SHARED INTELLIGENCE

NHS West Midlands Patient Experience Learning Programme

An Evaluation from Shared Intelligence

Final Report April 2011

CONTENTS

I EXECUTIVE SUMMARY

1. The West Midlands Patient Experience Learning Programme was funded and coordinated by West Midlands Strategic Health Authority and delivered by consultancy firm Impact Innovation. It aimed to support 36 NHS organisations from across the region to improve their knowledge and practice around patient experience. The programme used a mixture of face-to-face workshops, online learning sessions, action learning and one-to-one coaching. Alongside the programme, participants were encouraged to undertake workplace projects, focusing on one aspect of patient experience.

2. The programme was based on a national pilot run by the NHS Institute for Innovation and Improvement, and used a similar approach with some additional elements. The West Midlands programme ran between March 2010 and February 2011. This report presents final findings on the programme's effectiveness and learning outcomes.

Recruitment and Participation

3. All participants had been nominated by their Director or Line Manager to join the programme. The participant mix reflected varying levels of experience in the field of patient experience, and around half said they had 'some' rather than considerable expertise in the field.

4. Participants came from organizations with a 'strong' commitment to patient experience, and personal motivations for attending tended to be to learn specific patient experience-skills, as well as an opportunity for networking and professional development.

5. Across all participating organisations, 30 of the 36 attended at least six of the eleven sessions. Although full attendance was a condition of participation in the programme, only one organisation was present at all eleven sessions. Attendance levels were fairly stable and only one participant withdrew from the programme.

6. Pressures on time were the key challenge to full participation.

Design and Delivery Effectiveness

7. All participants viewed the PELP as useful overall.

8. The most influential tools were Experience Based Design, The Patient Experience Roadmap, Action Learning Sets and the Private Sector case studies. These all had similar levels of influence on participants' day jobs.

9. There is great strength of agreement that the programme has had an impact on how participants feel and act in their roles. Particularly strong was feeling 'part of a network around patient experience' and as though they had increased their understanding around 'creating a fantastic patient experience'.

10. The programme has helped almost all participants make tangible and practical improvements to patient experience in their workplaces, such as developing or beginning to develop systems for collection of patient feedback. By contrast, influencing, particularly of commissioners, remains an area where the programme is not as strong.

11. Participants felt that workshops were the most valuable aspect of the programme. These were seen to be useful for providing 'interactive' and 'lively' activities as well as opportunities to network with peers.

12. Action learning sets were valued as a way to connect with peers and have practical conversations that connected workplace experiences to the programme. Over two-thirds of participants were keen to continue their action learning sets beyond the life of the programme.

13. Some participants felt that the programme did not cater as well as it could for its broad audience. For example, some content and 'pitch' of the programme did not suit all participants. Participants also had mixed views on the use of WebEx and the Service Safari element of the programme.

Workplace Projects

14. A common trend amongst organisations was to focus on 'real time' data collection and using different methods and tools to engage with patients.

15. Participants were not always clear about the specific outcomes they would like to achieve locally, and sometimes were vague around how their work or project would lead to service improvement.

16. Key challenges to the completion of workplace projects and progress of work streams were organisational changes as a result of the NHS reforms, time and capacity, and unrealistic time scales.

17. For most participants there were benefits to identifying work to complete alongside the programme and to which learning could be applied. It gave participants both directly applicable tools to use as well as a 'space' away from their workplace to think creatively in a supportive environment.

18. In some organisations, work has taken longer than planned, or projects been extended beyond the timetable of the programme. For those that have been concluded, mainly practical outcomes have been achieved (eg. implementation of a system) whereas wider outcomes about influence and increased capacity are yet to be realised.

1. INTRODUCTION

1.1. This report presents the findings of the evaluation of the NHS West Midlands Patient Experience Learning Programme (West Midlands PELP). The programme was a regional adaptation of the national Patient Experience Learning Programme pilot, run by the NHS Institute for Innovation and Improvement between December 2009 and September 2010.

1.2. The West Midlands PELP began in March 2010 and concluded in February 2011. The programme aimed to provide patient experience leads in the West Midlands with skills that could be applied within their organisations and to develop a supportive regional network.

The NHS West Midlands Patient Experience Learning Programme

1.3. The NHS West Midlands PELP was hosted and funded by the West Midlands Strategic Health Authority (SHA). The programme was established as a response to high regional demand for places on the NHS Institute for Innovation and Improvement's national Patient Experience Learning Programme.

1.4. The SHA also recognised that locally some organisations in the region were underperforming in relation to national Inpatient Survey results and local information on patient perceptions. The programme therefore aimed to:

- Encourage Patient Experience Leads to ensure that learning is shared back within their organisations
- Develop a cohesive network of Patient Experience Leads
- Facilitate the ongoing collaborative working of participants to ensure sustainability of the learning at regional and sub-regional levels.

1.5. The objectives of the programme were to seek:

- The participation of all NHS commissioners and providers of care - both acute and mental health - within the West Midlands SHA
- To learn from the national programme whilst also adapting to meet local needs, and enhancing engagement and participation
- To facilitate the development of action learning sets in line with sub-regional clusters, consisting of commissioners and providers and with the aim of providing a cohesive and sustainable professional network.

1.6. The West Midlands PELP adapted much of the model and materials from the national programme into a regional context. To ensure continuity in delivery style, the SHA commissioned the same facilitators as the national programme, the consultancy firm Impact Innovation, to deliver the regional programme.

1.7. The NHS West Midlands programme consisted of the following elements, which are similar to the national programme:

- Six full day workshops between March 2010 and February 2011
- Five online learning sessions for programme participants, using WebEx

1.8. As in the national programme, participants were encouraged to use their work – either through a distinct workplace project or an existing work stream - as a test-bed for programme. However, the West Midlands PELP also featured some additional elements that built on the workplace projects:

- Six action learning sets, based around existing clusters of NHS organisation
- A designated coach or course mentor for each participant (coaches were course facilitators, national programme participants and SHA leads)

1.9. The West Midlands programme was also supported by a planning group, made up of a mix of SHA leads, the facilitators and participants on the national programme who provide support, advice and guidance to the design of the programme and its delivery.

The evaluation

1.10. NHS West Midlands commissioned the research consultancy Shared Intelligence in June 2010 to evaluate the West Midlands PELP. The evaluators were asked to explore:

- The process of programme delivery, through feedback from participants
- How far the programme has enabled participants to apply patient experience tools and techniques
- The success of participants' workplace projects during the course of the programme

1.11. This interim report presented the findings from the first phase of the evaluation research, which included:

- An 'interim' online survey sent to all participants in June/July 2010 (30 responses were received from 36 participating organisations, an 83% response rate)
- Observations of one workshop in June 2010
- Desk analysis of programme monitoring data, namely attendance data and the delegate list
- In-depth qualitative interviews with a sample of 10 programme participants in November 2010. These were selected to ensure a representative spread of localities, occupational roles, workplace themes and types of organisation.

1.12. This final report builds upon the findings of the interim report. However it also reflects on additional research elements:

- Observation of the celebration event that marked the end of the programme in February 2011
- A 'follow up' survey of all participants conducted in February 2010, which probed learning outcomes and their practical application (24 responses were received from 36 participating organisations, 66% response rate)
- Analysis of updated programme monitoring data (attendance and delegate lists)
- Qualitative analysis of the participant-produced good practice compendium reports.

1.13. It should be noted that the NHS reforms which have been announced since the West Midlands PELP was commissioned mean that the West Midlands SHA will close in March 2012; therefore the PELP is unlikely to be replicated in its current form.

2. RECRUITMENT AND PARTICIPATION

2.1. This section examines the West Midlands Patient Experience Learning Programme's recruitment strategy, the expectations of participants, their attendance rates and withdrawals.

Recruitment to the programme

2.2. The approach to recruiting participants to the programme was through senior-level nomination of Patient Experience Leads. Tthe interim survey found that all participants had been nominated by their Director or Line Manager to join the programme which suggests that this method of recruitment was appropriate.

2.3. In total, 16 respondents to the interim survey provided explanations for their nomination. Ten said that they had been nominated because they had a formal responsibility for patient experience in their role and six had expressed an interest in patient experience, even though it was not a formal part of their role.

Who took part in the programme?

2.4. Participants came from a mix of different types of NHS organisations, including commissioners and provider Trusts, NHS Direct and the Ambulance Service. The West Midlands SHA targeted all 44 NHS organisations within the region and one NHS Direct organisation. 36 organisations were recruited as full participants on the programme. Of the remainder, four organisations were on the national programme, so did not take part in the regional programme (although one organisation chose to participate in both). Three organisations did not sign up at all, while one withdrew immediately without attending.

2.5. In total, there were 39 people in the original cohort, as three organisations sent two delegates to the programme.

Figure 1: Participating organisations

Organisation Type	Number of organisations participating
Provider - Acute	13
Provider - Mental Health and Learning Disabilities	4
Primary Care Trusts	17
Other (NHS Direct/Ambulance Service)	2
Total	**36**

2.6. The interim survey has shown that participant mix reflected varying levels of experience in the field of patient experience. The majority of delegates were Patient Experience Leads (12) or Leads or Analysts of Quality Standards (7),

spanning clinical quality, infection control and complaints. Others were patient involvement managers, service improvement or community relations. A small number of participants had operational managerial roles, including Nurse Programme Manager, Foundation Trust Officer and Ward Manager. A small minority of participants had no specific patient experience responsibilities.

Figure 2: Roles of participants

	Number
Patient Experience Lead/Manager	12
Quality Lead/Analyst	7
Patient and Public Involvement Manager	5
Service Improvement Lead/Manager/Facilitator	3
Head of Community Relations/Services	3
Nursing Programme Manager	1
Foundation Trust Officer	1
Ward Manager	1
Total	**33**

2.7. The interim survey revealed that the majority of respondents felt they had 'some' (47%, 14 respondents), or 'considerable' (30%, 9 respondents) knowledge or expertise in patient experience before joining the programme. Only three respondents said that they had little or no knowledge about patient experience prior to the programme. Where participants gave more details about the previous experience, there was a range of skills and backgrounds amongst the cohort. For example:

> *"I have worked in the retail sector at the leading retailer in London for 25 years; the customer experience was at the heart of our business operation. In my past 6 years in the NHS, I have helped to set up a PALS service and Expert Patient programme."*

> *"My role is specifically about patient experience. Since I started in the role a year ago I've been developing my knowledge."*

> *"Having worked as a PALS officer and latterly PALS manager, I feel I have some knowledge/expertise with regard to patient experience."*

> *"I worked as a Customer Relations Manager at a local Ambulance Service, my role involved shaping services with a patient focus. I used patients to co-designing the services."*

Existing buy-in and participant expectations

2.8. The interim survey asked participants a series of questions to ascertain how far they felt their organisation had 'bought into' the importance of patient experience, and how they would rate their organisation's approach to improving patient experience.

- The majority of respondents (64%, 19 respondents) said their organisation's approach to patient experience 'varied', with both strengths and weaknesses.
- Ten respondents (30%) rated their organisation as 'strong', while only three rated it as 'generally weak'.
- The extent of organisational buy-in was rated highly by respondents, with the majority saying buy-in was 'strong' or 'quite strong' (87%, 26 respondents). Again, only a small number said that buy-in was 'quite weak' and no-one thought it was 'very weak'.

2.9. This strong level of buy-in was mirrored in interviews with participants. Most felt that their organisation had been given a positive push in the last few years from the national policy agenda. As one participant explained:

> *"We feel that we are quite blessed with what we have here. We have had strong PPI for 10 – 13 years - we are probably ahead in many respects, the Whitehall push is refreshing to us - so we have now got the organizational will as well as the mechanics to record feedback".*

2.10. Open text responses to the survey also suggest that support for patient experience is a 'work in progress'. This means that while there is senior level or corporate buy-in there is some work needed to 'fully embed' the approach. As the following response explains:

> *"The organisation has bought into patient experience but this has yet to fully filter through to all levels - work is in progress to address this."*

2.11. The interim survey also asked participants to rate their personal motivations for joining the programme. This revealed that the main drivers for participants were the personal and professional development of skills and peer support. The following divers were marked by the majority as 'very important':

- Skills in patient experience measurement (73%, 23 respondents)
- The opportunity to draw on support from others in a similar position (68%, 22 respondents)
- Gain a wider awareness of the patient experience approach (59%, 19 respondents)

2.12. The qualitative responses from interviews reinforced these findings, with all ten sampled interviewees highlighting how they joined the regional programme to *"pick up new"* or *"innovative"* skills and use the opportunity *"to meet others in the same position"* within the region.

2.13. The interim survey also asked participants to rate how important it was to learn specific skills on the programme. Overall, participants are keen to learn the full range of skills in the patient experience approach, encompassing tools (such as EBD), measurement techniques, evaluation, influencing techniques and change management. As such, all skills were rated either 'important' or 'very important' by 90-97% of respondents.

2.14. In terms of expected achievements by the end of the programme, open responses to the interim survey revealed that participants are keen to see their learning from the programme implemented within their workplaces. They envisaged that this learning would support their workplace objectives; that the programme would leave them with supportive networks with other leads and that they would be in a position to embed patient experience approaches. Some examples of responses are highlighted below.

By February next year, I would like the Patient Experience Learning Programme to help me to….

> *"....actively take my project forward to be a mainstream activity, my role has developed with a much more focussed remit for patient experience"*

> *"....to complete my project, develop supportive future networks, develop my skills and further opportunities in improving and measuring patient experience"*

Attendance levels

2.15. In terms of programme attendance, the following table (Figure 3) illustrates the number of attendees for each workshop and WebEx session.

Figure 3: Programme attendance by session

	Number of organisations represented (% of original cohort of 36)	**Number of attendees**
Workshops		
Workshop 1 – Introductory day, March 2010	24 (66%)	25
Workshop 2 – Creating and Designing a Great Patient Experience – Part 1, May 2010	24 (66%)	25
Workshop 3 – Creating and Designing a Great Patient Experience – Part 2, July 2010	25 (69%)	27
Service Safari, September 2010	28 (78%)	29
Workshop 4 - Staff role in Patient Experience, December 2010	14 (39%)	15
Workshop 5 - Celebration, Learning & Peer Review, February 2011	25 (69%)	26

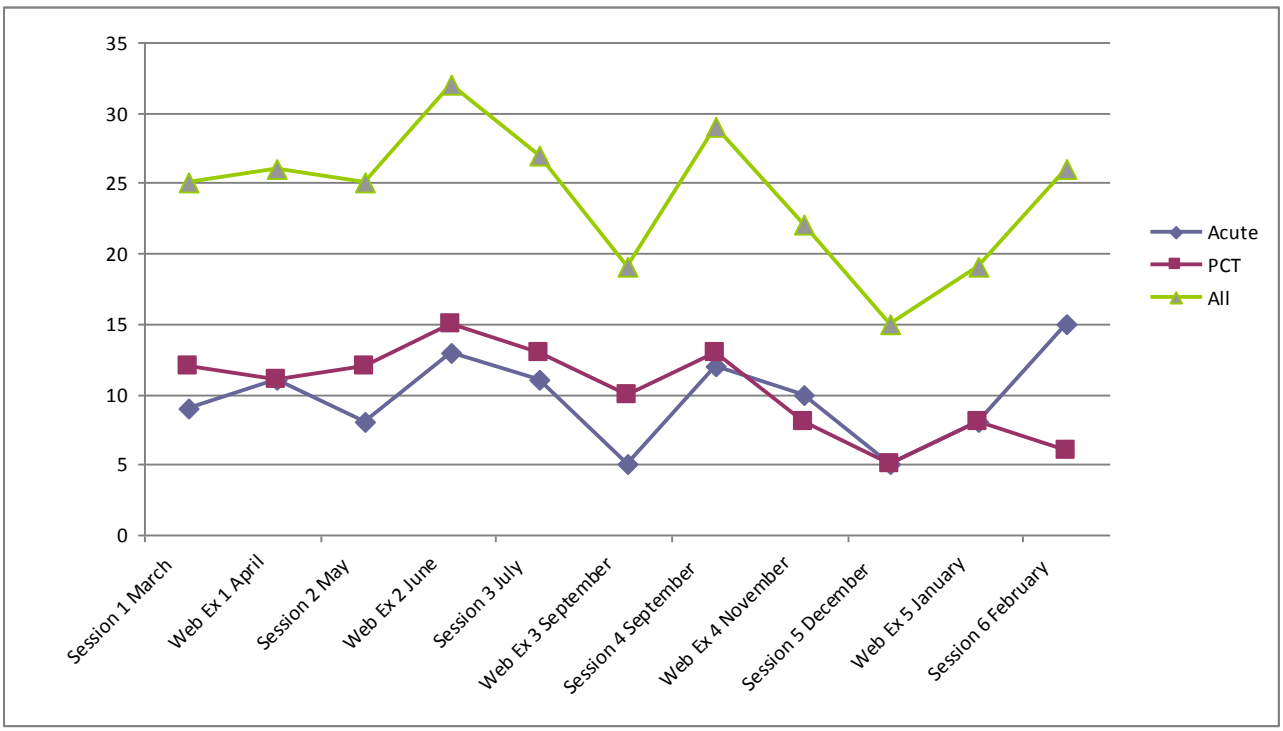
WebEx Sessions		
Session 1, April 2010	25 (69%)	26
Session 2, June 2010	31 (86%)	32
Session 3, September 2010	19 (53%)	19
Session 4, November 2010	21 (58%)	22
Session 5, January 2011	19 (53%)	19

2.16. The programme achieved a stable level of attendance for workshop sessions (65% on average), but there was dip in attendance levels for the 5th Workshop at the beginning of December due to severe poor weather. WebEx sessions have received more patchy attendance; the first two sessions received very high participation which waned in the three subsequent WebEx sessions, which had participants from between 50% - 60% organisations.

2.17. The majority of organisations (30, 83%) attended at least half of the sessions (6 or more across both Workshops and WebEx). One organisation attended all 11 sessions, and a further two attended 10 (including all 5 WebEx). Despite the mixed response to WebEx, around 75% of organisations attended at least three online sessions.

2.18. The timeline in Figure 4 below shows attendance over time. Attendance is characterised by peaks and troughs for both groups, however there is a more prolonged drop-off of PCT attendance towards the end of the programme. Overall, there is little distinction between the attendance patterns of attendees from Acute provider trusts and those from PCTs.

Figure 4: Attendance over programme duration – PCT and Acute



Programme withdrawals

2.19. According to programme monitoring data, the SHA was successful in ensuring that only one organisation withdrew from the programme. Seven participants were replaced at different stages during the programme for different reasons. The data shows there was an equal split between internal changes in roles (and therefore remits) and participants leaving the organisation (in one case this was to move from an acute provider to a PCT).

Figure 5: Reasons for withdrawing from the programme

	Number
Change in role	3
Left organisation	3
No reason given	1
Total	**7**

2.20. It should be noted that some respondents to the follow up survey at the end of the programme felt their level of participation fell into a grey area between attendance and withdrawal. Although not formally withdrawing, they felt they had not made the time commitments or been able to attend enough sessions to feel part of the programme. This was usually the case where demands from within their organisation made it difficult for them to participate in the formal elements of the programme.

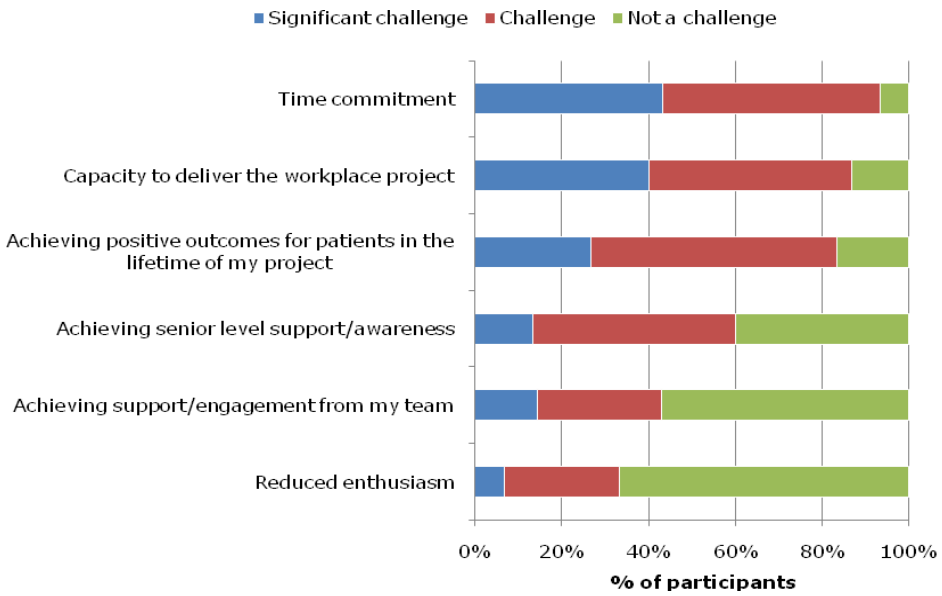
> *"I did not withdraw but due to staff changes I was unable to attend the final days. I did carry on the project within the work setting."*

> *"To say withdrew is probably misleading; suffice to say though that I don't feel I attended regularly enough to claim that I completed it. Unfortunately some very short term operational commitments led to me pulling out of many of the sessions."*

Challenges to programme participation

2.21. The interim survey asked participants about potential challenges to their involvement in the West Midlands PELP. The results are highlighted in the figure below. Practical delivery issues such as time commitment, capacity to deliver in the workplace (in particular through workplace projects) and moreover to deliver positive outcomes for patients were all a 'significant challenge' or a 'challenge' to over 80% of respondents (between 25 – 28 in each case).

Figure 6: What do you perceive as the main challenges to your participation in the programme?



Base: 28 – 30 per option

2.22. Qualitative comments from interviews also reveal similar findings in relation to the challenges around participation, particularly capacity, examples include:

> *"Timetabling, it's that capacity – for management duties, and so not being able to do as much as I'd like."*

> *"My time is limited; we had some sickness leave in PALs recently so we are always covering this section. My time gets taken with managing PALs a lot. A lot to take on and we have to respond – it's a priority."*

Key Messages

2.23. All participants had been nominated by their Director or Line Manager to join the programme. The participant mix reflected varying levels of experience in the field of patient experience, and around half said they had 'some' rather than considerable expertise in the field.

2.24. Participants came from organizations with a 'strong' commitment to patient experience, and personal motivations for attending tended to be to learn specific patient experience-skills, as well as an opportunity for networking and professional development.

2.25. Across all participating organisations, 30 of the 36 attended at least six of the eleven sessions. Although full attendance was a condition of participation in the programme, only one organisation was present at all eleven sessions. Attendance levels were fairly stable and only one participant withdrew from the programme.

2.26. Pressures on time were the key challenge to full participation.

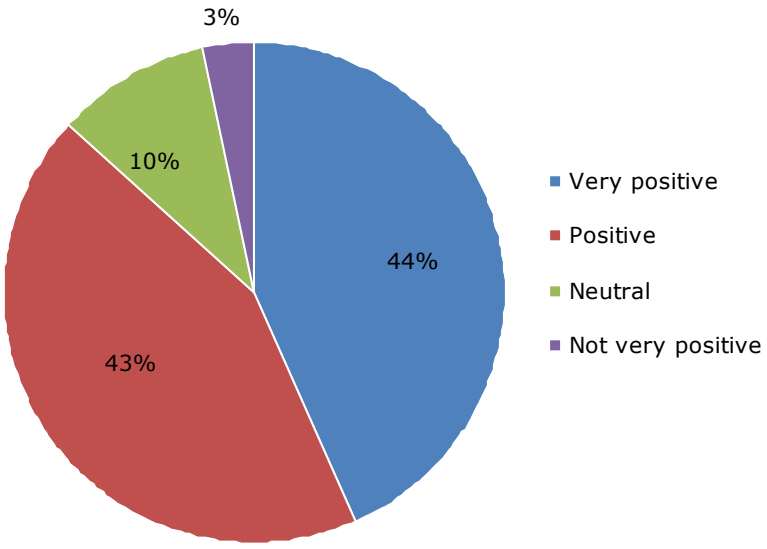
3. DESIGN AND DELIVERY EFFECTIVENESS

3.1. This section looks at how effectively the West Midlands PELP met the learning needs of participants. It also looks at the extent to which participants have applied their learning.

Overall satisfaction

3.2. Satisfaction was not assessed at the end of the programme, however at the mid-way point the interim survey revealed that 87% (26 respondents) had a 'very positive' or 'positive' experience of the programme, with only one respondent reporting a negative experience.

Figure 7: How positive do you feel about your participation in the Patient Experience Learning Programme to date?



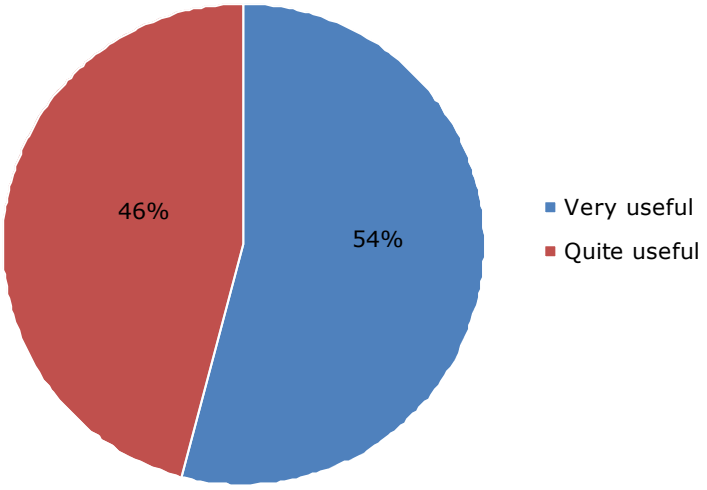
Base 30

3.3. Both interim and final survey results suggested that there were aspects of the PELP's design and delivery that were of particular value in comparison to other elements. The research found that the workshops and action learning sets are seen as of most value to participants, whilst WebEx sessions and 'pitch' of the teaching were seen as areas for refinement. We explore these issues in the following sections.

How was learning applied?

3.4. Findings from the final survey show that all participants viewed the PELP as useful overall.

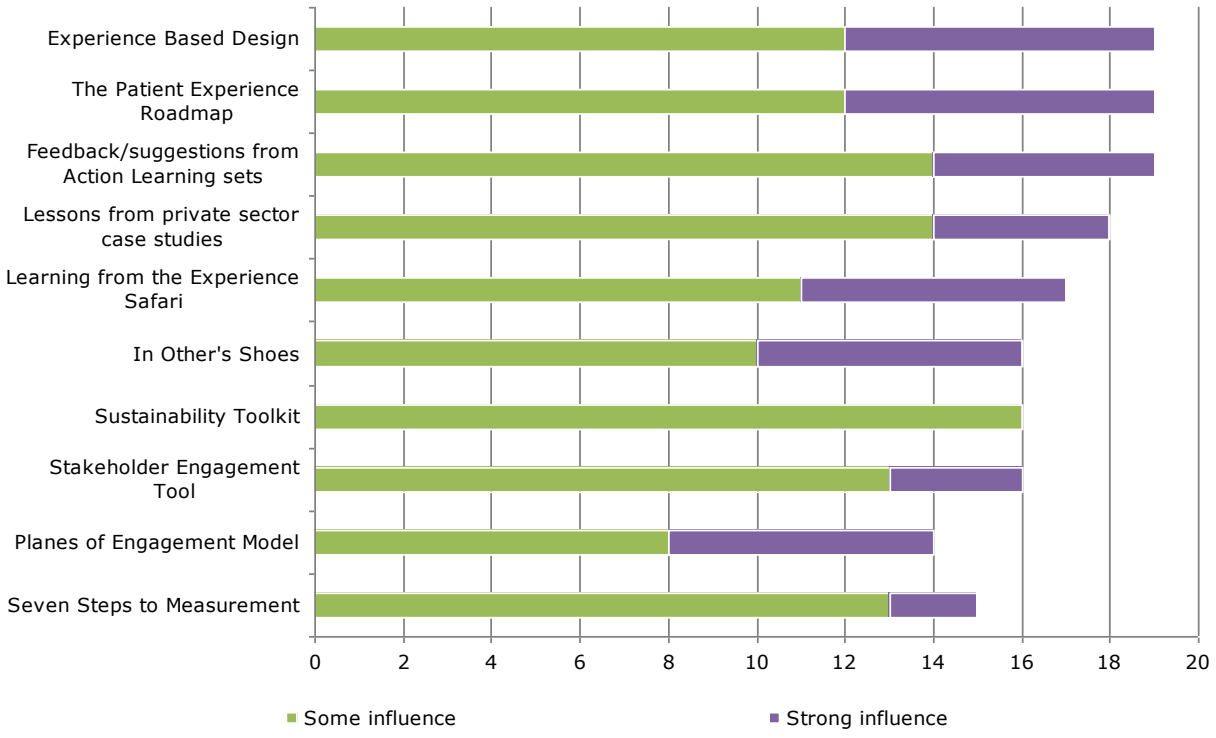
Figure 8: Overall, how useful did you find the West Midlands PELP?



Base 24

3.5. In terms of the practical applications of the programme, the figure below shows that all element of the programme have been influential for the majority of participants.

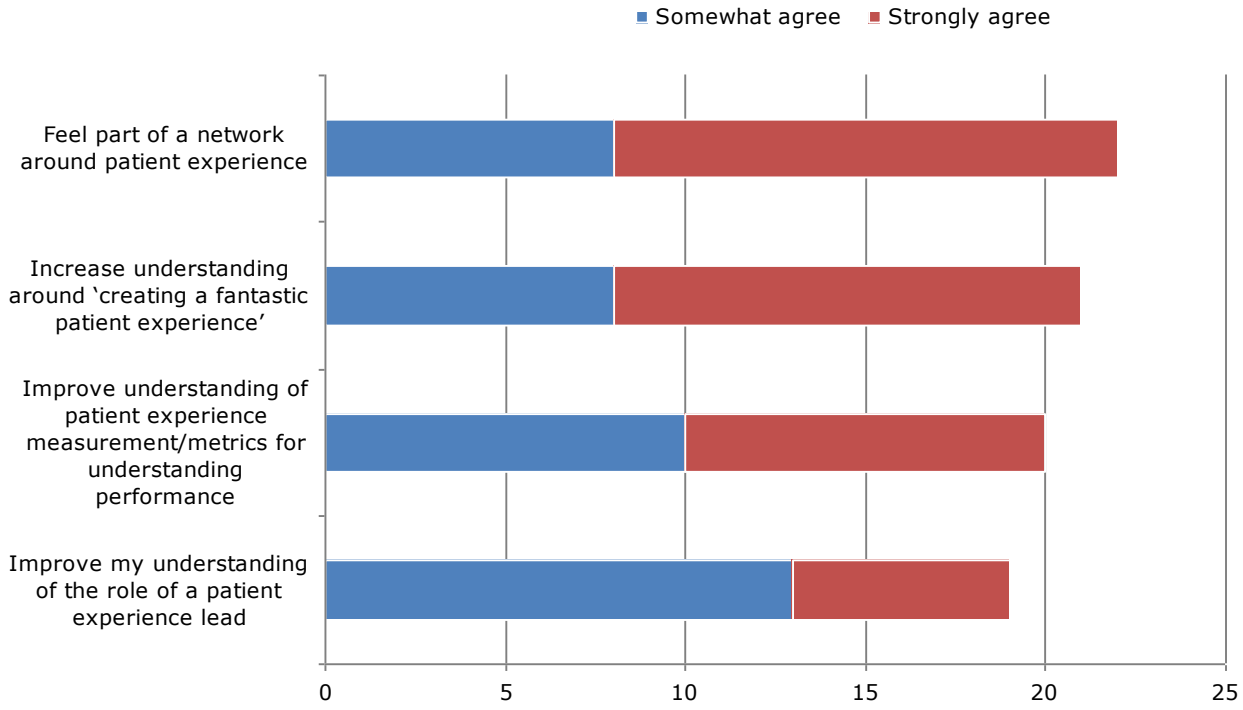
Figure 9: Which of the following have influenced how you do your day job?



3.6. The most influential features of the programme were Experience Based Design, The Patient Experience Roadmap, Action Learning Sets and the Private Sector case studies. These all had similar levels of influence on participants' day jobs.

3.7. Many participants joined the programme with the hope that it would offer them professional development and an opportunity to increase their knowledge and skills around patient experience generally. Results of the follow-up survey in Figure 10 show that key learning objectives were substantively achieved:

Figure 10: The Patient Experience Learning Programme helped me to…:



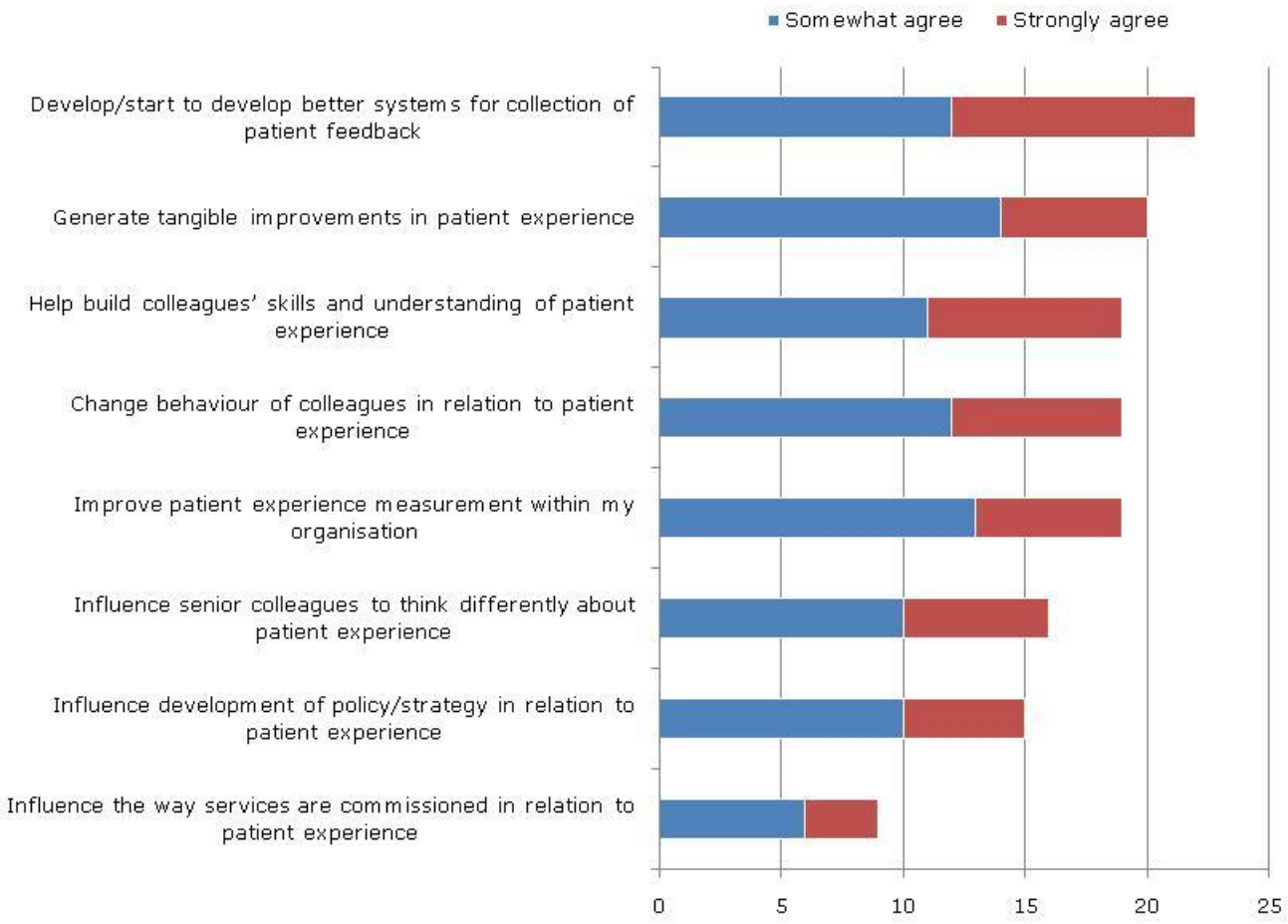
Base: 24 per option

3.8. Participants most keenly 'feel part of a network around patient experience' and as though they had increased their understanding around 'creating a fantastic patient experience'. The objective around understanding the role of Patient Experience lead received the most mixed response, including the largest proportion of 'disagree' or 'not an objective' responses. This may be partly due to the wide range of job roles represented on the programme, and even amongst those participants who were named PE leads, levels of experience varied.

3.9. Overall, there was great strength of agreement that the programme had had an impact on how participants feel and act in their roles, with only one of these outcomes receiving less than 80% agreement that it has been achieved.

3.10. Learning has clearly had a positive impact on the way participants feel in their role, as well as equipping them with tools to tackle the day to day work of a Patient Experience Lead. The extent to which this has been translated into impacts on their workplace is shown in figure 10 below.

Figure 11: The Patient Experience Learning Programme helped me to..:



3.11. Findings show that the programme has helped participants make tangible and practical improvements to patient experience in their workplaces. For example, 92% of participants agreed that the PELP had helped them develop or begin to develop systems for collection of patient feedback.

3.12. By contrast, influencing remains an area where the programme is not helping all respondents. In particular, influencing the commissioning of services was the weakest area where less than 40% agreed that the programme had helped them do this. In terms of influencing policy and strategy development, and influencing senior colleagues, only 60-70% agreed that the programme had helped them do this.

3.13. The challenge of the organisation and organisational culture should not be underestimated. This is evident in qualitative comments on this topic:

> *"I feel that the course supported my aim to embed patient experience in the organisation but that this was a small step along the way, true changes in culture take years"*

"I have gained a lot of insight into how to get a fantastic patient experience however translating that into the wider organisation is a big task."

3.14. Far from feeling like this is an impossible task, these comments suggest that programme is a 'step along the way' to achieving changes on a bigger scale.

What did participants think worked well?

3.15. The interim and final surveys asked participants what aspects of the programme were working well for them and which were of most value.

Workshop sessions

3.16. The workshops were the most valuable aspect of the programme as they were seen as the core of the programme and essential to its momentum.

"The full day events are really good – they re-energise me and make me more enthusiastic. My enthusiasm can dip in-between sessions."

"Some of the presentations and speakers have been brilliant, promote innovation and are motivational."

3.17. The interim survey revealed how 93% (28) of participants felt workshop facilitation was 'very good' or 'good'. Interviews also showed that participants liked the style of workshops. These were seen to be useful for providing 'interactive' and 'lively' activities which maintained participant "motivation", "energy" and "interest" in the patient experience approach.

"Phil's style is very enthusiastic and I never feel bored".

"It isn't just the information and skills that are learnt, it is the way the programme is delivered in such an innovative way. It's fresh and lively and has injected life into what can be a difficult area."

"The facilitator is very good at drilling out the key points, without being patronising. It is common sense, and you think you know it, but the way he delivers makes you think 'no I don't do that, I don't ask…'"

3.18. In addition, participants had had very positive experiences of the programme's opportunities to network with peers (93%, 28 respondents rated it as 'very good' or 'good' in this aspect). Interviews also revealed that participants valued being given the space to meet people who are 'in the same position'.

"It's given us the opportunity to get together which I don't think would have happened otherwise."

> *"We get to learn from each other, we're in the same position – a chance to offload and network in the region. Space to talk about the problems we face."*

3.19. Such opportunities also made participants feel like they were part of a regional approach to improvement. For some trusts, networking allowed for benchmarking. This was particularly the case for the NHS Ambulance Trust and NHS Direct who saw networking as an opportunity to "*understand how and what other Trusts were doing in patient experience*."

3.20. The interim survey also showed that the structure of the workshop sessions provided a good "medium for learning". Twenty-seven respondents (89%), rated the workshop structure as 'very good' or 'good'. Interviews with participants reinforced this message:

> *"The content is great, and interactive – for example in one session we were asked to explain what patient experience meant, using different materials – e.g., fabrics, material, smelly things. That was really about broadening horizons in terms of what demonstrates patient experience. And that exercise would work in a community environment. Also the demonstration with shoes! That was clever. Certain elements of the programme stick in your mind, and it's very hands on."*

3.21. In addition, participants gave positive ratings for information received prior to the workshops (89%, 26 respondents 'very good' or good'). According to interviewees, participants appreciated the information packs they had received prior to joining the programme and the resources that were accessible during the programme sessions.

Coaching and Mentoring

3.22. Finally, interviews revealed that the assignment of project coaches or mentors was useful to those that had used this. Participants were positive about their discussions with coaches using the support to 'sound out' ideas or discuss concerns. Examples include:

> *"She (mentor) helped to give me ideas for the future, so I will do my next leaflet differently following my conversation with her."*

> *"I talked about my concerns around the White Paper; they (mentor) gave some useful suggestions about what is happening in the wider West Midlands and other areas of the country."*

Action learning sets

3.23. The West Midlands PELP has six action learning clusters, which relate to the geographic clustering of trusts within the region. Sessions were self-facilitated, run between workshops, and facilitation is shared by the participants of each

group, although one individual was identified and supported to lead the organisation of learning sets. Groups were made up of a mix of different NHS organisations and Trusts and a typical session included an update on workplace experience and a group task set by the programme facilitators. The programme organisers offered support to participants in administering and running their sessions if needed.

Figure 12: Examples Action Learning tasks set by facilitators	
Session 1	Project Discussion- share/review/support Programme Task - Discuss stakeholder engagement, sustainability, the Roadmap – where you are in your project
Session 2	Project Discussion - check agreed actions from previous session; review and agree further actions Programme Task - Observation DVD and card pack – do the observation exercise – note down key learnings
Session 3	Project Discussion - Review of project/work progress and actions Programme Task - Find an example in your organisation of some change or improvement, big or small, that worked really well with patients And…find an example aimed at staff Share and discuss these examples, why they worked well. What elements made them successful – that others could adapt and fit for their organisation.

3.24. The majority of interviews with participants revealed that action learning was a valuable aspect of the programme. The reasons for this centred on its ability to connect peers at a sub-regional level, provide practical conversations, build trust between peers and connect workplace experience to the programme.

> *"The action learning sets are good and I have learnt from my peers – I liked the sound boarding, the wealth of experience in the group is good – some very experienced people – it's very valuable."*

> *"Networking opportunities are fantastic and very valued! The peer connections are also followed up through the action learning sets outside of the course. In our cluster area – we were a mix of PCTs and providers – I liked the fact I could speak to other PCTs and see how far they have got and test some ideas out. It's about benchmarking new ideas and innovative practice. We also discuss the challenges."*

3.25. While the experiences of participants within the action learning sets were overall positive, some also pointed to particular problems in the way the action learning clusters were operating; as such they felt there were areas for refinement. These included:

- **Organisation –** Some interviewees have had issues with the organisation of action learning sessions and in particular, who takes responsibility for hosting and facilitating the sessions. As one participant explained "*I am organising all my group's meetings and it should be shared.*" Participants in this position felt that pre-determined meeting dates would alleviate the

situation; however this would be at the cost of flexibility. Practical support and monitoring was offered by the programme organisers however it was not often taken up.

- **Action learning methodology –** Some participants were also unsure about how much other participants understood about the 'action learning' method. As one participant explained "*I have done action learning before...because I know what I am doing, the others are leaning on me to facilitate and get things moving*." Another suggested that their sessions required them to undertake tasks which were not providing sufficient learning outcomes. The example was given of the observation DVD, which a number of the group had already seen. Finally, some participants also felt that sessions were concentrating too heavily on the problems as opposed to peers jointly developing solutions: *"it tends to end up being about the problems, – not a positive atmosphere about problem solving".*
- **Attendance and participation -** Most of the sets have achieved good attendance, but some have been harder to organise and attendance has been lower. As such, some participants felt that they didn't "*get the most out of the sessions*" because opportunities for shared learning were limited without full attendance. Similarly one participant (from a PCT) explained that without the participation of neighbouring provider trusts, the action learning sets could not fully support their everyday practice.

3.26. When asked about the sustainability of their action learning sets, participants gave a mixed response, although they broadly favoured continuing the sets. 71% said that they were likely to continue meeting in their sets, with a small number stating that they have already agreed to this, and in some cases had meetings already in their diaries.

What did participants think worked less well?

3.27. The evaluation asked participants to identify areas of the learning offer that were not as useful or less supportive. The responses are outlined below.

3.28. Some more experienced participants felt that the teaching had not been at a deep enough level given their existing level of knowledge.

> *"In terms of measurement, we are already implementing PET (patient experience trackers) locally. I don't feel like I am hearing anything new."*
>
> *"I think that the programme needs to establish its baseline – what is the existing knowledge – where are the gaps and then ask where participants want to go/where they want to be. It could even include modules that people can opt in and out of"*

3.29. Some participants perceived the level of teaching to be more suited to frontline NHS staff, who may not be as supportive of the patient experience approach. As one participant explains:

> *"It's working well and it's a great opportunity but I think it would work better on people that are not converted to the patient experience agenda – you see we already are – that's our job. You'd see better results with a frontline staff audience."*

3.30. There were also particular concerns for participants from commissioning organisations on the programme. Some were concerned that there was not enough of relevance in the West Midlands PELP to their particular roles. Examples include the perception that the Service Safari was "more relevant" to provider organisations or that the programme did not have enough content for "*those that were responsible for influencing provider organisations to change*."

3.31. While participants were extremely positive about workshops and action learning clusters, they showed a very mixed view on the added value of WebEx sessions. Some were finding them hard to engage with, repetitive of previous sessions and lengthy. A few examples include:

> *"It doesn't work for me; I like to see who I'm talking to. So I don't participate too much, it felt a bit detached."*

> *"Not so sure about the WebEx sessions - very limited in terms of interaction – just needs the slides and the notes - I don't think it needs to be presented. It doesn't really engage us."*

> *"The WebEx doesn't really engage us – the content wasn't making us interact – it's good for cost saving but it's not a good method of learning. I did my emails during the last one."*

3.32. In all elements of our research other participants have reflected on how they enjoyed using the WebEx technology and praised the way the programme had 'opened their eyes' to remote meetings. This is a clear example of where participants have learnt a new skill and technique that has taken them out of their comfort zone, but ultimately proved rewarding.

> *"I've been introduced to Web-Ex and I thought it was a good tool – learning experiences are good."*

> *"I am now more confident in the use of IT, like WebEx"*

3.33. The Service Safari also received a mixed response, with some seeing it as beneficial training in observation techniques, whilst others felt they had such skills already as part of their roles. Some but not all saw the potential for Service Safari as a tool or method to influence staff more widely within their organisations.

> *"The Experience Safari especially has influenced my day to day work. Everything that we do - I now take time to look at it through the eyes of a patient and see how they would view it."*

"There was the Service Safari - I think I could use that principle for training for staff to understand what quality means. But I had that sort of insight anyway! I'm quite a critical shopper, and the more you work in patient experience, the more you become aware of this."

Key Messages

3.34. All participants viewed the PELP as useful overall.

3.35. The most influential tools were Experience Based Design, The Patient Experience Roadmap, Action Learning Sets and the Private Sector case studies. These all had similar levels of influence on participants' day jobs.

3.36. There is great strength of agreement that the programme has had an impact on how participants feel and act in their roles. Particularly strong was feeling 'part of a network around patient experience' and as though they had increased their understanding around 'creating a fantastic patient experience'.

3.37. The programme has helped almost all participants make tangible and practical improvements to patient experience in their workplaces, such as developing or beginning to develop systems for collection of patient feedback. By contrast, influencing, particularly of commissioners, remains an area where the programme is not as strong.

3.38. Participants felt that workshops were the most valuable aspect of the programme. These were seen to be useful for providing 'interactive' and 'lively' activities as well as opportunities to network with peers.

3.39. Action learning sets were valued as a way to connect with peers and have practical conversations that connected workplace experiences to the programme. Over two-thirds of participants were keen to continue their action learning sets beyond the life of the programme.

3.40. Some participants felt that the programme did not cater as well as it could for its broad audience. For example, some content and 'pitch' of the programme did not suit all participants. Participants also had mixed views on the use of WebEx and the Service Safari element of the programme.

4. WORKPLACE EXPERIENCE

4.1. Keeping with the national programme, participants were encouraged to consider how they were applying learning to their work or a project they were working alongside the programme. Programme organisers deliberately kept requirements for this type of work open, and did not stipulate that work be an additional or discrete project. However, a number of participants did take the opportunity to focus on a particular piece of work or project.

4.2. This section examines the broad themes that have emerged from participants' patient experience in the workplace, and asks to what extent this work has been implemented and what the existing or expected outcomes were.

What types of work have participants done?

4.3. Programme monitoring data provided details of the focus of work being undertaken by the participating organisations. 32 of the 36 participating organisations provided details, which are summarised in the table below.

4.4. A common trend amongst organisations was to choose work with a focus on 'real time' data collection and using different methods and tools to engage with patients. This group included both provider and commissioners. Five organisations were concentrating on improving the patient experience pathway; through coordinated care, and improvements for patients who don't speak English. Developing strategies and creating an awareness of patient experience/engagement was the focus for four organisations.

Figure 13: Workplace themes

	Number
Implementing 'real time' data collection	16
Improving the patient experience pathway	5
Developing patient experience strategy	4
Giving patients access to easy to read information	2
Patient experience training for staff/empowering staff	2
End of life care	1
Pain relief	1
Dignity/essence of care	1
Total	**32**

Implementation & Progress

4.5. The ten qualitative interviews found that, by October-November 2010, the majority of projects and workstreams had not made substantial progress, however all participants had a clear plan for what they needed to work on. Interviewees were not in a position to "discuss the big conclusions yet" but

were sure work on their objectives would continue beyond the lifetime of the programme. At the time of these interviews:

- eight projects or pieces of work were in the early stages of implementation – participants had, for example, planned focus groups, were analysing feedback data or were recruiting staff/patients to take part in events
- one participant had completed a project, which was to develop a patient experience performance tool before joining the WM PELP
- one participant had delayed a patient experience project because of wider restructures

4.6. Interviews with participants showed they were selecting areas to work in on clear evidence of need. Others, though, had decided the focus for their work on an assumption that improvement was needed, rather than actual evidence of the need for change. As a result, some participants found that they needed to adjust their plans.

> *"[Improving the complaints process] was an area where we needed to improve - audits, and other monitoring said that certain things weren't in place."*

> *"We thought we should take this area on more widely within the trust – but we found that some consultants did this anyway, there wasn't a consistent problem."*

Intentions

4.7. The interim survey asked participants to identify what they would perceive as a successful application of learning to the workplace. Responses clustered around the following areas of change:

- **Accurate and timely measurement of patient experience** – for many this was about being able to robustly evidence Patient Experience. *"[I'll know it's successful if there is] evidence that staff and patients' experiences have significantly improved"*
- **Actual improvement in patient experience** - in particular where patient experience data is used to facilitate changes to services. Participants were keen to be at the stage where they could feed back evidence of these improvements to patients. *"The change I want to see is to have more members staying on the programme for longer and have high satisfaction and see the value of the service."*
- **Improved staff morale and behaviour**– typically a situation where formal complaints are reduced, and *"[I'll know it's successful] if staff are enthusiastic and feel valued at work. Our quality improvements are owned and shared by staff"*
- **Increased expertise within trusts** – with the skills and expertise of patient experience leads recognised and called upon by other members of staff. For example, *"[I'll know it's successful] when consultants approach me for ideas to improve their patients' and carers' experiences!!"*

- **To realise improvements within wider performance frameworks -** one participant commented that *"to achieve the CQUIN would be fantastic"*, for another this was around the positive "adoption" of a performance toolkit they had developed
- **To collect feedback and make service changes** - in particular, to ensure that *"we get people's experience of the system to improve it, to get their complaints dealt with on time and for the system to be more efficient"*
- **To have a fully supported patient experience system** - For one participant, *"to successfully procure a project supported by the trust. Supporting the principles we signed up to. Have useful, meaningful data – have our own data so we don't need to go external."*

4.8. Interviews found that participants were not always clear about the specific outcomes they would like to achieve locally, and sometimes were vague around how their work would lead to service improvement.

> *"Once staff have had the feedback, we will reaudit and hopefully see a change in feedback."*
>
> *"The final outcome will be that I get that feedback from x amount of people, but the main thing which is a focus for the trusts is learning from the changes."*

4.9. One participant mentioned that it would be useful if there were an evaluation reporting structure within the PELP.

Challenges to implementation

4.10. Interim interviews revealed a number of local challenges with regard to the patient experience work, which participants felt were delaying or preventing steady course. These were identified as:

- Lack of capacity, in particular, having the time to implement patient experience work "on top of the day job"
- Lack of financial resources to support work
- Difficulties in partnership working, for example accessing data from partners
- Overambitious aims, such as trying to achieve trust-wide change in a short space of time
- Local restructures, delaying work or changing local priorities - particularly for PCTs

4.11. By the end of the programme, similar challenges were identified in feedback from 20 participating organisations. Organisational changes and time demands appear to have had the biggest impact on participants' progress.

- Organisational changes have obstructed particular progress routes around patient experience

"The biggest challenge for my project was the uncertainty generated by the White Paper and the inability to progress a key part of the project due to undefined structures"

- Time and capacity to deliver a non-core work, which was for some exacerbated by organisational changes, including a change in staff role:

"[Time is] an issue only in as much as my role has changed during the project and I have been given extra responsibilities"

"I have struggled to commit … to developing the work on top of the 'day job'"

- Delays occurred due to the "unrealistic time scales" set by participants, particularly in relation to projects. These tended to be procedural, for example the timely return of feedback surveys or the agreement of project plans
- Once implemented, service changes have required more time to embed than planned

Combination of workplace and programme elements

4.12. The timeframe provided by the programme doesn't appear to have been long enough for most organisations to see the benefits of their work, or for projects to be completed. However in terms of learning, benefits were realised by bringing these two elements together.

4.13. Firstly, there was scope for a direct application of the programme tools to the workplace as the programme anticipated the practicalities and detail of patient experience work. Some participants could identify particular applications of tools in their workplace, for example:

"The programme input at the beginning of the project, with regard to 'Planes of engagement' allowed me to consciously test a variety of different influencing techniques to gain 'sign up' for the project pilot"

"The programme helps you think about the finer details of project"

4.14. Additionally, the programme also acted as 'space' away from the day to day of the workplace. As a result, some participants felt this created an environment where they could think differently about patient experience.

"Time away from the actual process made it easier to identify what needed to be done and the support of colleagues on the programme, ideas and tools together with the expertise of the facilitators all helped"

"Being away from your working environment also gives you the opportunity and permission to think laterally and

creatively about how your project develops with the help of peers'

4.15. However, a small number of participants felt that programme didn't support their progress in the workplace as well as it could. This was to do with the type of work they had chosen, for example a project that focused on working with clinicians on patient experience without direct contact with patients or the public, and a project which drew together a number of existing strands of work. These were both felt to require different types of skills and techniques to be successful.

Progress and Outcomes

4.16. By the end of the West Midlands PELP it was clear that a number of projects have overrun the programme timeline, and much work has not yet come to 'fruition'. However some projects had reached completion and some have been extended to include additional tasks.

4.17. A sample of around one third of participating organisations (11 organisations) who gave detailed reflections on their workplace experience gave an indication of how their work has progressed. This sample showed that in the larger half of organisations (6) work has been delivered, and two of these had been extended their stream of work to include additional tasks. The remaining five were still progressing patient experience work in their organisation.

4.18. The concluded work has yielded the following outcomes:

- A full patient experience feedback system has been implemented, collecting and analysing data, feeding back to staff and formulating action plans
- A pilot running for recording and improving dignified care standards has been established. This includes consultation and EBD with patients, introduction of 'Dignity Displays', and the involvement of staff in this process
- Patient community group meetings have been both encouraged and also used as a source of patient experience feedback
- Implementation of a system to handle patient experience data: to collate, aggregate and triangulate date. Developing a system to enhance accountability for action on this data has been added to this project and is in progress
- Implementation of a patient tracker monitoring system
- A reviewed and clarified complaints process, with increased transparency for patients

4.19. Very few participants felt they had achieved the broad range of outcomes that had been intended. All had collected feedback and implemented service change, and were now measuring PE in an 'accurate and timely' way. However only two had registered an improvement in standards. Involvement of staff was a more prominent theme, with a number reflecting on the success of

getting 'buy-in' from other staff, or finding enthusiastic supporters amongst other staff.

4.20. Few of the broader changes, such as increased expertise within organisations, and improved staff morale have yet featured in participant's work experience. This reinforces the finding that the programme has been most successful in supporting learning around practical implementation rather than 'softer' outcomes such as influencing. However these outcomes are also associated with longer term change and so it is likely that these features would develop with time rather than have immediate impact.

Key Messages

4.21. A common trend amongst organisations was to focus on 'real time' data collection and using different methods and tools to engage with patients.

4.22. Participants were not always clear about the specific outcomes they would like to achieve locally, and sometimes were vague around how their work or project would lead to service improvement.

4.23. Key challenges to the completion of workplace projects and progress of work streams were organisational changes as a result of the NHS reforms, time and capacity, and unrealistic time scales.

4.24. For most participants there were benefits to identifying work to complete alongside the programme and to which learning could be applied. It gave participants both directly applicable tools to use as well as a 'space' away from their workplace to think creatively in a supportive environment.

4.25. In some organisations, work has taken longer than planned, or projects been extended beyond the timetable of the programme. For those that have been concluded, mainly practical outcomes have been achieved (eg. implementation of a system) whereas wider outcomes about influence and increased capacity are yet to be realised.

5. THE FUTURE OF WEST MIDLANDS PELP

5.1. Overall, there is perceived demand for programmes such as the West Midlands PELP. 87% of respondents to the follow up survey said they would recommend the programme to a colleague.

5.2. However, there are some caveats to this; the course was seen as most useful for staff of a certain grade, type of remit and also with sufficient time. Two respondents suggested that the programme might be suitable for colleagues who might 'challenge' the value of Patient Experience:

> *"My view is that many colleagues may have still a "blinkered" view about customer experiences in the NHS ... there is a serious 'draught' of innovative, outside the box thinking and doing by many."*

5.3. The key selling points to those who would recommend the course were the opportunities to network, to learn 'credible' tools and think about new ideas. That the programme combines these elements is seen as particularly valuable.

> *"There were so many opportunities to put into practice the learning from the programme"*

> *"It provides a wealth of information and innovative methodologies in patient experience. It offers a supportive learning environment where your views and experiences are valued. You have the opportunity of being part of a wide network where you have access to an extensive knowledge bank."*

5.4. 92% of respondents to the follow-up survey thought that establishing an e-network for participants would be beneficial (71% considering it 'very' beneficial). This option is more popular than maintaining the Action Learning Sets (where 71% said they were likely to continue meeting) however these are both very high and encouraging results. Although it must be remembered that this level of interest will not necessarily lead to the same level of usage, it is clear that participants are keen to continue their network in some form.

6. CONCLUSIONS

Recruitment & Attendance

6.1. The mix of participants reflected varying amounts of experience in the patient experience field and participants reported mixed levels of expertise. This meant that the programme met some participant's needs better than others. In particular the course appeared to be geared towards Patient Experience Leads / Managers rather than the smaller number of participants with wider remits, such as strategists or service improvement professionals.

6.2. Participants came to the programme with strong organisational and personal motivations to use the opportunity to learn more about patient experience. However, only one organisation was represented at all 11 sessions. Despite the high levels of motivation that many participants had, time commitments made full attendance a challenge. Given that full attendance was a condition of participation, there may be a role for sponsors of participants enable and encourage full attendance of their staff.

Design & Delivery Effectiveness

6.3. All participants found the West Midlands PELP useful. They learnt how to use a number of tools in their work life, the programme had an impact on how they felt and acted in their roles and had enabled almost all participants to make tangible and practical improvements to patient experience in their workplaces.

6.4. However, by the end of the programme, some of the 'softer' outcomes around ability to influence other staff or tackle cultural change were not evidenced. These are long term changes and so the ability of the programme to influence these is difficult to judge at this stage.

6.5. Participants were motivated to participate by the opportunity to network and learn from peers. For this reason workshop sessions were seen as the most valuable element of the programme. Less popular elements included the use of WebEx as a learning environment and the Service Safari session, but these were still valued by some participants showing that what works for one participant is not necessarily the same for another. There is evidence that the variety of methods used on this programme is one of its strengths.

6.6. Action learning sets were an additional opportunity for peer learning and networking. These were a popular addition to the programme, but could have benefited from more structured support around their organisation and methodology. Success is partly evident in the two-thirds of participants who want to continue their sets beyond the lifespan of the programme.

Workplace Experience

6.7. Workplace activity provided a useful parallel to the programme. The two elements were mutually supportive and the evaluation found many examples of where programme learning had been successfully applied to specific issues

in the workplace. However there is an incompatibility of timescales between the programme and the time it takes to see results from workplace activity. Maintaining momentum in their workplaces once the PELP is over may be a challenge for some participants who benefited for the 'energy' of the programme workshops.

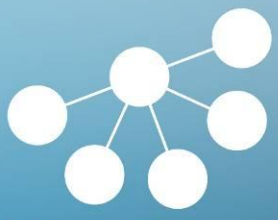
6.8. Participants were often vague about the outcomes they wanted to achieve as a result of their work, and commonly stopped at the collection of feedback, or the implementation of a system. Therefore there may be a role for the programme to look explicitly at how to move from implementing procedures to making noticeable improvements in patient experience.

Future of the West Midlands PELP

6.9. Facilitators of the West Midlands PELP stressed the importance of peer-support throughout the programme, and this is evident in the high value placed by participants on developing and using a network.

6.10. It is clear that participants are keen to continue their network in some form and to some extent are already functioning as a network. Participants said they were likely to use an online resource to sustain this network; however this online resource should also encourage or allow opportunities for face to face meetings to be arranged.

6.11. Patient Experience needs to be maintained as a priority for the West Midlands region. With closure in 2013, NHS West Midlands should look as part of its legacy to embed patient experience learning into infrastructure above individual trusts in the region.



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