Evaluation of the Patient Deterioration Programme

Formative feedback summary report on Kōrero mai cohort two

Jessica Adams

Nishadie Edirisuriya

Dr Sarah Appleton-Dyer

SYNERGIA

30 September 2019

Acknowledgements

Synergia would like to acknowledge the Health Quality & Safety Commission (the Commission) patient deterioration programme Kōrero mai leads for their support of this evaluation, and their insights, expertise and engagement throughout the evaluation. The Commission have shown strength in their ability to lead a responsive and adaptative programme structure that is building co-design capability with DHB and hospital teams across New Zealand.

We would like to also acknowledge the support of hospital site project leads and teams involved in cohort two. Over the last six months, the teams have welcomed us to the hospital sites and have shared their experiences and reflections through interviews for this evaluation report.

This report is the result of our collective endeavour and we would like to thank you for your time and support throughout this formative phase of the evaluation. The knowledge and insights that were shared with us have supported us in providing a comprehensive insight into Kōrero mai.

Contents

Overview of this brief formative report

This brief formative feedback summary on Kōrero mai presents an overview of key insights from our engagement with cohort two of the patient deterioration programme workstream two: the patient, family and whānau escalation system (**Appendix one**).

At the time of our engagement, cohort two DHB hospital sites were in the development and testing phase of workstream two. The insights discussed in this report are a reflection of the hospital sites experiences with co-design as an approach to developing escalation ideas during this phase of the workstream.

This report also reflects on the experiences of cohort two with adaptations made to the workstream, ideas to strengthen the cultural appropriateness of the co-design capability building approach, as well as insights into how the hospital sites sought to ensure responsiveness to Māori. The report concludes with key considerations to support ongoing implementation and improvement of Kōrero mai including advice from DHBs to the Commission and other DHBs.

Introduction

The purpose of this brief formative summary evaluation report

Cohort two DHB hospital sites

The purpose of this brief report

Synergia has been contracted to evaluate the patient deterioration programme from June 2017 to June 2020. The evaluation is being conducted in partnership with our Māori evaluation partner, Shaun Akroyd (Akroyd Research and Evaluation).

This report is part of a broader evaluation programme that is designed to conduct a formative and summative evaluation of the patient deterioration programme (**Appendix two**).Therefore, it only provides a snapshot of the work so far. A full summative report will be provided in June 2020.

The previous evaluation summary reports focused on the development and implementation phases of cohort one. The Commission has responded to the feedback provided in these reports and made adaptations to the programme for cohort two. Adaptations include flipped classroom style workshops, more upfront support provided by the Commission, and flexible timeframes to progress work. The effect of these adaptations and cohort two experiences using co-design will be explored in this report.

The evaluation approach used for these reports can be found in **Appendix three** of this report.

Cohort Two DHB Hospital Sites

The Commission is working with four DHB hospital sites across New Zealand as part of cohort two. These DHBs are a mix of large and small DHBs providing services to urban and rural populations.

Cohort two are being supported by the Commission in using co-design as an approach to develop and embed a patient whānau escalation process in their in-patient settings.

At the time of engagement with cohort two, project teams were still in the development and testing phase of their journey.

This summary report aims to provide an overview of cohort two experiences and important considerations for feasibility, sustainability, and cultural appropriateness of using co-design as an approach.

The four DHB hospital sites involved in cohort two are:

TARANAKI DISTRICT HEALTH BOARD

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Approach to data collection

For this reporting period, the evaluation draws on interviews with cohort two DHB hospital site teams engaged in the development and testing phase of the co-design process.

This approach is designed to provide rapid formative feedback to support the testing and development phase for subsequent cohorts.

v

The purpose of the site visits were to engage with DHB project teams to understand how they were working and their experiences with Kōrero mai. The site visits were around a day each and conducted by a member of our evaluation team.

During these site visits DHB Kōrero mai project team members were interviewed to gather insights about their initial experiences with co-designing a patient, family and whānau escalation system.

Site visits and interviews in March and April 2019 to
Whanganui DHB
Taranaki DHB
Capital & Coast DHB
MidCentral DHB

Interviewees were asked questions about

- What their understanding of co-design is?
- What approach to co-design is the DHB taking including being inclusive of Māori views?
- What data is being collected?
- What has supported or challenged the co-design process so far?
- What involvement do they have from consumers and whānau?
- What is their understanding of success looks like at their DHB?
- What improvements could be made to the workstream?

The purpose of the follow up interviews were to collect insights from the Kōrero mai project leads and any key project team members from each DHB regarding the progress made with Kōrero mai.

The follow up telephone calls were around 40-50 minutes each and conducted by a member of our evaluation team.

Follow up telelphone interviews in June 2019
Whanganui DHB
Taranaki DHB
Capital & Coast DHB
MidCentral DHB

Interviewees were asked questions about

- How the workstream has progressed since we last spoke?
- What escalation idea(s) were developed for testing and implementation through co-design?
- What has supported or challenged the feasibility of developing, testing and implementing?
- How have they found the adaptations made to the workstream?
- How has the DHB engaged in regular measurement?
- What has been their experience with co-design?
- How has the DHB been responsive to Māori?

People interviewed during site visits and follow up telephone calls

DHBs	People intereviewed during site visits in March-April 2019	Follow up telephone interview in June 2019
Whanganui	1. Project lead 2. Project sponsor 3. Māori advisor 4. Consumer representative 5. Data analyst 6. Communications manager	1. Project lead 2. Data analyst* *Provides active project management support to the project lead and team
Capital & Coast	1. Project lead 2. Patient safety coordinator 3. Ward representatives (n=2) 4. Consumer representative	1. Project lead
MidCentral	1. Project lead 2. Consumer representatives (n=2) 3. Whānau ora link nurse 4. Manager of Māori workforce development	1. Project lead 2. Consumer representative 3. Clinical lead
Taranaki	1. Project lead 2. Associate director of nursing 3. Nurse educator 4. Equity educator and advisor (from Māori team)	1. Project lead
Total:	**n = 20** people across the DHBs	**n = 7** people across the DHBs

Summary of activity at DHBs from March-April site visits

DHB summaries based on site visits in March and April 2019

- Ideas being developed and tested
- Factors supporting and challenging co-design
- Initial experiences with co-design
- Recommendations for DHBs and the Commission

Capital & Coast District Health Board

How has the DHB engaged and captured insights as part of the co-design approach?

PHASE: Testing

Kōrero mai is led by a clinical nurse specialist with support from the patient safety coordinator, ward representatives and consumer representatives.

The Kōrero mai team have consumer representatives on their working group who have played an active role in the co-design and implementation process.

Ward representatives used the Commission observation tool to observe interactions between patients, whānau and staff upon admission. Consumer representatives interviewed 20 patients on the wards about their experiences.

Consumer representatives will be engaging with patients to gather their feedback on their posters. Patient At Risk (PAR) nurse will uniquely code all calls from the phone line into the intensive care unit patient database. The database will be checked daily for these calls. If patients have used the phone line they will be followed up to understand their experience.

Developing an escalation process

Kōrero mai poster – encourages patients and whānau to speak with their primary nurse about any concerns first before calling the 0800 number.

An escalation phone line for patients and whānau to raise concerns through. The phone line will be managed by PAR nurses.

Insights into using co-design

There was some initial nervousness about working with consumers in a co-design process. However, the process was seen as a very valuable opportunity to learn from the consumers and the co-design process. The consumers were seen as bringing a unique perspective to the co-design, where clinicians were seen to be desensitised to the concepts raised by the consumers. The consumers were very passionate and brought great ideas to the co-design process.

Having the consumers playing a role in interviewing the patients to inform the co-design process was very useful as the patients were able to better relate to the consumers.

The consumers at times felt that they weren't adding value to the process, particularly when discussing clinical issues, however they put their trust in the process and knew that eventually they would be able to make a meaningful contribution.

Supports

Very engaged consumer representatives. The consumer representatives were able to contribute their views and perspectives to the co-design process as well as support data collection.

Staff on the wards where the posters and number will be tested are on board and supportive of the idea.

Support from the Commission was very useful.

Buy in and support from management advocating for quality improvement and engaging consumers.

Payment for consumers to participate in co-design process including covering travel costs.

Challenges

Engaging the Māori team for representation and input into the co-design process.

More time was spent on planning and the implementation was rushed. There should have been a greater focus on the outcomes of the intervention.

The Webex's were very time intensive. Some of the content was repetitive and it would have been useful to have a practical component including use of case studies.

The limited time to input into this process.

Recommendations to the Commission

Māori and Pacific advisors for DHBs to access.

Spend more time with DHBs focussing on what intervention they are going to implement.

Useful to have dedicated time and resource to implement the co-design process and interventions.

Consider the contribution of time and resource that the Commission is requesting from DHBs to participate in these programmes as this is on top of high workloads for staff.

Recommendations to DHBs

Focus on engaging with Māori early.

Allocate protected and dedicated time for teams to support this process.

Ensure staff understand the concept of the co-design process and overall goals of the process.

Select someone to lead the team who is passionate about the content of the co-design process.

Engage with consumers and ward staff to ensure the co-designed escalation process is going to benefit them.

MidCentral District Health Board

PHASE: Testing

How has the DHB engaged and captured insights as part of the co-design approach?

Kōrero mai is led by the director of nursing and her team.

Co-design between the Māori team (Poira) and Kōrero mai team led to using the Mahi Tahi approach.

A number of patients and whānau interviewed to understand how they were experiencing care and helping their whānau who needed care. Whānau experienced issues around visiting hours and barriers to being a part of patient care.

The Mahi Tahi approach was tested using Plan Do Study Act (PDSA) on a ward.

Patient and whānau feedback through survey monkey available on ipad and/or postcard in wards.

DHB have patient survey and feedback postcards available on the ward. Feedback is collected, analysed and reported on frequently by project management team. The Mahi Tahi governance board are very interested in this feedback so that adaptations can be made to the programme to ensure its success.

Developing an escalation process

Mahi Tahi is the first point of call. Patients allocate a kaimanaaki (Person caring for a patient) who become part of the care team. Mahi Tahi is added as a health referral. If you are participating as a partner in care, you have a number of privileges such as 24 hour access to the ward, meals, parking support, and take part in the discussions.

An escalation phone line to be managed by afterhour nurses.

Insights into using co-design

The Kōrero mai team found the co-design process supported them in gathering useful insights from their patients, whānau and staff to understand the need for change and to develop an escalation process reflective of peoples' experiences and context.

Consumer representatives found co-design a useful process for engaging with patients and whānau.

The consumers especially enjoyed interviewing patients to understand their experiences with escalating concerns in the ward, and revealed to them the benefit in developing an escalation process catering to their own people instead of following the same solutions as cohort one.

Supports

Strong consumer presence, who has a good understanding of clinical aspects of the intervention and the bigger picture.

Team leaders with quality improvement experience who are passionate about making a difference in this space.

Whānau and some staff had issues with the visiting hours and so they could see value in this intervention.

The formal structure provided through this process has supported feasibility of implementation.

Challenges

Testing and socialising the concept has been a challenge.

Time and resource constraints and people having to manage competing priorities. There is a risk that by not following due process that important aspects for the co-design and implementation may be missed.

A lot of people wanted to be part of the Patient Deterioration programme and this can be difficult when it is more efficient to have a smaller team working on the project.

Recommendations to the Commission

Providing more clarity about the desired outcomes for this process. This would also support the buy in of key clinical staff.

Providing more structure for the DHBs to follow, as the brief initially was too broad.

Holding a meeting with the Commission and the DHB prior to starting the co-design process to discuss the context and resource the DHB has available.

Education for patients about what patient deterioration means and the importance of asking questions and the types of questions to ask.

Recommendations to DHBs

Take time to understand the issue and current escalation process so that the co-design process results in something that will make a true difference for staff, patients and whānau.

It is important to not make assumptions when you are taking part in a co-design process. It is valuable to look at other examples for inspiration. However, it is important to go through the process of co-design to see what is required in each specific DHB.

Need the buy in and respect of key drivers and staff to make a change.

Whanganui District Health Board

How has the DHB engaged and captured insights as part of the co-design approach?

PHASE: Pre-testing

Kōrero mai sits with the patient safety team who have strong connections to the Māori team. The Kōrero mai working group has a Haumoana (navigator) who has engaged with whānau and community to provide feedback on their experiences with escalating care.

The Kōrero mai team also have consumer representatives on their working group who are involved in designing of the idea(s) and collecting feedback from patients and whānau.

The project lead has reviewed the DHB's complaints and compliments data, 777 calls, and other important service data to understand current trends in patient escalation.

Kōrero mai team have completed staff, patient and whānau interviews. Plan to collect further feedback regularly once the team are testing.

Developing an escalation process

Patients are encouraged to raise concerns with ward staff as first port of call. Staff may wear Kōrero mai – speak to be badges. This is still in development.

An escalation phone line to be managed afterhours by Duty Nurse Managers (DNMs). If the call is during ward hours the concern is passed onto the Charge Nurse to resolve.

Insights into using co-design

The DHB is used to working in collaboration with their Māori and consumer representative groups. The project team developed an action plan and idea(s) to test based on knowledge from cohort one and previous experiences with patient deterioration.

The project team described their initial experience with co-design as the "storming phase."

The practical workshops and regular support from the Commission supported the team in learning about co-design and the importance of gathering information to inform the development of an escalation process before implementation.

Supports

The DHB has existing working relationships with their Māori team and consumer representatives group.

The DHB have merged their "Speaking up for safety campaign" and Kōrero mai governance boards together – creating more credibility and support for the work.

Having a team where everyone knows each other and the way we work "Everyone is in the same waka."

Challenges

The DHB initially felt the workstream timeframe was moving too slow and did not accommodate to the needs/context of a small DHB.

Working group members had to balance this work with their other priorities and existing projects.

Recommendations to the Commission

Adapt the co-design workstream timeframe to each DHB to be responsive to their context and needs. This includes:
- Separate workshops
- Separate meetings during the start of the workstream

"One size does not fit all"

Recommendations to DHBs

Every DHB working group should have consumer representatives on their team from the start of the project.

Involve communications team from the beginning so they understand the need and context.

Trust the co-design process and take the time needed to understand the issues before jumping into solutions.

Taranaki District Health Board

How has the DHB engaged and captured insights as part of the co-design approach?

PHASE: Pre-testing

The project lead has reviewed all incidents, complaints and compliments data to identify themes in escalation at the DHB. The findings from this work informed the co-design process.

The DHB were initially challenged with efficiently recruiting consumer representatives and Māori advisors to the project team. The DHB is currently recruiting a patient at risk nurse (PAR) who will play an important role in the escalation process.

The project lead will be conducting regular PDSA cycles throughout the testing and implementation phase to make ongoing adjustments to the escalation process.

The team is working on collecting feedback from patients and whānau about experiences with escalating concerns in the in-patient setting.

Developing an escalation process

TBC

The DHB is working on developing their escalation process and is unable to comment on what ideas they plan to test. The project team has been encouraged to not be influenced by cohort one and use feedback from patients and whānau at Taranaki DHB to understand what would work best for their context.

The DHB has chosen their acute stroke and rehab ward to test their idea(s) on. The Nursing Manager of this ward is in charge of developing the PAR nurse role, is on the Kōrero mai team and understands what it is trying to achieve. They plan to trial from end of July for a month.

Insights into using co-design

The DHB project team is new to using co-design as an approach and are careful in ensuring the right people are involved from the start.

The team found the first co-design workshop informative and helpful in supporting their learning about co-design.

The team were initially worried about slow progress. However connection with other DHBs and the Commission has helped the project team share ideas and learnings about co-design. This has increased knowledge and confidence in co-design "Slow progress is better than no progress."

Supports

The project lead's experience with quality improvement has enabled her in reviewing appropriate data sets and to make a plan for development and testing.

The project team are supported by the views and experiences of actively engaged consumer representatives and Māori advisors.

Support from the executive and management team has affirmed the worth of the programme to staff and enabled progress to be made.

Challenges

Time to progress work has been the biggest challenge for the project team. The size of the DHB means people are often working across multiple projects and often do not have dedicated time for Kōrero mai.

The project lead especially struggled during the initial phase of the workstream because the project team was not set up yet.

Recommendations to the Commission

Ensure project leads have active support from leadership prior to starting. Taranaki DHB did not have a Director of Nursing during the set up phase of this work and this challenged the project lead's capacity to progress work efficiently.

Provide more support to smaller DHBs during the planning phase of the workstream e.g. Forming a project team.

Recommendations to DHBs

Be bold and have conversations with staff, patients and whānau about escalation – "it seems scary and out of your comfort zone but consumers are very receptive. Push the barrier."

Key insights from June follow up interviews

- What supports or challenges feasibility?
- How are DHBs engaging in regular measurement?
- What is needed to build a desire for ongoing improvement practices?
- How is Kōrero mai being integrated into the DHB recognition and response system?
- How are DHBs planning for spread and sustainability?

What supports or challenges feasibility?

Feasibility of the workstream is dependent on a number of factors including DHB size, capacity and connection to resources. Below is a selection of main insights outlining what factors have supported and challenged the feasibility of this work:

DHBs with limited resource were more likely to find it challenging to progress work:

- Project leads from smaller DHBs were constrained for time and resource needed to progress work in a timely manner
- Difficult for clinical roles to make time for involvement in quality improvement projects such as Kōrero mai despite expressing an interest. Working around busy schedules can cause delays in the co-design process.

The capability and capacity of project leads could either support or challenge the feasibility of the work:

- Project leads with experience in project management and quality improvement found managing and leading the workstream more feasible
- Project leads with dedicated time were able to manage and lead the workstream more effectively and efficiently e.g. setting up a working group and scoping data for feedback.

What supports or challenges feasibility?

A strong working group inclusive of consumer representatives, Māori advisors, management and leadership roles supports a more meaningful conversation as part of the co-design process.

DHBs with strong consumer representatives able to interview patients and whānau supported the working group in collecting rich data about escalation experiences to inform their co-design process.

DHBs with support and involvement from DHB Māori advisors enabled the working group to understand the experiences and views of Māori patients and whānau better. Māori advisors on working groups are actively providing insights into how to engage with Māori to create a successful escalation process.

How are DHBs engaging in regular measurement?

All four DHBs see the value in collecting regular feedback and measurement to inform their progress.

Based on interviews with project team members there are a number of ways in which DHBs currently plan to engage in regular measurement, these include:

- Reviewing risk and incident data bases for trends in complaints and compliments reported by patients and whānau
- Consumer feedback on co-design idea(s) e.g. feedback on Kōrero mai posters face to face or through a survey available online and on paper in wards
- Conducting regular PDSA cycles during the testing phase to make necessary adaptions and inform further roll out of co-design ideas.

How are DHBs engaging in regular measurement?

Project teams see regular measurement as a useful part of their co-design work. Project teams are flexible in making refinements to the data they collect to refine their co-designed ideas. Only two DHBs including MidCentral DHB and Capital & Coast are in the testing phase and are currently engaging in regular measurement.

The benefits to this flexible data measurement approach are already visible for some DHBs including MidCentral DHB who have tailored the data they collect (e.g. How many whānau are attending to a patient daily) to the Mahi Tahi data they collect to help them understand how the programme is working and where improvements should be made.

The other two DHBs, Taranaki DHB and Whanganui DHB were still in the development phase of work and were looking to incorporate regular feedback from staff, patients and whānau when they were up to the testing phase of work.

What is needed to build a desire for ongoing improvement practices?

DHBs recognise and prioritise the need for ongoing improvement practices in their settings. DHBs involved in cohort two view Kōrero mai as an opportunity to build on their growing desire and interest in supporting staff capability.

For example, MidCentral DHB is currently working on strengthening their improvement practice culture through using the Health Quality & Safety Commission's From Knowledge to Action Framework to guide the way they work. Kōrero mai is one of many projects staff are being supported through this Framework to build quality improvement knowledge and skills.

Through interviews we have learnt the following factors support DHBs to continue building this desire:

- Visible support from executive and management communications to staff the importance of projects such as Kōrero mai in building staff capability in improvement practices
- Continuous engagement between people involved in improvement projects and DHB staff creates a culture of feedback and learning. In Kōrero mai, meeting with staff has enabled project teams to provide reassurance and educate staff about co-design - "We have to trust the co-design process."

How is Kōrero mai being integrated with the wider DHB recognition and response system?

Although project teams are still at the pre-testing and testing phases of co-designing an escalation system, they recognise the need to connect their emerging escalation pathway with their wider recognition and response system. Project teams plan to do this through:

- Continuously providing staff with the opportunity for feedback and discuss their concerns. Educating staff through discussions enables the project team to equip staff to navigate the recognition and response system easier
- Involving key people across all three patient deterioration programme workstreams to share learnings and not re-invent the wheel where possible.

How are DHBs planning for spread and sustainability?

DHBs plan to use a phased approach to implementing and embedding their co-designed escalation process. This is to allow the project enough time to educate and ensure the process is socialised well prior to testing and implementation. The project team members are trusted to use their leadership and connections to advocate for implementation with their dedicated departments.

The main approach in planning for spread and sustainability of this work is through educating staff about the use of co-design as an approach to developing a patient and whānau escalation process. Education to staff is mainly provided through:

- Creating dedicated space for project teams to hear staff feedback and provide information to staff to increase knowledge about Kōrero mai
- Developing and refining communications to make sure key messages about the work are provided to staff, patients and whānau.

Interviews with project leads highlighted the importance of ensuring staff are on board with the changes and understand the implications of it on their practice before implementation and roll out.

How are DHBs planning for spread and sustainability?

One of the key challenges faced by smaller DHBs is supporting staff resource through the implementation and spread of work.

Smaller DHBs are finding useful ways of using their resources, especially staff to efficiently work through the process.

For example, MidCentral DHB has merged their Kōrero mai and speaking up for safety campaign governance groups to make better use of staff time and provide Kōrero mai with the credibility needed when socialising work with staff. MidCentral DHB explained they are using the same approach to education and implementation used by the speaking up for safety campaign which involved staff forums to inform how they transition from testing to implementation.

This connection to existing programmes is seen as a valuable approach to embedding the co-designed escalation process as business as usual.

Feedback on adaptations made to the workstream

DHB responses to adapations made to workstream structure by the Commission

Feedback on adaptations made to the workstream

Based on feedback from cohort one a number of adaptations were made to the co-design process for cohort two. The following slides provide brief feedback about these adapations from cohort two:

Flipped class-room styled workshops:

- DHBs like the practical style of workshops. It provided project teams with a dedicated space and time to work through important tasks and use Commission expertise to build knowledge about co-design
- Whanganui, Taranaki and MidCentral DHBs found workshop one especially helpful to their planning and provided useful guidance about identifying scope and resource needed
- Whanganui and MidCentral DHBs suggested having separate workshops to each other instead of combined so they could work through their specific context, timeframes, and needs
- DHBs mentioned initially feeling overwhelmed at their first workshop because they did not know what to expect and often felt unprepared for it. These concerns have been actively addressed by the Commission Kōrero mai lead who has visited DHBs on multiple occasions to provide onging support and reassurance about the co-design process.

Feedback on adaptations made to the workstream

Briefing information provided to DHB project leads at the start of the workstream:

- DHB project leads were satisfied with the amount of information provided to them at the start of the workstream
- Project leads felt informed about what was required of them and their project teams
- Hearing success stories from cohort one helped reaffirm the purpose and benefit of this work to project teams during the initial phase of the workstream.

Ongoing 1:1 support from the Commission:

- All four DHB project leads highlighted the value of having a dedicated contact person at the Commission who would regulary check-in on them and provide one to one support when needed. This support enabled project leads to build their own co-design capability and work more effectively with their project teams
- DHB project leads especially liked knowing they could contact a dedicated person from the Commission whenever they needed. They appreciated the face to face visits and follow up workshops with their teams to address concerns and support them in learning about conducting a co-design process.

Feedback on adaptations made to the workstream

Flexible timeframes

The need for flexible timeframes for co-design was one of the key recommendations made by cohort one. Based on this, the Commission have created more flexible timeframes for cohort two to progress through the workstream. Cohort two have valued and appreciated the flexible timeframe approach given to them by the Commission.

For some DHBs including Taranaki having the opportunity to work at their own pace supported the project lead in gathering the right people with needed influence and experience to be a part of the project team.

The Taranaki project lead explained the flexible timeframe allowed her to spend time during the start of the workstream to recruit consumer representatives and build connections with the Māori team without pressure. This connection and involvement from consumers and Māori is considered by the project team to be their greatest strength and learning from co-design so far.

Feedback on adaptations made to the workstream

Feedback on the partners in care programme

We visited Capital & Coast DHB (CCDHB) in April 2019 to interview the project team, and followed up via telephone with the project lead in June 2019 to learn about their experiences with partners of care. The CCDHB team in particular had webex sessions instead of workshops with the Commission. This difference and the value added to learning was explored through our interviews.

The team enjoyed the first webex and found it informed them about co-design. Subsequent webex sessions were considered time consuming and added limited value to their work. The team would have preferred more practical workshops to support progressing their work.

CCDHB emphasised the value added to their learning by hearing the experiences and learnings of cohort one. This connection to cohort one and the other DHBs helped the project lead to promote this work among her project team and encourage the co-design process.

Regular contact with the Commission project lead was also considered very useful to help her in supporting the team to keep momentum going.

Co-design as an approach to developing an escalation process

- DHB feedback on the co-design process
- Exploring co-design responsiveness to Māori and cultural appropriateness

Co-design as an approach for escalation

DHBs valued the co-design process and found it a learning process for them.

DHBs valued the opportunity to engage with patients and whānau to hear their voices as part of the co-design process. This added value to the learning experiences of the project teams and allowed them to explore escalation trends and patterns through a more informed lens.

For some DHBs including Whanganui DHB, the co-design process has reaffirmed their current collaborative way of working with their communities, and highlighted opportunities for further learning.

> *"Surprised how much I've actually enjoyed the process... really didn't know what I was expecting, maybe it would be tip toeing around consumers, but actually it's easier than what you think and gives you a different perspective.. and it reminds you not to talk jargon all the time."*

Exploring responsiveness to Māori and cultural appropriateness of co-design

Experiences with engaging Māori have been different across the four DHBs involved in cohort two. Three out of the four DHBs involved in cohort two are working with their Māori team. Analysis of interviews show some key ways in which these DHBs are making sure their co-design process and escalation idea(s) are responsive to the needs of Māori. These include:

1. Working with the Māori whānau to build stronger connections. For example, MidCentral DHB's Mahi Tahi programme was developed as a way of building better connections with whānau visiting patients and creating a culture of working together. The working group are using this programme as their main pathway for escalation. Insights and expertise from Māori at the DHB and community are included in continuous improvements made to the programme. This partnership approach has supported the DHB in accessing further resource and continued interest from their Māori team for Kōrero mai.

2. Taking time to build connections with the Māori team. Project leads at both Whanganui DHB and Taranaki DHB took their time to meet with Māori team members and understand their worldviews. This approach built trust between both parties and affirmed the knowledge and skills Māori advisors could add to Kōrero mai.

Exploring responsiveness to Māori and cultural appropriateness of co-design

Cohort two DHBs are learning to develop a co-design process that accurately reflects the various cultures their DHBs deliver care to. While none of the DHBs involved in cohort two have taken a similar approach to cohort one in hosting a hui or fono with their community, they have had greater success in engaging with their Māori teams.

All DHBs except CCDHB were able to involve their Māori team in Kōrero mai.

Based on analysis of cohort two experiences, DHBs where the project lead had existing connections to the DHB Māori team experienced easier involvement from their Māori teams.

Responsiveness to Māori and cultural appropriateness of co-design

The most common approach to ensuring the perspectives of other cultures, especially Māori, are included in the co-design process is through involving Māori advisors on project teams. DHBs are working to ensure inclusion of Māori advisors on their project teams is not tokenistic and adapts the co-design process to reflect different world views and approaches to working.

For example, the project team at Whanganui DHB includes a passionate Māori advisor. He has used his connections to Māori at the local Marae, Iwi and whānau in communities to collect meaningful and real experiences about with escalating concerns in a hospital. Feedback from these interviews provided the project team with rich knowledge about how Māori view escalation and explore what factors challenge or support whānau to escalate and resolve their concerns.

Another key approach used to ensure the co-design process is culturally appropriate is through the inclusion of consumer representatives in project teams. Cohort two DHBs are working towards involving the consumer representatives who accurately reflect the needs and experiences of the community. DHBs are sometimes limited in selection of consumer representatives and describe the need for more Māori and Pacific Peoples on their consumer boards. Taranaki DHB and CCDHB were the only sites to not use their current consumer board and actively seek out consumer represenatives that they felt were best suited for Kōrero mai.

DHB advice to other DHBs

Cohort two valued the advice provided to them by cohort one and adaptations made to the workstream by the Commission. In reflecting on their experiences with co-design so far, DHBs provided the following advice to other DHBs thinking about taking on similar work to them:

1. Be willing to learn about co-design and go through the process so the best outcome can be achieved for staff, patients, and whānau- "Take time to understand the issue and current escalation process so that whatever is decided will make a true difference/change to staff, patients and whānau"
2. Make sure people with the right skill mix and diversity in experience and backgrounds are included in the project from the beginning, especially consumer representatives and Māori advisors
3. Establish your governance structure so executive and management roles actively champion Kōrero mai with staff and take part in the learning
4. Take time to talk with staff throughout the co-design process. This helps socialise the expected change and pave the way for a more informed testing and implementation phase.

DHB advice to the Commission

All four DHBs involved in cohort two were pleased with the level of support received from the Commission. Project leads particularly highlighted the value of having a dedicated person at the Commission who could visit and help them learn about leading co-design. Key advice from DHBs to the Commission included:

- Maintaining the national level support for individual DHBs during the co-design process.
- Ensure national support and recognition for developing a patient and whānau escalation process continues. This was valued by all four DHBs, especially smaller DHBs who were able to tap into resources from the Commission and other DHBS to develop their capability. Staff were also more likely to view co-design as a credible process because it was being promoted as an approach by the Commission.
- Maintain the practical and applied approach to engaging DHBs. DHBs provided positive feedback to the adaptations made to the workstream including practical style workshops, more upfront information and guidance, regular support and flexible timeframes. DHBs especially enjoyed the workshops and found it supported their learning.
- DHBs suggested having separate workshops to one another so they could cut down on travel time and focus their efforts on working through their specific needs. This suggestion was especially important for MidCentral and Whanganui DHB who enjoyed working together but would have preferred to have separate workshops dedicated to their context and needs.

Key considerations and conclusions

Key considerations and conclusions

The evaluation provides evidence on the value of adaptations implemented by the Commission to support cohort two. This included the flipped classroom, one-on-one support for DHBs and flexible project implementation timelines. Overall, DHBs felt well supported by the Commission to establish and implement a co-design process to develop a patient escalation pathway.

For cohort two, the Commission also continued to emphasise the importance of engaging with Māori. This is reflected in the ways in which DHBs are engaging with Māori staff and whānau to develop an escalation process that is culturally appropriate.

In terms of considerations, the evaluation identified the following:

- Continue to provide the applied and context specific support to DHBs through the flipped classroom approach and the Kōrero mai leader. The establishment of a key contact to support them was highly valued
- Continue to highlight the importance of working with Māori whānau and Māori teams to support responsiveness for Māori
- Emphasise the importance of collecting DHB context specific data to inform the design of an escalation pathway for new DHBs as this is something that other DHBs have valued.
- Maintain the flexible timeframe for DHBs but consider the practicalities of having joint workshops for those with long travel times
- Continue to encourage DHB teams to engage leadership to support the co-design approach and resulting co-design ideas
- Encourage DHBs to build and strengthen linkages across the three workstreams to enhance the contribution of the different workstreams for patient escalation.

Appendices

Appendix one: The Commission’s Patient Deterioration Programme

Appendix two: The Health Quality & Safety Commission

Appendix three: Evaluation approach

Appendix One: The Commission's Patient Deterioration Programme

The aim of the Commission's patient deterioration programme is to reduce the harm from failures to recognise or respond to acute physical deterioration of adult inpatients (excluding maternity) by 2021.

The programme has three workstreams:

The workstreams are supported by engagement with patients, families and whānau, sector management and a measurement framework.

Appendix Two: The Health Quality & Safety Commission

The Commission is a stand-alone Crown Entity, established in November 2010 to help private and public providers across the health and disability sector improve service safety and quality. The Commission is working towards the New Zealand Triple Aim for quality and safety outcomes which will mean:

- Improved quality, safety and experience of care
- Improved health and equity for all participants
- Better value for public health system resources.

The Commission manages a number of quality improvement programmes including the patient deterioration programme, which commenced in July 2016.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Appendix Three: Evaluation approach

The evaluation adopts a mixed methods design, drawing on the views and experiences of staff, patients and whānau, as well as data collected through the workstreams. The evaluation so far has specifically focused on the patient, family/whānau escalation workstream, including the co-design phase and the refine and implementation phases.

The evaluation will also integrate Commission gathered key insights and analysis from workstream one and a formative evaluation of workstream three to support a summative evaluation report in June 2020.