K2A: EBCD

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30/04/15
SPOT Edith Strauss Interactive Day, Montreal

KNOWLEDGE TO ACTION: The case of experience-based co-design

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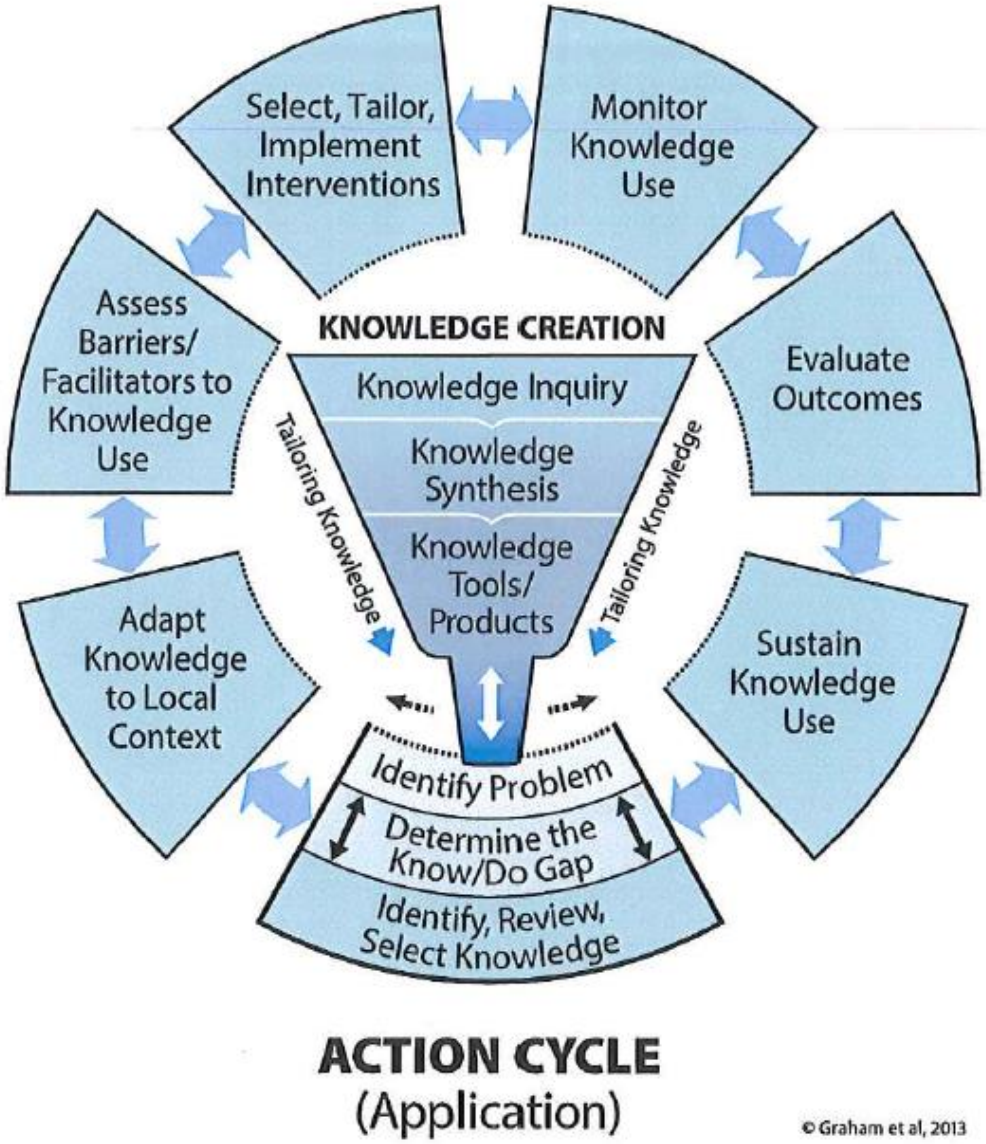
SPOT Edith Strauss Interactive Day, Montreal

Overview

- **Thinking about KT from both sides now .. ♫**
- **Funny things happen … a story**
- **What is evidence?**
- **Experience-Based Co-Design (EBCD)**
- **Implementation – live at St. Mary's**
- **Concluding thoughts**

The 2013 version of the K2A Cycle



KT and me

- **Manager – getting hooked**
- **Funder – drinking the Kool-Aid**
- **Researcher – walking the talk**
- **Manager of Research – teaching them to fish**
- **Human being … messing up**

- *I've looked at clouds from both sides now*
  From up and down, and still somehow
  It's cloud illusions I recall
  I really don't know clouds at all
- *Joni Mitchell 1967*

A funny thing happened …

- What I did
- A(nother) lesson learned …

Evidence comes in kinds

Context-free

Both scientific

Context-sensitive

Similar objects

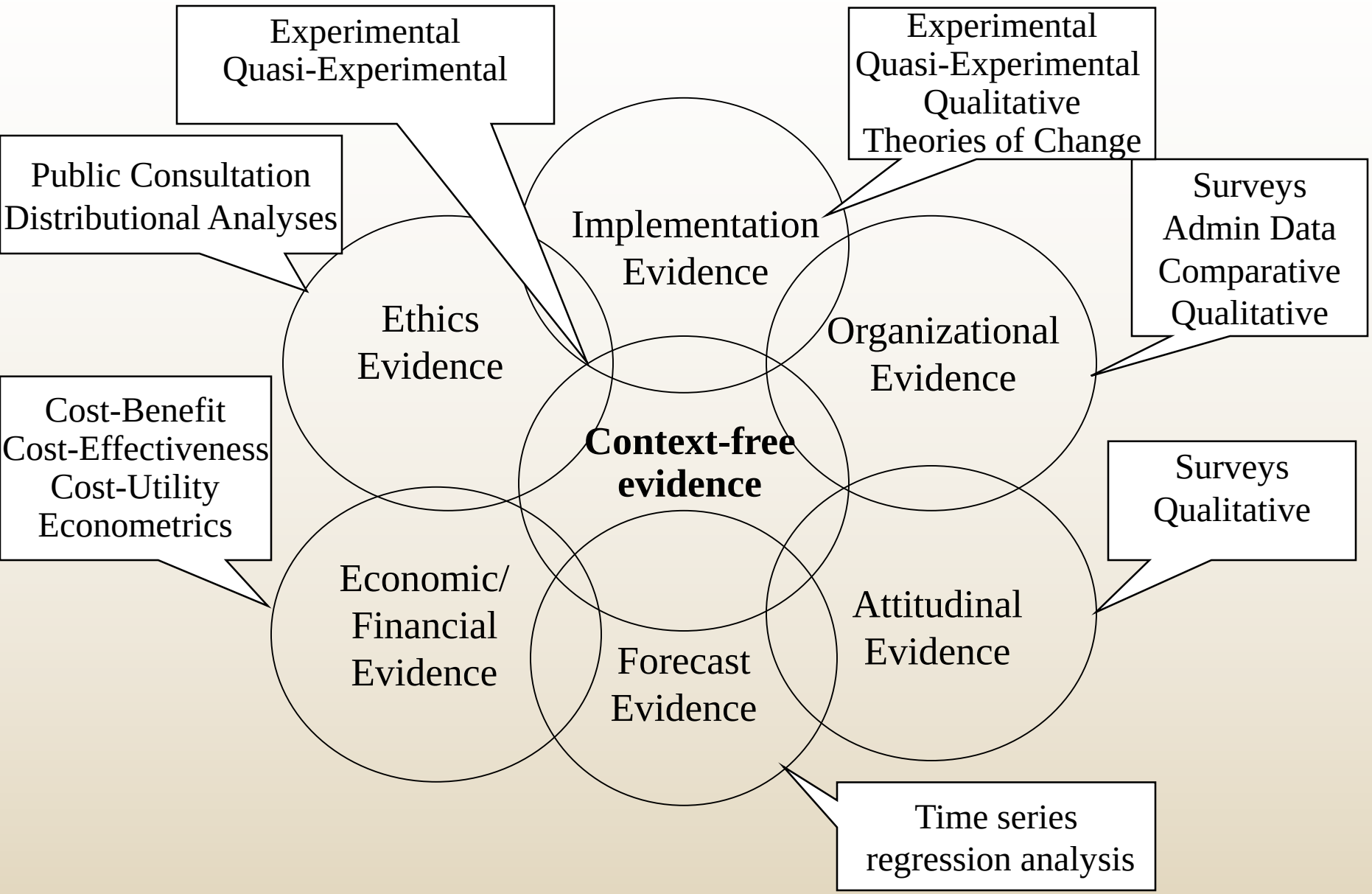
Colloquial

Context

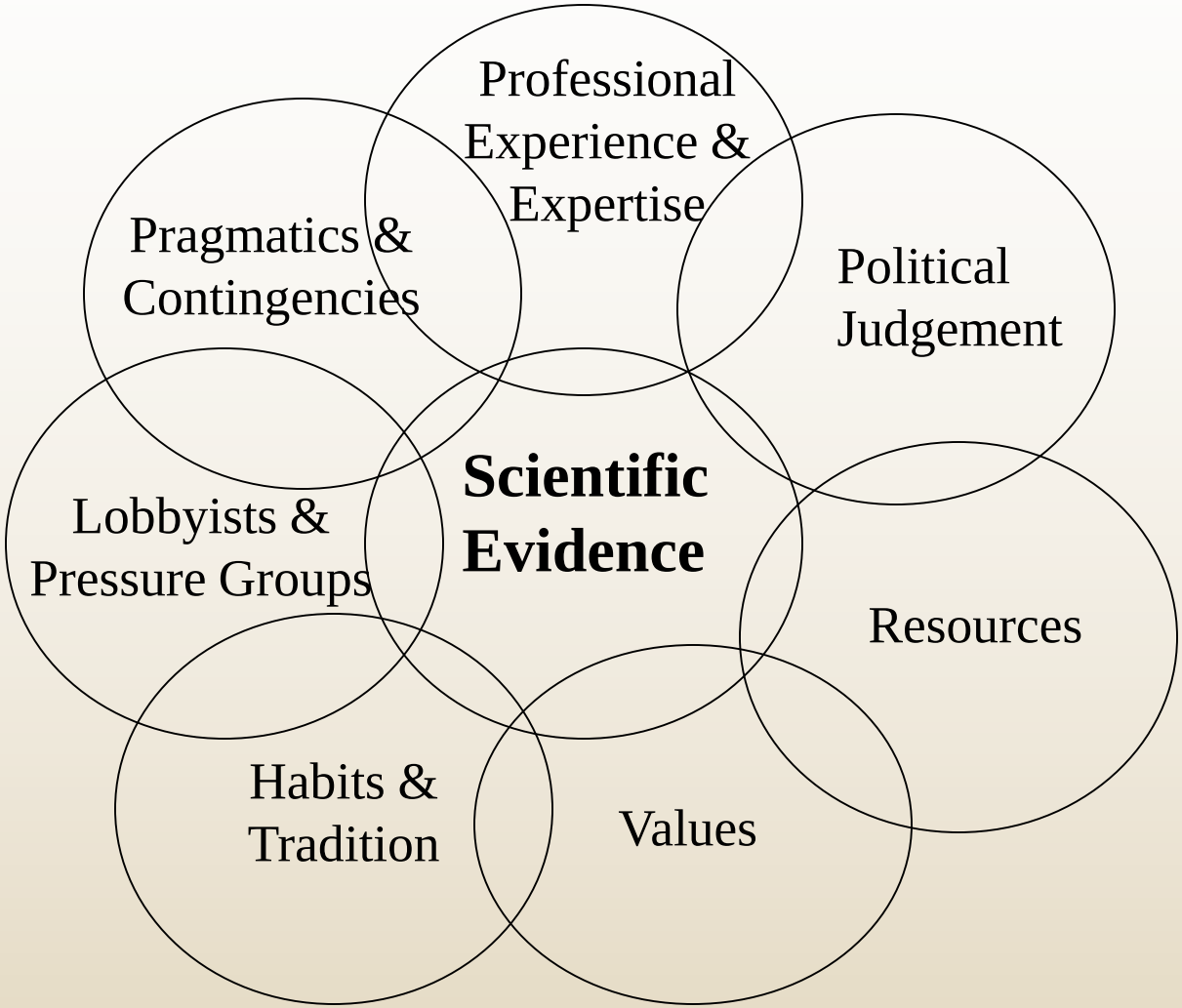
With respect to evidence-informed guidance, context refers to the conditions of implementation. A proven intervention will be more or less effective depending on the context in which it is deployed.

reason for believing something" (Oxford American Dictionary)

Scientific evidence: Context-sensitive complements context-free



Colloquial evidence informs scientific evidence



Evidence defined

CHSRF Mission

To support **evidence**-based decision-making in the organization, management and delivery of health services through funding research, building capacity and transferring knowledge.

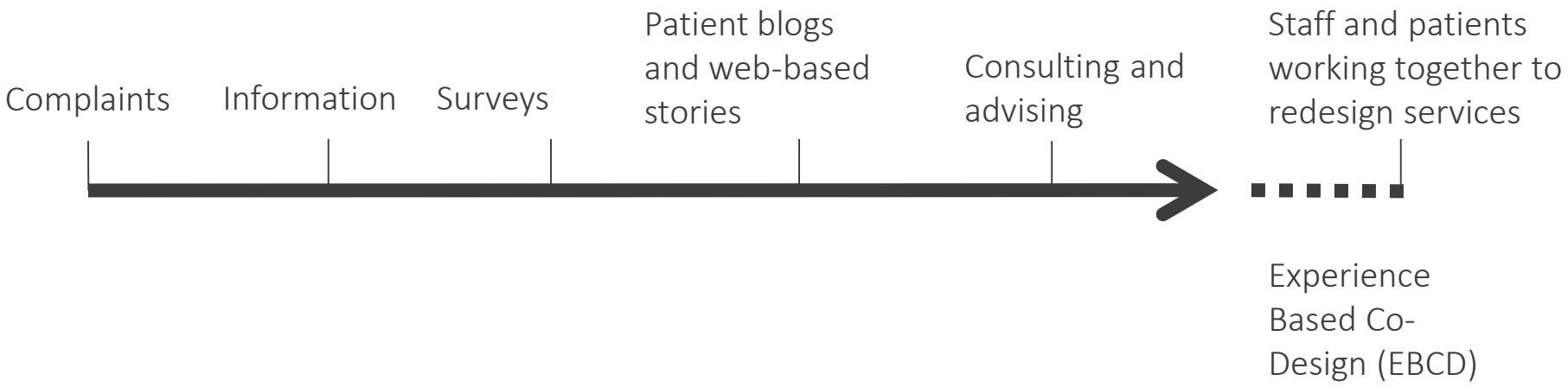
Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high quality, methodologically appropriate research are the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience – while privileging the former over the latter.

Knowledge to Action:

The case of experience-based co-design

- An example of a process that combines knowledge production, integrated KT, combining different sorts of evidence, and implementation
- Starts with deeper knowledge about patient and family experience and the intent for patients and clinicians to work together to change something for the better

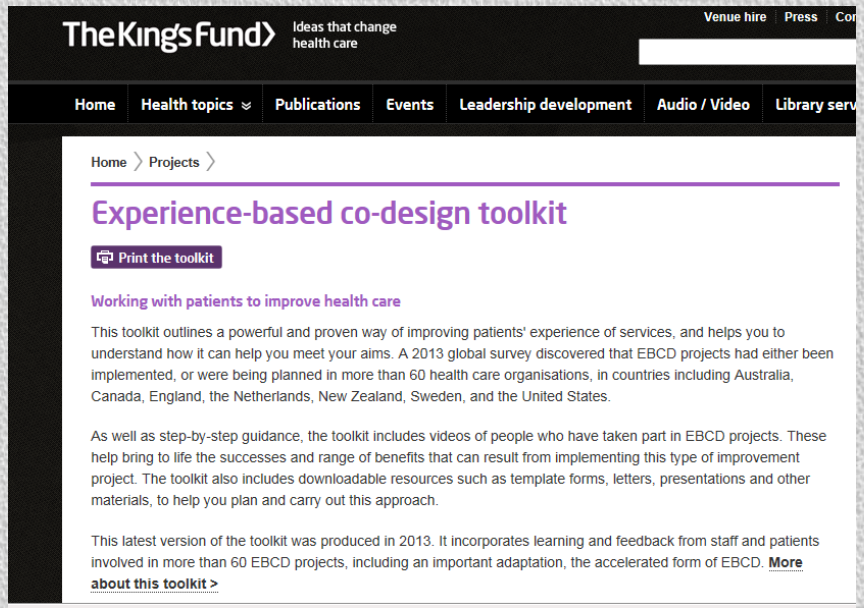
Different ways of involving patients



Adapted from Bate P, Robert G (2006). 'Experience-based design: from redesigning the system around the patient to co-designing services with the patient'. *Quality and Safety in Health Care* vol 15 (5), pp 307–10

Experience-based co-design

- EBCD term coined by Prof Glenn Robert, King's College London, Chair in Healthcare Quality and Innovation
- A participatory action research approach that combines: a user-centred orientation (EB) and a collaborative change process (CD)
- Comprehensive tool-kit:
- Accelerated co-design



EBCD process

Phase	Activity
Phase 1	observation of clinical areas and selection of priority area/project team
Phase 2	interview staff, patients and families
Phase 3	edit interviews and video material to 25-30 mins with themed chapters – 'trigger films'
Phase 4	hold staff feedback event – agree areas to share with patients
Phase 5	hold patient feedback event – agree improvement areas
Phase 6	hold patient-staff event to share experiences and agree areas for improvement
Phase 7	form co-design working groups to work on improvements over 4-6 months
Phase 8	Celebration event

Why observation matters – patient experience

With thanks to L Locock

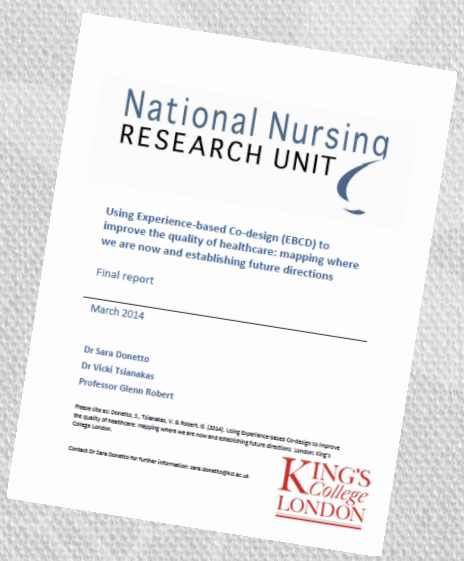
EBCD Trigger films

- Trigger films are designed to be used as part of a facilitated quality improvement process; their purpose is to get local people, patients, families and NHS staff talking together about how they can jointly improve people's experience.

- http://www.healthtalk.org/peoples-experiences/improving-health-care/intensive-care-unit

- *This film was put together from analysis of a national sample of 40 people who have been in intensive care, and 38 family members and friends. Researchers at the University of Oxford collected interviews with people all round the country, many on video, some audio or written only. They present findings from these interviews on the patient information website www.healthtalkonline.org The interviews are not just about NHS care but also much wider experiences, for example their emotional reactions to being in intensive care, how it affected family members, the impact on work, and their recovery at home.*

EBCD Survey, 2013


National Nursing RESEARCH UNIT

Using Experience-based Co-design (EBCD) to improve the quality of healthcare: mapping where we are now and establishing future directions

Final report

March 2014

Dr Sara Donetto
Dr Vicki Tsianakas
Professor Glenn Robert

Please cite as: Donetto, S., Tsianakas, V. & Robert, G. (2014). Using Experience-based Co-design to improve the quality of healthcare: mapping where we are now and establishing future directions. London: King's College London.

Contact: Dr Sara Donetto for further information: sara.donetto@kcl.ac.uk

KING'S College LONDON

- 59 EBCD projects implemented in 6 countries worldwide (2005–13) and further 27 in planning
- Implemented in a variety of clinical areas (including emergency medicine, drug and alcohol services, cancer services, paediatrics, diabetes care and mental health services)

Evidence of Effectiveness

- Evaluations in UK and Australia suggest it is effective in achieving change – both individual improvements and attitudinal change

The primary strength of EBCD over and above other service development methodologies was its ability to bring about improvements in both the operational efficiency and the inter-personal dynamics of care at the same time.

Iedema R, Merrick E, Piper D *et al* (2010). 'Co-designing as a discursive practice in emergency health services: the architecture of deliberation'. *The Journal of Applied Behavioural Science*, vol 46 (1), 73–91.

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EBCD & Patient Engagement – Canada

- Cancer Care Ontario – 25 EBD teams
- CHEO – EBCD project for cancer care
- London HSC – EBCD (on hold); 75 patient films
- Patients as Partners Program – U de Montreal
  - Focus on co-design of teaching, research partners
- CFHI – patient engagement initiatives, including:
  - MUHC – patient engagement to re-design care
  - St. Mary's Patient Engagement Projects

Montreal Workshop – Feb 10th 2015

- EBCD teams in Ontario (CHEO and LHSC)
- Patient engagement initiatives in ON and QC
- With Prof Louise Locock, U of Oxford
- Shared experiences of EBD and related initiatives; key issues:
  - leadership; sustainability; funding; methods
- But unanimous re evidence of effectiveness – experience-based change in services, culture, experiences and outcomes; collaborations between project staff and researchers

Some thoughts on implementation

- Like KT, implementation of change is a contact sport
  - Relevance matters
  - Relationships matter
  - Readiness matters
  - Risk (and perception of risk) matters

- A recent implementation meeting at St. Mary's
  - Quiet time project
  - Stakeholder meeting
  - 1 hour only

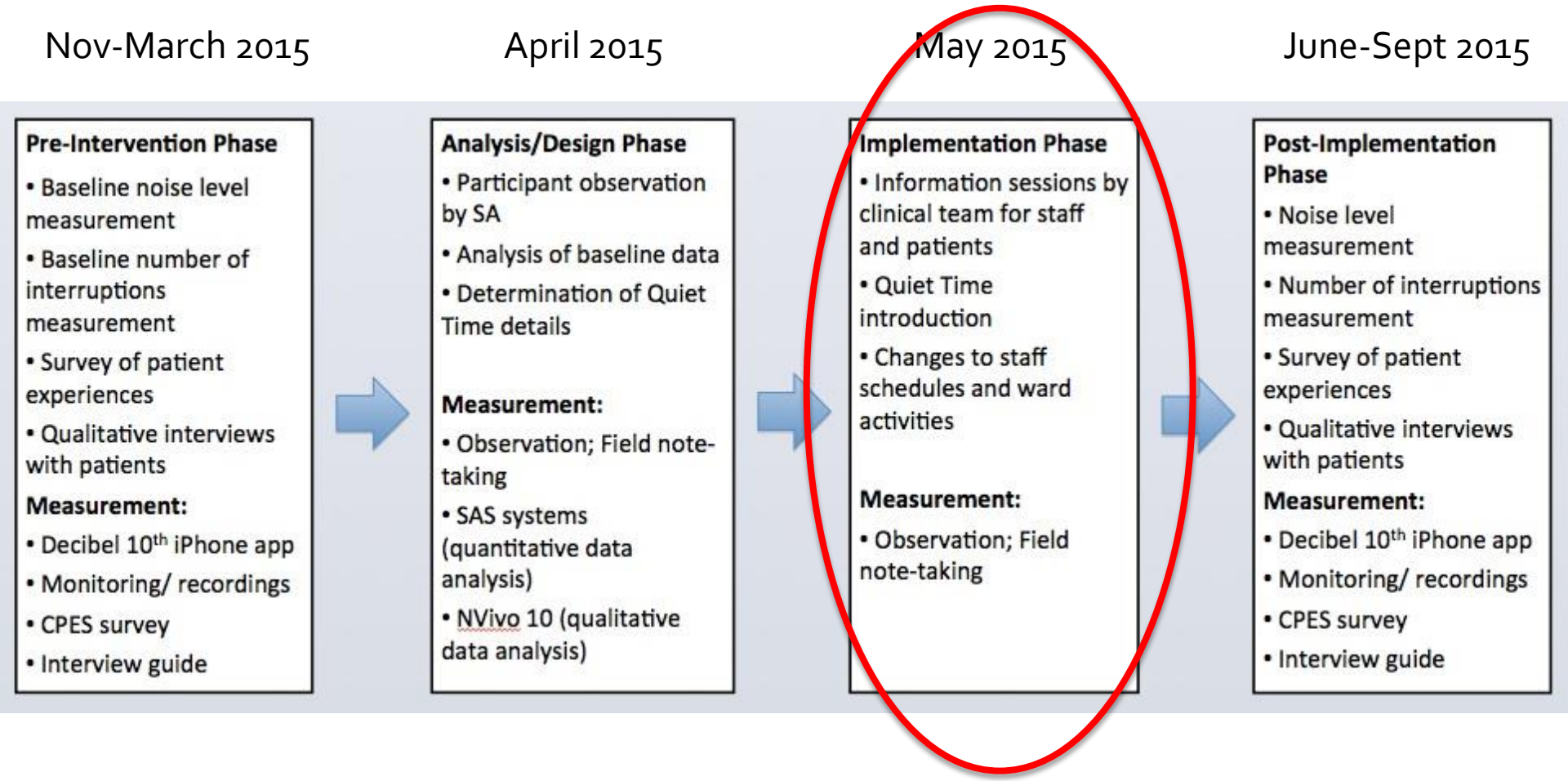
Introducing a Quiet Time Intervention on a Maternity Ward: Engaging Patients and Staff to Assess Barriers and Benefits

Safina Adatia, Susan Law, Jeannie Haggerty (Research Centre)
Marie-France Brizard, Jennifer Somera (Clinical Leads – Maternity Ward)
Advisory Board Meeting
March 12, 2015

Methods

- Mixed methods design – convergent, parallel
  - Qualitative: semi-structured interviews
    - Patients (10-15 interviews)
    - Staff: physicians, nurses, ward clerks, kitchen, labs (10-15 interviews)
  - Quantitative: CPES survey
    - Patients (200 pre, 200 post)
- Pre-test/Post-test design
- Participatory research approach
  - Advisory group (pt reps, nursing staff, physicians, other stakeholders)
- Ethics approval obtained at St. Mary's Hospital

Methods


Nov-March 2015
April 2015
May 2015
June-Sept 2015
Pre-Intervention Phase
• Baseline noise level measurement
• Baseline number of interruptions measurement
• Survey of patient experiences
• Qualitative interviews with patients
Measurement:
• Decibel 10th iPhone app
• Monitoring/ recordings
• CPES survey
• Interview guide
Analysis/Design Phase
• Participant observation by SA
• Analysis of baseline data
• Determination of Quiet Time details
Measurement:
• Observation; Field note-taking
• SAS systems (quantitative data analysis)
• NVivo 10 (qualitative data analysis)
Implementation Phase
• Information sessions by clinical team for staff and patients
• Quiet Time introduction
• Changes to staff schedules and ward activities
Measurement:
• Observation; Field note-taking
Post-Implementation Phase
• Noise level measurement
• Number of interruptions measurement
• Survey of patient experiences
• Qualitative interviews with patients
Measurement:
• Decibel 10th iPhone app
• Monitoring/ recordings
• CPES survey
• Interview guide

Observation notes from the meeting

Purpose of the meeting: plan the implementation

- Attendance – all there but physicians
- No written agenda
- Review of progress:
  - Time for quiet time previously agreed (ie 2:45-3:45pm daily)
  - What did the patients think?
  - Biggest implication – nursing pra
- Congrats re appearance that physicians on board
- Contingencies considered – and what to do (e.g. security)
- Fit with hospital policy??
- Major focus was on communication – to whom and how
  - Concern re how to empower patients to tell their family to stay away
  - Signs, notification of change and of daily QT
- Staff training sessions agreed
- Overall tone and participant 'attitude'? Very positive. 'Can do'.
- Leadership style of chair (program manager) – consensus-building
- Recap of who is to do what + plan to meet soon after implementation

Did the evidence matter?

- Was pretty simple stuff but …
- Helped to define the problem
- Contributed to identifying appropriate timing and implications of the intervention (+ confidence in the proposed action)
- Barriers to change were reduced given profile of the project
- Built some capacity for understanding research process
- Engaged clinicians in research and KT
- Sparked interest and commitment to post-implementation measurement

From Practice back to Theory?? (Graham)

- Implementation considerations in practice contexts:
  - **Structural factors:**
    - Decision-making, policies, resources, work pressures, physical space, technology
  - **Social factors:**
    - Culture and beliefs, leadership, politics and personalities, peers
  - **Other factors:**
    - Patient preferences, medico-legal issues, systems issues

Concluding thoughts

- KT (and particularly iKT) is ***hard work*** (physical and emotional investment) – relationships to be built and sustained; challenges to be overcome; relationships to be re-built; attention to global and local factors at once
- (Macaulay) – there are good reasons why it is difficult to find evidence of ***negative experiences*** with community-researcher collaborations:
  - Risks to relationships
  - Objectivity of researcher?
  - Need for thoughtful and independent evaluation
- But – how else to bring about ***evidence-informed change in complex systems ?***

Thank you – merci!

- Questions, comments, experiences to share??

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