Feedback sheets were completed by participants at the end of workshop 2 to gather immediate reactions. These are summarised in Appendix 6..

We also interviewed a range of participants to gain a more in-depth understanding of how they experienced the process and how they perceived its value. A full evaluation report will be available in mid-March.

A very public process

As a very public process, Working Together for Change had the potential to feel challenging in its presentation of a 'warts and all' overview of what is happening in the lives of the people we support and also how successful we are in supporting them.

It is important that services do not shy away from discussing what is not working for people: it is as much a mark of quality for a service to acknowledge and tackle things that are not

working as it is to be able to point to all of the things that are. As we also state earlier, things that are not working will not necessarily be caused by failings within a service.

It is understandable however that services may be a little cautious about how detailed information about what is not working will appear to people outside of the service.

An example of a potentially sensitive area raised in the workshops was around GP receptionists and their customer service skills. We had many statements in the PCR's around getting through to the receptionist, a lack of understanding of the condition and its urgency and their general attitudes to helping.

It is worth noting that while we would not want to shy away from these sensitive issues it is important that they are kept in context and presented as facts not opinion and that an opportunity for discussion and solution can be found. In this case this issue was presented at a LCG meeting and it was acknowledged that this can be an issue and thought was given in a positive way to find a solution and improve the patient experience.

It is also worth noting that the process allows us also to focus and celebrate the very positive things that are working well across the sectors. This is easily forgotten in busy stressful services and is a good opportunity to consider what we can do to ensure we keep and maybe do more of what's working well.

Contributing to the culture

We believe that a process such as Working Together for Change contributes to a culture of openness and honesty about how we are doing, not as a stick for others to beat us with but to spur ourselves on to do a better job, and to bring the knowledge and commitment of others into our service development. It is important to remember that by no means all of what is not working will be things that a service is doing 'wrong': the information is, first and foremost, about what is happening in the lives of the people we support and as such it encompasses a wide range of factors, some of which will not be the service's area of responsibility (for example, relationships between the people the service supports and their families).

Some will be out of the service's control (for example, closure of other services used by the people the service supports), and some of which the service can only have a partial or mitigatory impact upon (for example, declining health due to getting older or normal disease progression).