Digital Devon Accelerator

Interim Learning Report I

An evaluation of an initial 3-month PDSA cycle, supporting GP practices to implement online consultation towards a scaleable evidence based blueprint.

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Table of Contents

Executive Summary *2*

Background **2**

Aims and scope **2**

Evaluation methodology **2**

Key findings **2**

Summary and future developments **3**

1. Introduction and Background *5*

UXC Approach – Change Capable Teams **5**

People first model of implementation **5**

Lining expectations with reality – implementation rate **6**

2 Overview of the evaluation *7*

2.2 Evaluation methodology **7**

Design 7

Sampling Strategy 7

Data Acquired 7

2.3 Data Protection Governance **8**

2.4 Analysis **8**

Description of the DDA project development and meetings 8

Process Analysis. 8

Change model development 9

Extracted learning 9

2.5 Governance **9**

2.6 Credibility Checks **9**

3 Overview of progress at 3 months *10*

3.1 Current online consultation uptake patterns **11**

3.2 An outline of the early staged change model **12**

3.3 The challenges and progress in implementing online consultation **13**

3.3.1 Connecting with drivers to engage 13

3.3.2 Generating collaborative working 15

3.3.3 Activating within practice engagement 17

3.3.4 Emerging strategies for change 19

3.3.5 Emerging Barriers to change 21

3.4.6 Strategies for supporting practices 21

5 Summary *23*

Executive Summary

Background

This evaluation was commissioned by the Devon STP as a component of the Devon Digital Accelerator project (DDA), to support the implementation and learning identification generated via the supported implementation of online consultation into Primary Care services. The aim of the project is to support change management in the member practices, towards the implementation and increased patient use of online consultation (with the option of an eHub trial) and to ultimately develop a blueprint for national spread. Towards this goal, the project is represented as the pilot stage of a spread model with aspirations to develop a blue-print that is both capable of supporting national spread. This is the first interim report at only 3 months into the initial 9-month funded period of implementation research and support.

Aims and scope

This report provides a qualitative evaluation of the first 3-months of the DDA. It identifies current progress and indicates the needed future direction in order to achieve the successful implementation and development of a spread model.

At this very early stage, all of this learning should be viewed as valuable for the DDA team and not yet ready for replication at scale.

Evaluation methodology

The approach involved detailed qualitative analysis of interviews and workshop discussions held during the early development of the DDA project. The process involved monthly meetings with practice representatives, weekly project planning meetings and regular direct interventions with practices including at practice support and coaching.

48 data sources were identified including 33 interviews, recordings and observation notes from DDA workshops. These were subjected to a rigorous qualitative analysis and psychological interpretation by field experts, applying thematic analysis of the development meetings, process analysis of interviews, change model development and extracted learning analysis. This was subject to rigorous qualitative analysis credibility checks and supported by descriptive quantitative analysis of patient uptake of online consultations.

Key findings

Findings needed to be interpreted cautiously, in line with the very early stage of the project. However, they demonstrated significant change in how people discussed engagement, clear identification of numerous possible engagement strategies and identification of relevant challenges that will need future development of solutions.

Use of online consultations is currently low, although significantly increased since the inception of the project. Strategies are in varying stages of initiation to impact on patient use, reflecting the different challenges of individual practices and/or networks.

A model of engagement with the project and motivation to implement was emergent, recognising 4 tentative stages for member practices:

1. Initiation and intention formation
2. Questioning engagement
3. Collaboration, Trust and Future Confidence
4. Engaging with the specifics of change.

These seemed to represent the differing ways that practice representatives themselves engaged with the project and their practices. This forms the early development of a potential change model to support spread, which will be given more focus as the project continues and data is collected.

Relationships between the project and individual practice challenges were complex. Six areas of central challenges and progress with implementation were dominant, representing the learning identified in the full report report. These include:

1. Connecting people with their drivers is effective in order to enhance motivation and engagement. Learning around this, on multiple levels, is represented.
2. Generating collaborative working via psychological consultation in the project enabled enhanced methods to be developed for collaboration; demonstrating psychological safety in the group being formed and strategies for maintaining this.
3. Activating within practice engagement was identified as a key shared need with a range of strategies suggested and the learning shared across teams.
4. Emerging strategies for change included around promotion of use, patient engagement, staff engagement, managerial / planning, access to DDA resources. These represents plans in action and the focus of learning into the next 3 months.
5. Emerging barriers to change were observed as plans were enacted included challenges with communication, power struggles and accessing opportunities. Again, learning and support in these areas are key objectives for the next 3 months.
6. Strategies for supporting practices. This includes the learning that is taking place in the context of provision of the UXC model of learning to understand not only the drivers, but where these were blocked by fear, logistics or capacity building needs, working in the spaces between the practicalities of project and the application of the innovation within people's daily working lives. The impact of this alongside project management support (CCG) and how they best integrate, is ongoing and central to the model.

Summary and future developments

- This is an early report and only able to provide an indication of some of the learning as relevant to Devon practices.
- This knowledge and the developmental use of these strategies are informing the development of a detailed spread model, over time.
- It is likely that this first pilot and evaluation will need to continue for up to a 24-month period (total time) to fully develop a spread capable implementation blueprint.
- The current intense psychological intervention, consultation and evidenced based revision of the process will continue in the next phase, in order to capture in detail how these planning stages are followed up within the implementation.

A full representation of the project method, learning, emerging models and evidence is provided in the report below.

1. Introduction and Background

This evaluation was commissioned by the Devon STP as a component of the Devon Digital Accelerator project (DDA), to support the implementation and learning identification generated via the supported implementation of online consultation (OC) into Primary Care services. The overall aims of the DDA include driving the use of online consultation within a selection of Plymouth GP practices and piloting a hub model to support outsourcing of triage capacity from struggling practices. The project is tasked to provide NHS England with a blueprint to support continued implementation nationally. The full outline of this project is provided in the accompanying Devon STP interim report and also the Project Initiation Document (PID) and so is not repeated here.

UXC Approach – Change Capable Teams

UXC provide a unique support package into implementation projects. This approach has emerged out of the concept that for innovation to be successfully implemented, teams need to be change capable. Change capable teams require specific skills and support, commonly recognised in the corporate world of innovation teams – including, team development, leadership coaching, implementation learning, data analysis, model generation and sustainability planning. These needs are not specific to the corporate world, but reflect both the needs and explicitly stated objectives of health innovation:

- identifying what learning takes place at regional levels to underpin the spread success of innovation across the NHS[1].
- top level initiatives to upskill teams to meet the challenge of digital innovation[2].
- a national staffing crisis in the NHS in terms of both recruitment and retention.
- supporting a culture of primary care change capability[3].
- The NHS long term plan[4].

To meet these areas of need UXC offer specialist support to teams and project managers in respect of their change management, leadership development, team development, project management, psychological safety and learning acceleration. This approach is informed by recognised health quality improvement methods (including Logic Modelling and PDSA cycles) alongside recognised approaches to multi-site learning sharing[5] and spread strategies[6].

To provide the above support package, these approaches have been modified and expanded upon with the integration of user experience methodologies, team interactions analysis, learning identification and extraction methods and theory informed system modelling approaches. The UXC group are experienced innovation leads with a focus on people development – we help teams to frame innovation challenges as catalysts for growth and success.

People first model of implementation

This project is introduced in recognition of the challenge of innovation implementation into healthcare settings and the added challenge of national spread of innovation success. Numerous accounts of local success failing at the point of national spread are common in the NHS and present the greatest threat to the hope that new innovations bring – this being that the 'how' of implementation does not get the same focus as the 'why' and 'what'. An eagerness to evaluate

[1] The spread challenge. The Health Foundation (2018)
[2] Preparing the healthcare workforce to deliver the digital future. The Topol Review. (2019).
[3] Digital First Primary Care, NHSE (2019)
[4] NHSE. The NHS Long Term Plan. (2019).
[5] The Breakthrough Series. Institute for Healthcare Improvement (2003)
[6] The Spread Academy, SW-AHSN.

success often suffocates the environment needed to nurture an innovative team culture, or stated more succinctly, “evaluation is the enemy of innovation”. To this end, the DDA project puts the project delivery itself under constant evaluative scrutiny, at the level of the project leadership, rather than the endeavours of the teams – using this scrutiny to rapidly adapt the model of support and encouraging a culture of change. Everyone is safe to try and failure is the learning needed to achieve success.

Lining expectations with reality – implementation rate

In respect to digital innovation, it is well evidenced that complex service interventions present significant challenges to implementation in active health services. Primary care represents a service that is nationally recognised to be under-resourced and over stretched. The opportunities provided by new innovations are hindered by the scale of challenge faced in stimulating service change in teams. This is often in the context of multiple innovation demands being placed on these teams. In the context of a concept of ‘team readiness’ to change, it can be difficult to see how these teams can be seen as capable, when current demand is constantly outstripping resource.

Health service implementation, in terms of primary care, has been evidenced as a slow process. Recent research in Devon (the ‘Connect’ project) has demonstrated that the implementation of numerous innovations into primary care typically took 24 months or more, independent of the function of the innovation. The challenges of awareness, will building and capability building within single teams are often significant and even disruptive to the daily functioning and coherent working of practice teams. Based on this awareness, particularly in the context of Devon practices, this project explicitly states that the learning model to support national online consultation implementation will likely take at least 24 months to capture the mixed experience of teams that are more and less ready and capable to support the implementation of a complex intervention. Modelling the spread of this learning being a further objective.

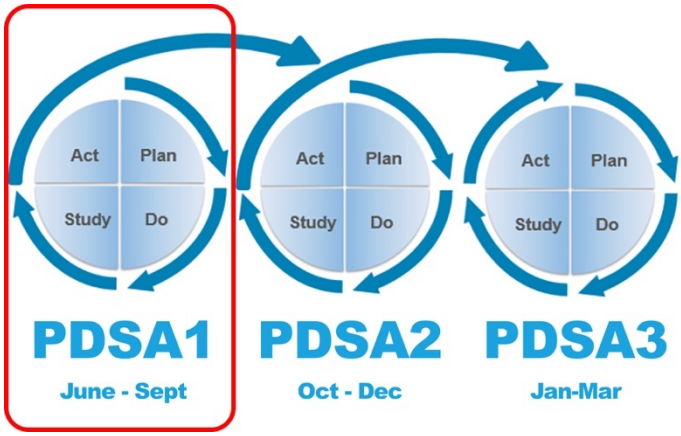
2 Overview of the evaluation

This report aims:

To produce a qualitative evaluation of the first 3 months of the pilot stage of a spread model for implementing online consultations.

This represents completion of the PDSA cycle 1, in a planned series of 3 cycles until March 2020 (see Figure 1):

Figure 1: Three planned PDSA cycles of the DDA project, currently planned.



This report identifies current progress (from PDSA1) and indicates the needed future direction in order to achieve the successful implementation and development of a spread model. It is the first interim report of the Devon Digital Accelerator (DDA) programme, covering June to September, 2019.

At this stage, the methods of support are provided at their most intense level with in-depth capture and analysis to discover where the impact points occur and what features of the model can be reduced or removed for the x5 to x10 expansion in year 2.

At this very early stage, all of this learning should be viewed as valuable for the DDA team and not yet ready for replication at scale

The intention is that we can review the progress of the learning, and then re-evaluate this at the completion of the project in March 2020.

2.2 Evaluation methodology

Design. A multi-method qualitative project was conducted. Data included interviews, meeting observations and usage reports of consultations.

Sampling Strategy. A purposive sampling approach was taken, to enable a broad spectrum of views, from practices and stakeholders, to be captured. 4 PCNs including 22 practices were represented within the sample along with the CCG project manager and regional CCIO. Selection was limited by staff availability.

Data Acquired

Quantitative – quantitative monitoring of online consultation patient usage was obtained. This data was available to practices involved.

Qualitative - Data included 48 distinct sources broken down to:

1) 33 interviews collected at 3 time points (average time 20-45 minutes)
2) 5 recordings from DDA meetings (whole day)
3) 10 observation and support documents from DDA meetings

Details of the practice member and project leadership team forming the DDA learning group are presented in Table 1. This included a total of 2,400 minutes of data that was transcribed.

Table 1: Participants list, by role, of the DDA learning team.

Role	Details
DDA practice representative	5x General Practitioners, 3x Practice Managers, 1x Chief Operating Officer, 1x Project Manager, 1 x Data quality & IT support
DDA Project Manager	Project Manager, Devon STP
Project Lead	General Practitioner and CCIO, Devon
Workshop and learning facilitation.	UXC, Director UXC, Research Assistant

2.3 Data Protection Governance

All interviews included audio informed consent, and each participant was offered the right to withdraw up to two weeks post the recording. Data was stored according to UXC's GDPR data processing protocol, more information relating to this can be found in the privacy terms on the website www.uxclinician.com.

2.4 Analysis

Quantitative data is reported as online consultation usage rates and is represented in the interim report and not here.

All qualitative data were analysed at 4 levels.

Description of the DDA project development and meetings.
Firstly, the project level meetings are described and observations from these are reported at each stage of the project (4 meetings included) in order to structure how the learning has been achieved over the duration of the project.

Process Analysis.
Using a form of thematic analysis, a detailed inductive analysis of process was conducted in order to understand how GP Practices and Networks were responding to and implementing change. The

analysis focused on strategies that were used, experiences described of the project, challenges to implementation and how progress was made. Analysis was conducted at 6 levels, based on 1268 codes.

Change model development
The change model was developed based on the major themes from the process analysis, and the major analytic foci that transacted the process analysis.

Extracted learning.
Themes related to future learning were extracted separately and analysed alongside researcher reflections in order to develop an 'oversight' of the learning for future projects.

The analysis was conducted by a professional team of psychologists skilled in the complex interpretation and aggregation of large data sets obtained in organisations; and involved the flexible integration of findings with organisational theory through a detailed abductive approach.

2.5 Governance

Detail of methods and audit trail is held by UXC. All analysis followed the rigorous protocols set out by UXC, using electronic software to facilitate reorganisation and building up of coding schedule.

2.6 Credibility Checks

Inter-rater reliability checks were conducted between 2 coders of 20% of the data. There was a high level of congruence. Differences were discussed. These related to naming of categories, identification of categories was the same. To enhance the learning, analysis included reflections on the UXC team's own responses to the data and psychological interpretation as appropriate. This was integrated into the analysis. Credibility was enhanced through weekly supervision of analysis, and tri-weekly data analysis sessions.

3 Overview of progress at 3 months

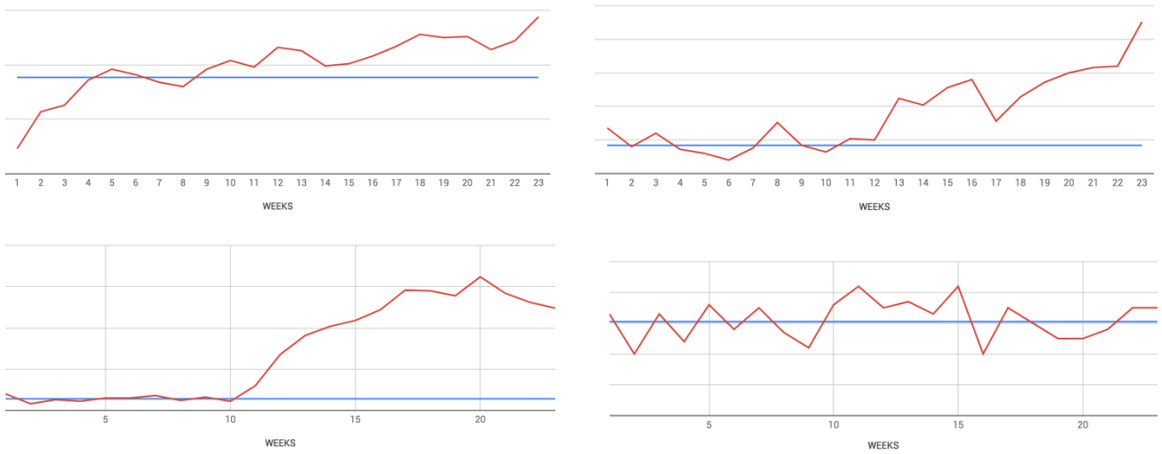
Assessing progress at 3 months enables us to identify some of the early learning that is relevant to this cohort of teams. 3 main areas of the findings are reported here. These are relevant to implementation in these Devon teams, and will guide the subsequent development of the implementation model (both locally, and for later transferability). These are:

1. Online consultation uptake patterns
2. Identification of early stages in the processes underpinning the implementation
3. Learning themes of challenges and progress in implementing online consultation

3.1 Current online consultation uptake patterns

Importantly, the member practices are at a very early stage in the project and patient use of online consultation does not yet serve as an evaluative variable for the DDA project as a whole. Rather, online consultation usage statistics are utilised as a feedback tool for practices to see the real world impact of their strategies on patient engagement. Teams and project leads have restricted access to a live dashboard similar to Figure 1 (numbers have been removed for this illustration), which informs all members on how activity in their PCN / practice is responding to their team based endeavours.

Figure 1: Run charts illustrating PCN online consultation rates over time (all labels removed), one graph represents one PCN.



This usage context helps to interpret the qualitative findings. Success for the practices is not framed around quantitative parameters but on extraction of learning around implementation that initially can be used in this project and subsequently can be replicated. The patterns illustrate that there engagement is increasing, but full implementation is still distant. Therefore the learning thus far refers to the engagement and set up stages of the implementation.

Performance in terms of online consultation activity is reported in the accompanying STP generated report.

3.2 An outline of the early staged change model

The DDA project has involved continuous evaluation and revision between each meeting, including analysis of participant interviews to tweak each workshop focus, support offerings and model pace. This being a bespoke project management approach that is reflexive around participant experience and need, rather than manualised.

Early mapping of the experience of the process of implementation highlights how a psychologically informed approach has led to enhanced engagement and to a position where more effective progress is possible in implementation. The group appear to have moved through 4 stages, which are important to capture as a future spread model will seek to create awareness of this process and the support needed to facilitate progression.

The current evidence indicates that these stages are accompanied by a range of different challenges and facilitators or emergent strategies that have been seen (reported in detail in the next section). A very brief introduction is provided here, to provide some transparency on the development of a spread model.

4 early stages of change:

Stage 1: Initiation and intention formation

This included discussion of issues such as consultation, both within and externally to the practice.

> *'I've just this morning had an hour and a half meeting with our patient participation group … to discuss it with them and get their feelings and so yeah we're signed up and ready to go live we-we're having … quite in depth discussions between a smaller steering group within the partnership about how hard or soft a launch to go with'*

Stage 2: Questioning engagement

The next observed stage was related to questioning of engagement – questioning whether this was really feasible and it feeling like a huge project. There also seemed to be a recognition of differing levels of engagement within and between practices:

> *'We honestly thought we were more joined up than we had been so it was a bit of a step back for us to realise that only three of the six were actually on board with this as much as we thought they were'*

Stage 3: Collaboration, trust and future confidence

The third stage has been a development of trust, collaboration and confidence within the project. People's approach to the project and meetings changed:

> *'it's encouraging this atmosphere where we can discuss and support'*

Stage 4: Engaging the specifics of change

This psychologically facilitated development seems to have been hugely significant in enabling people to engage more directly with the specific challenges facing them in order to establish successful implementation. Many of these specific challenges are set out in the next section, as the springboard for the next round of implementation. As the project develops, it will be possible to map the journey at all stages in greater detail.

3.3 The challenges and progress in implementing online consultation

This section details the learning gained to date, which falls into 5 areas of an emerging future blueprint:

1. Connecting with drivers to engage
2. Generating collaborative working
3. Activating within practice engagement
4. Emerging strategies for change
5. Emerging barriers to change
6. Strategies for supporting practices

3.3.1 Connecting with drivers to engage

The primary learning objective of project leads, at the inception of the project, was to understand the drivers for engagement within the DDA team and to build a project narrative that connects with practice, role and personal drivers for involvement.

Patient benefit was a strong driver, with people valuing the potential for the innovation to support access to services and the design of the software itself being perceived as well designed for the task.

'we're… under pressure for getting patients seen in a reasonable amount of time for a routine appointment and technology like this would allow us to at least reassure the patient of an outcome within a couple of days'

'I think that the tool is well generally well designed so I think it's intuitive enough for patients'

Beyond patient benefit, there was a sense of urgency for some teams who represented the project as less of a choice and more of a necessity.

'the current option is really un-sustainable'

'ideally if we could wait till February to roll all these out… and do a proper job on it … but with winter pressures I don't think we could last another winter under pressure'

This recognition of urgency was significant. Firstly, as urgency can be a powerful driver in change management processes[7] and is something to capitalise on in building sustainable will, a requirement for the spread of adoption. However, project leads also recognised that for some teams change was framed as a solution to a perceived risk of a breaking point. People disclosed experiences of pressure, fear, risk and panic, which were evidenced as an emotional state that required support – which the project provided.

Pre-interviews, ahead of the first project meeting, identified personal drivers from the future team members to be involved in a digital innovation project, to work with other teams, to plan better, learn from others and learn how to better implement change.

'I'd like to think managing change isn't my worst …area but there are always one or two team members that are more reluctant than other team members. It is learning how to manage those I think it would be great. If Plymouth could be on the map for something other than negative press, cause we've got terrible numbers of GPs and have bad general practices… and actually to have a nationally look at how we made it work and what we achieved'

[7] Beyond Performance 2.0. Keller & Schaninger (2019). Wiley

In response to the collection and analysis of drivers, the project was presented as an opportunity for people to receive support in facilitating the development of joined up working and provide an opportunity to develop a nationally replicable model of innovation for the NHS. Later, team members were observed to capture this and spread it back to their own teams, using it to facilitate engagement. The rationale for this was clearly described by one person:

'communication needs to instil in people working in the team that they are doing something exceptional and they are in the spotlight… they are gonna do some great good and they're gonna get appreciation'

Resistance. Engagement also met with resistance. It became clear, early in the project, that this implementation project was likely to present a significant culture change issue for teams and patients at the point of established ways of working, which would be highly resistant to change without a strong case for change:

'I think my generation of the thirty year olds… we weren't getting mobile phones 'til we were fourteen fifteen so this idea of what we can do now with technology is still novel for a significant portion of people and I think that creates a reluctance to sort of change from what's always been the case of, "I've always been able to call my GP and get an appointment why would I change that".

'with online consultations in general a lot of people are anti - online consultation so trying to get everyone on board …'

Teams needed support in meeting engagement challenges, including how to communicate and evidence supporting the case for change.

Others found that the term 'complexity' was an excuse not to engage:

'I'm still wary about how much people rely on complexity as a reason to not do things'

Or had recently experienced multiple team changes:

'we've had a lot of …senior management changes over the last kind of couple of months or like six weeks'

The in-depth enquiry of experience with each team, revealed that despite common themes, specific team support needs varied considerably.

Support seeking capability

NHSE and NHS Improvement recently listed GP practice responsibilities, in their July 2019 communications around digital first implementation. One of these responsibilities states that practices must, "review own capability (ask the CCG for help if needed)". It was interesting to observe, in the DDA project, that practices made specific reference to wanting support from the CCG, but showed difficulty in describing the support needed and/or an absence of processes to request this support. The awareness of this as a dichotomous position for many team members (stating need but not accessing stated support) was an early realisation that stimulated workshop activity around this. This represented an engagement issue that has been seen to be resolved through team sharing – reinforcing engagement. The value of this learning and the multi-faceted needs of teams, in enabling support seeking, is an evidenced requirement.

Learning going forwards

Extracted learning that has been positively described is provided below. These approaches are being carried forward into PDSA 2 and any spread opportunities, to support engaging practices into the implementation project:

- Have a clear list of implementation benefits for the specific practice, e.g to increase availability of services to patients; to match triaging with complexity.
- To ringfence time for meetings / workshops early on, to discuss interest and potential barriers.
- To identify possible resistances and strategies to manage these, e.g:
  Time difficulties might be addressed by considering the prioritisation of improved futures requiring more effort in the immediate term to relieve pressures.
  Engagement in technology - access to technology is often higher than people expect, with many older people now using apps such as Facebook.
- Realisation of the added value might force a review of current practices, to recognise gaps.
- Encourage people to reflect on work prioritisation and delegation.
- Address support seeking behaviours directly and with cross network experience sharing.
- Consider investing in coaching to facilitate change in working approaches.

3.3.2 Generating collaborative working

The project sought to facilitate an environment of Psychological Safety and shared learning as informed by change management, team development and quality improvement literatures and the team members' hopes and needs, as expressed above.

However, people did not arrive into the project in this way. There were expressions of cautiousness, suspicion and competitiveness around working with different practices and the CCG.

> *'there are lots of different personalities in the team and my concern is that people will come to be to be part of the team but also sometimes have an ulterior motive. This project is offering funding and support, but what it gives away is the intention that an individual or a group of people might get [from] doing something transformational. So I was a little bit concerned that some of the characters in there might be along for the ride but not really fully committed'*

> *'the challenge for us is in getting that teamwork, learning to trust each other really'*

> *'I've been on other projects before where we've gone in as 2 different groups.. and then the CCG have just turned around and given it to one of the other groups, and then it just makes it very resentful. They end up being the ones that get picked and piloted and then you think, "hang on, why couldn't we do it as all of us"…'*

The project delivery team focused a great deal of energy into supporting change in this area – utilising the interviews with each member to better understand the individual and collective mindset of the group and gaps in experience or formulation capacity around how a Psychological Space is accessed. Utilising Gestalt informed organisational development and team coaching methods, a range of team facilitation approaches were designed into each monthly workshop with support of the insights created by the data analysis, project manager and UXC. UXC served as lead facilitator of all project workshops, to support this primary aim for safety through psychological facilitation.

The reported experience of the team was observed to be transformed rapidly across the 3-months, with team members arriving at describing the project, positively,

'it's encouraging this atmosphere where we can discuss and support'

and

'…actually have that safety of coming up with things that may potentially not work'

As time progressed, team members described being motivated by taking a new approach to creating change, stripping away roles and working together on an equal footing to create momentum and shared engagement. This presented challenges in the workshops, which often required Psychological support – as defences, competitiveness and outcome driven behaviours are common in implementation projects and required a nurturing environment to transform into innovative teaming.

This began tentatively, where people started to recognise parameters;

'so it's a much more task orientated session I think there was much greater clarity of the scope the reporting the responsibilities of individuals, networks and of the organisers actually so that was a good conversations so then we could understand the parameters in which we're working'

and later seemed to extend into more psychological spaces:

'when I raise up in the [workshop] that emotion of being under pressure and what that might feel like in terms of self-esteem and challenge - your coping strategies perhaps was revealed and you all switched into doing problem solving mode'

'…that sort of sense of psychological safety has been immense in helping me sort of put forth views on the day'

The creation of a psychologically safe environment for innovation is repeatedly evidenced as a requirement in health and corporate settings. The DDA project has learned how to foster this rapidly and is undertaking analysis to focus in better on areas of the model that can be reduced further, to support spread. In the context of this, it was witnessed that numerous team members expressed that they had not felt safety of this type in their previous working career. These statements are increasingly frequent and often carry a sense of alarm ,as team members are recognising the contrast between this new feeling of safety and the pressure of work which is sometimes expressed as a risky way of working:

'I was driving here today thinking I need to do something to get my self-esteem back up again because I feel that everything I do is not quite good enough at the moment because you're up against the patients you're up against you know colleagues and staff doing stuff and saying - so you know for me to have something that gives you that actually you're doing a really cracking job that doesn't come from anywhere does it'

'I'm always happy to be here, as it feels like an island of calm reflection in a rather stormy sea around… because I find that during the week there are so many competing demands that completely carry you away. At the end of each day I feel like I couldn't do several things I needed to do and that is quite unsatisfactory. But that has been the case for a long long time. So I'm happy to be in an actually protected place where you can think and talk.'

'I feel quite tired generally because work is really relentless and difficult… increasingly I really look forward to these sessions… it's the only area of my life at the minute where I can focus on one thing at a time.. everything else is… constant bombardment of tasks in all directions with very little control.'

'we are being asked to multi-task to such a level that all creativity is stifled completely… we have got to a way of working that feels unsafe. It takes stepping out into a project like this to realise that work doesn't have to be like that. A project like this… can feel safe and doable. '

In response to this, numerous team members have asked for additional coaching from UXC on a 1 to 1 basis. 9 of the 13 team members have requested this support, which the CCG has agreed to fund for 6 months. Learning is a continued goal in this offering and UXC will explore with team members the respective impact and spread potential for staff in the future. It cannot be ignored that the success of making staff feel safe in one space can raise an awareness of feeling unsafe other areas, where insight may be lacking.

3.3.3 Activating within practice engagement

The team had limited clarity on the project on arrival. They spoke in terms of what they 'thought' the project was about, but with no definitive clarity for how to get there.

'I think it's our aim is to be able to use er digital er well to digitalise the practice well and the practices across where we work'

People were able to articulate drivers, and even urgency, but there were difficulties in identifying how to start. Indeed, 45 rationales for why teams could not initiate a change management programme were identified in pre-interviews (before the teams attended the first workshop). Teams had many questions and these seemed to prevent even imagination that practices could engage in change implementation. Some examples of resistance include:

'because obviously …with everything else and the new contracts and everything as well you're being pulled in all directions.'

The project witnessed a sustained shift in practice level project planning and DDA team reflections towards clinician engagement. As extrapolated in recognised change management models, the team component of change management was surfacing as an area of need despite a recognised acceptance in DDA meetings that the solution would bring value in a context of urgency. The team component in this case being mostly referenced as the GP partners in each practice or network; and the broader team if the partners had formed agreement to go ahead.

It was observed here how the impact of a message of 'urgency' can be stimulating in change management projects:

'we've got an agreement from the partners to go with this because it was the only solution on the table that would work'

For others, it was seen that access to partner meetings was challenging and/or the structure of their hosting PCN did not offer opportunities for single board decisions that directed the activity of member practices.

'…we honestly thought we were more joined up than we had been, so it was a bit of a step back for us to realise that actually only three of the six were actually on board with this as much as we thought they were'

In all contexts, it was seen that DDA team members were working to improve communication in multiple ways, particularly ensuring this was a 'good news story' and did not become bad news; and engaging in methods of considering how to reduce 'risk', that is, of excluding people, or missing major healthcare concerns. Engagement in this context was observed to be multi-faceted in terms of stating

the need and communicating what work had been done to reduce risk and present a strong message of a solution.

'we need to make sure we're not souring you know creating a bad news story'

The project learned that the online consultation review process was helpful for some, as it led some practices to realise that they are offering more appointments than would be expected, a self recognition of how over worked they are:

'we didn't realise that until eConsult sort of prompted us to say, "you know are you actually meeting, actually doing your capacity" And so without realise-realising it we've pushed ourselves beyond what is expected and because of this negative PR and demand … but actually we're going above and beyond and we're still being asked to do more'

It is not uncommon for implementation efforts to generate engagement, as the outcomes of change spread within teams. There is some observation of this, as above, in distinct practices. As time progresses, it is expected that this will occur between and within practices in the DDA project.

There is evidence that this process is in effect. Some DDA team members have already reported how they are approaching change management, crisis management and team working differently in their practice both as a consequence of new approaches introduced in the workshops and as a consequence of wanting to create similar reflective space for themselves and their teams.

'it also made me think within my own team … what people's values are and what is important and it's been it's been quite huge as it brought stuff not just to the project, it's brought stuff to my own team which I didn't expect that to do… so yeah that for me was quite an eye opener to be honest'

The facilitation of psychological safety and reflective spaces, in practices, can potentially increase engagement and the change capability of teams. Future analysis will reveal the success of spread in this area.

Learning to take forward

A range of effective practice engagement strategies have been extracted, listed here. These are cautiously presented here. They may be useful for informing other teams who are planning engagement activities. However, their generalisability and long term effects have not yet fully been explored, given the early stage of this report.

- If there is an opportunity to discuss successful intervention with others, take it.
- Clarify that implementation can be done at the pace of the practice.
- Ensure that specific time for online consultations is in the work plan.
- Consider soft (partial use) versus full implementation. Some used it initially just for fit notes, for example, allowing longer adjustment time.
- Emphasise the advantages of online consultation – such as time saving and increased collaboration between different professionals (pharmacists, phlebotomists, etc).
- Produce a list of FAQs for clinicians.
- Notice clinicians who are particularly interested. Support and encourage them. Give opportunities for them to lead on parts of project delivery. Involvement is known to increase job satisfaction and engagement of individuals and to increase spread to peers.

3.3.4 Emerging strategies for change

The project has provided substantial support to practices around project planning at the level of each practice and/or network. This intense work has led to a range of helpful strategies emerging across a range of activity categories and change management themes, between groups. These are summarised in Table 1.

Again, interpretation is cautious at this stage. Currently, these strategies represent how learning needs of participating practices are being met. Relationships have not yet been established between strategies and performance. Only preliminary evidence is currently available. Table 2 offers a reference, not supported for dissemination into implementation projects, unless to inform exploratory activity.

Table 2: Summarised current emergent practice level strategies for implementation in the DDA network.

Category	Strategy
Promotion specific	• 'Online Consultation Champion' role in own practice (non-clinical staff member) • Promoting champion role across network • 'Clinical Champion' to engage resistant GPs
Patient engagement	• Leaflets on reception (plus accessible leaflets for non-readers) • Website – banners, information as on leaflets • In house technology – tablets • Floor walkers – demonstrate to patients • PPG supporting in waiting rooms- demonstrating to other patients • Using flu clinic as a captive audience for a demonstration • Consider other media strategies for publicity and increased awareness. • Consider whether the admin staff could support online consultations for patients in different ways • Discussion of information with patients, to develop an information form from a patients perspective
Staff engagement	• Training – roll out to all staff Half day training for all Demonstrate what it will look like and how they will interact with patients • Working through clinical cases with other staff in eConsult • Create a list of benefits For GPs *and* others in the practice – reception team / managers • Presentation to PCN board – share learning from project • Create a practice / PCN specific strap line • Discussion in meetings, putting online consultation on the big screen to talk through it together • Focus on the project itself rather than the innovation – onus on digital acceleration and learning • Engage GPs specifically; give them the confidence that things can be changed, trust in the accelerators, feel comfortable with reasons behind the project
Managerial / planning	• Channel demand to online consultation as a separate avenue for patients

	• Channel demand to online consultation by blocking other access routes for some issues • Ringfence appointments for OC • Identify top ten patient requests and link to OC • Using the receptionists to manage the flow of online consultation (to GPs) • Using other staff e.g. nurse practitioners to answer online consultation • Created a clear policy for reception – being a test patient, ensuring patient satisfaction with the online consultation process • Process Mapping – how online consultation will be accessed by patients how all elements will other system elements will interact • Identify clear roles within the practice (with realistic expectations on the limits of each role): o Technical implementation o Being a digital champion – bringing the ideas into the practice o Gaining clinical and / or partner level engagement o Having a clinical champion
DDA resources to access	• Funding for protected time– outside of DDA workshops. • Funding for kit – iPad / tablets • Project manager expertise- for advice, help, removal of blockers • Coaching

Strategies for implementation described included '*battening down the hatches'* to enable change to happen, and '*sort of letting it happen organically*'. This organic approach involved not being too prescribed, but rather letting things unfold within practice teams. Organic approaches can be difficult for project management models that prescribe early evaluation, as the picture becomes complex, but they enable greater creativity and problem solving. For example, for people to learn more about themselves, and how they could best affect change in their teams.

> *"… part of this is about me. I'm normally a quite controlling person in terms of my personality. So for me this project has been about letting … go of control and trusting other people to .. deliver all the stuff … … so I left the last meeting feeling quite confident that those people were capable of delivering the vision that we sort of set out sort of the vision that came from me'*

A developmental approach has therefore created transformational spaces for some.

The key learning for maintaining this approach and supporting emergent strategies and learning is informed by what the teams did in the context of this project. This includes:

1) Access support from experts when needed.
2) Develop an organic approach to implementation
3) Ensure effective support for own teams through facilitation
4) Access support for back fill where appropriate.

Learning going forwards is related to how to activate these approaches in teams, rapidly, and how to maintain them. As the project continues we will monitor the relative value of the strategies listed in Table 1, to develop clearer evidence towards an effective spreadable blueprint.

3.3.5 Emerging Barriers to change

As the DDA team are engaging with the specifics of change, moving towards implementation, multiple barriers to implementation and factors creating friction in delivery are being identified. These range across capacity, staff illness, burnout, communication, patient involvement, patient awareness and practice based project management approaches.

People talk about struggling to access available resources:

'we've not been really very good at taking up the offer of doing additional stuff'

'getting people together is a nightmare'

'our biggest thing is that getting that information out to patients raising the profile of eConsultation as an alternative to sitting in a telephone queue'

and they discuss the importance of recognising differences between practices and networks, which will subsequently be explored further as the programme develops:

'but we're very different'

At this point, it serves the project to recognise these are emerging themes of need that reflect the ongoing challenge of primary care that online consultation seeks to support. The DDA accelerator therefore plans to stimulate shared reflection and learning within the team, on these barriers. It will be key to the success of the spread model to identify how teams solve these problems as implementation progresses and what support they need to achieve this, if any.

3.4.6 Strategies for supporting practices

The project management aspiration of DDA is to connect the delivery method with the personal and professional drivers of the team members. Their engagement is central in creating a willingness to participate in full, in a project that promotes implementation, shared learning, openness and varied support offerings. The project's provision of the UXC model of learning – a continuous cycle of interview, analysis, reflection and project design - represents a monthly PDSA cycle for the project management team that has proved invaluable in understanding not only the drivers but where these drivers were blocked by fear, logistics or capacity building needs.

The project PDSA cycle has informed learning on which project planning model to use and how open to make the group to visitors or co-facilitators, both of which showed significant potential to disrupt the safety and congruence of the group.

P1: 'I think in all fairness, if you look at the feedback… you almost lost us at that point…
P2: and it was a happy accident that we came back to this place where we are all safe

The project has shown success in creating a psychologically safe space for the DDA team, in the context of urgent need and perceived risk. Learning around how to best support their planning has demonstrated an ability to generate meaningful goal setting and capacity building around project planning and delivery.

'when I've spoken to people and the others speak about it as well who are involved it's always very positive'

'at the time it just made you come out with what you're thinking and other people are thinking about ways, and I think that worked very well. It was interesting to see some of the issues other people had and actually be able to help and maybe give some suggestions that maybe will not work with them but … I think … that was the value in that … so it's the openness of it all'

'I did like the smaller group working with people that … aren't necessarily in your PCN, because sometimes you get stuck in your own issues and it was quite nice to have other views to write comments on, and explain those out further… I like that part'

Ongoing learning is capturing the extent of project management, resource and financial support needed by practices to deliver on their plans and overcome practice specific challenges. Tracking the quality and quantity of this input is ongoing and, as indicated, organic in nature. At this stage, support has been substantial for most teams. Future analysis will reveal the areas of impact and aid in providing a refined understanding of the resource requirement for implementation success.

5 Summary

In overview, this is the first interim report from the Devon Digital Accelerator Project, which has now been running since May 2019, with the first 3-month PDSA cycle starting in June 2019. The project is an ambitious attempt to engage GP practices and networks with online consultation across 4 Plymouth based PCNs, towards piloting an eHub. This project, aiming at national implementation impact, intends to develop a model of change intervention that can accommodate a spread approach to impact.

The main learning is that it is helpful to have a flexible support system for practices and representatives, and we have developed a learning support focused PDSA model to accommodate this. This is based on psychological principles in order to capture the development and engagement that is often the greatest challenge within innovation projects.

At this early stage, we have already begun to map the pre-implementation phase of change. We find that the development of a psychologically safe space in order to ensure that all of the detailed challenges of change can be addressed, is particularly important. We have seen people go through the following stages, which are each accompanied by different challenges that facilitators might want to focus on within supporting groups. These are:

1. Initiation and intention formation
2. Questioning engagement
3. Collaboration, Trust and Future Confidence
4. Engaging the specifics of change.

Subsequent reports will further evaluate and evidence the impact points within this model in order to track the process of innovation, and produce a map that can be applied at larger scale. We hope that the second report will capture the initiation of implementation in detail for some practices, and that the final report will capture how this is then sustained into longer term engagement. This is stated in the context of knowing that implementation in 9 months is unlikely for most and timescales will require expansion if a fully represented model is to be achieved.

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