

Co-design Partners in Care case study

Doing things better so you feel better (Travis Medical Centre/Pegasus PHO)

Reducing the progression of mental illness, thus improving a person's future health, community participation and socioeconomic outcomes by considering what can be done differently within the context of the service delivered in a general practice surgery.

Context

The clinical need for mental health services across the system, which has continued to escalate since the 2011 earthquakes, cannot be met by existing services. This project explores ways to enhance the service offered in a general practice surgery by incorporating more of a consumer perspective. The primary mental health service Brief Intervention Counselling (BIC), community-based non-governmental organisation (NGO) providers, and the district health board (DHB)-level specialist services are all underpinned by an agreed system-wide outcomes framework. General practice based teams may be able to create a better experience and better utilise existing funding and other resources by trying a different approach.

Aim

Our project aimed to:

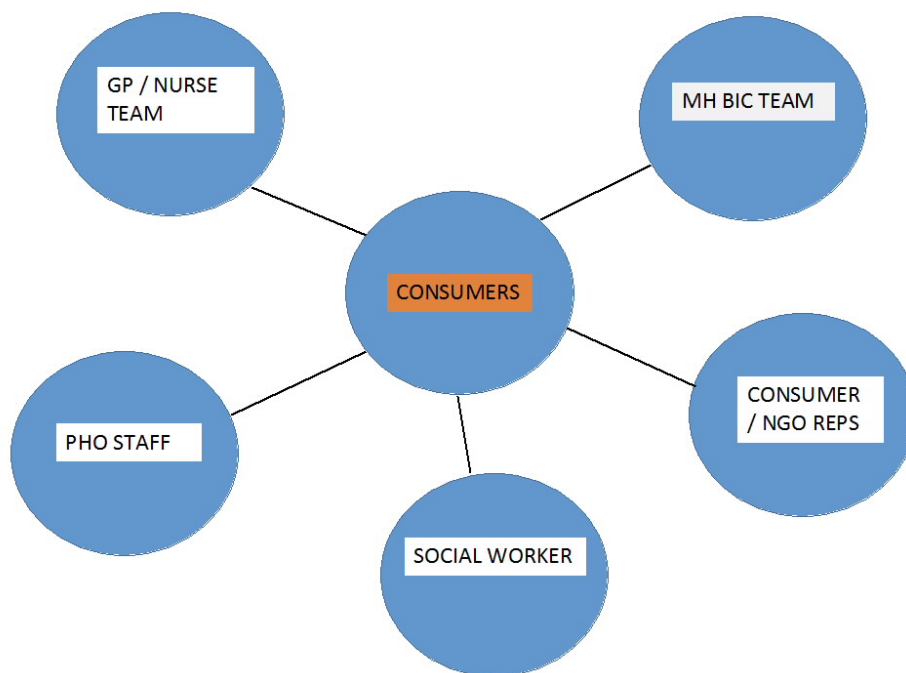
- better understand the experiences of patients who have been referred but do not attend counselling within mental health services
- apply a co-design approach to ensuring that the general practice-based service is timely, cost-effective and best suited to the needs of people who present to general practice with psychological distress.

Start up

Faced with challenges of system-wide resource constraints, change fatigue amongst clinicians, and a growing demand for services, we were seeking a fresh approach, embedded in a consumer perspective, with its foundations in evidence-based practice.

There had already been specific local interest in the Auckland-based 'Closing the loop' pilot service. This offers Focused Acceptance & Commitment Therapy (FACT) in a stepped approach to mental health care delivery in general practice settings. It involves innovative roles for health improvement and health coaching. The team was willing to explore how this could be the next step of an already established model of integrated care delivery in the practice. There have also been previous, but stalled, attempts to introduce more patient/consumer involvement in various other service innovations at the surgery. The co-design project provided an opportunity to bring these to the fore.

Figure 1: Project contributors



The project team consumer members were invited on the basis of their personal experience of accessing mental health support from both general practice and specialist services. In addition to their 'lived experience', their contribution included making phone calls to survey participants, commenting on findings and service improvement recommendations, and attending webinars, workshops, team meetings and provider–stakeholder–staff meetings. Consumers agreed to sign a confidentiality form which meant they could confidently declare to potential survey respondents that any information they shared would remain confidential. This was a respectful way to build confidence and emphasise the value being placed on both consumer and provider perspectives, even though the results were being anonymised. In an attempt to address the potential of power imbalance within the team, all members shared their own realities of being influenced by personal and professional experiences of the challenges around mental health service delivery.

We identified people who had been referred by the general practice team to the primary health organisation (PHO)-funded BIC service between January and October 2018 to explore their experience, regardless of whether they engaged with the counselling service or not. The project was underpinned by a set of principles that had been developed by staff and consumers in other co-design projects. These include:

- partnership between those providing a service and those utilising that service
- mutual respect based on agreed purpose and safe engagement
- teamwork which recognises all perspectives
- ensuring safety for all involved relating to information and future service parameters and processes
- adding value at individual, team and system levels
- being true to the agreed goals, processes and outcomes.

The primary care patient experience survey is a national three-monthly online survey which gathers feedback from patients enrolled with participating general practices. It provides a comparison between DHBs and national data, which relates to patients' care between their general practice, diagnostic services, specialists and hospital experiences to inform service improvements. We incorporated the primary care patient experience survey domains of communication, coordination, partnership, and physical and emotional needs to also guide our work.

Engage

In order to help stakeholders understand what the project involved, we developed an 'elevator pitch' as a short narrative about the project to engage and help people understand the reason for the work and how they might contribute.

Senior project leader support was negotiated, which led to the dedicated involvement of a data analyst and secured 'buy-in' from other stakeholders. Background information to the project was outlined at practice team meetings. We personally invited consumers to be involved in the project based on recommendations from general practice team clinicians.

There were 160 patients referred from the practice to the primary care based BIC service between January and October 2018, and these were the people we were keen to contact to explore their experiences of the service. They were contacted by telephone and invited to contribute to an initial 10-question online survey, which was returned as an anonymous response. Initially, this survey was developed by staff members of the project team. The consumer members of the team then helped to refine the survey questions, which was invaluable.

Calls were made at various times of day, in acknowledgment of people's busy lives. Calls made at weekends were appreciated by consumers, who commented about the indication of how much their input was being valued. Consumers could contribute by email, using SurveyMonkey, posted paper-based survey with reply paid envelope, or face-to-face discussion at the surgery or at home. Based on the advice of the project team consumer members, a clear relationship with the person's doctor was emphasised in the introductory call, which was based on an agreed script 'elevator pitch'.

We recognised that some people have reduced literacy skills and offered help for them with completing the survey as we valued their contribution. We did make sure these participants were aware that the person helping them would maintain confidentiality at all times.

Keeping the social and psychological barriers for this cohort front-of-mind, we used three approaches to data capture. We began with this anonymously returned survey, followed by an opportunity to contribute further through a more in-depth, one-on-one conversation with one of the project team and to complete a specific experience survey about emotional impact.

We discussed the potential of triggering an emotional response from the people we are engaging with, due to the nature of mental health illness. As well as offering Helpline numbers if indicated, we agreed to be prepared with safety-focused, de-escalating responses, such as:

- You sound upset and I am sorry if my call has caused that.
- Do you want to speak to your doctor or one of the nurses?
- When is a good time for you?

Early advice from the project team consumers changed the projects teams assumptions about what would comprise potential service improvements.

The project leader maintained engagement and cohesion of the project team members together with relevant stakeholder-advisors by providing regular updates and loading documents onto a shared platform.

Capture

We used three different capture methods:

- a survey that explored the overall process of the patient presentation with emotional distress at a general practice surgery and the subsequent referral to counselling
- a self-assessed experiential rating scale survey that focused on emotional responses/how they felt at each stage of their care journey

- one-to-one conversations directed by key questions, based on input from consumers who were part of the project team, which explored participants' experiences more deeply and sought ideas to inform potential service improvements.

The 10-question survey, which focused on the process of care that patients went through, was loaded onto the SurveyMonkey platform and linked to a template email message. A master copy of a paper version was also used for people who preferred to have it posted. It ended with a section providing clinical 'safety netting' in case of ongoing distress or need to access urgent support, and an explicit 'thank you' message.

A roster of project team members who committed to ringing consumers was loaded (along with project-related documents) onto Google Docs for shared access. The consumers in the project team were also part of the roster as it was recognised that some respondents may be happier to speak to another consumer rather than a provider. Consumers on the project team all signed a confidentiality agreement prior to contacting any patients.

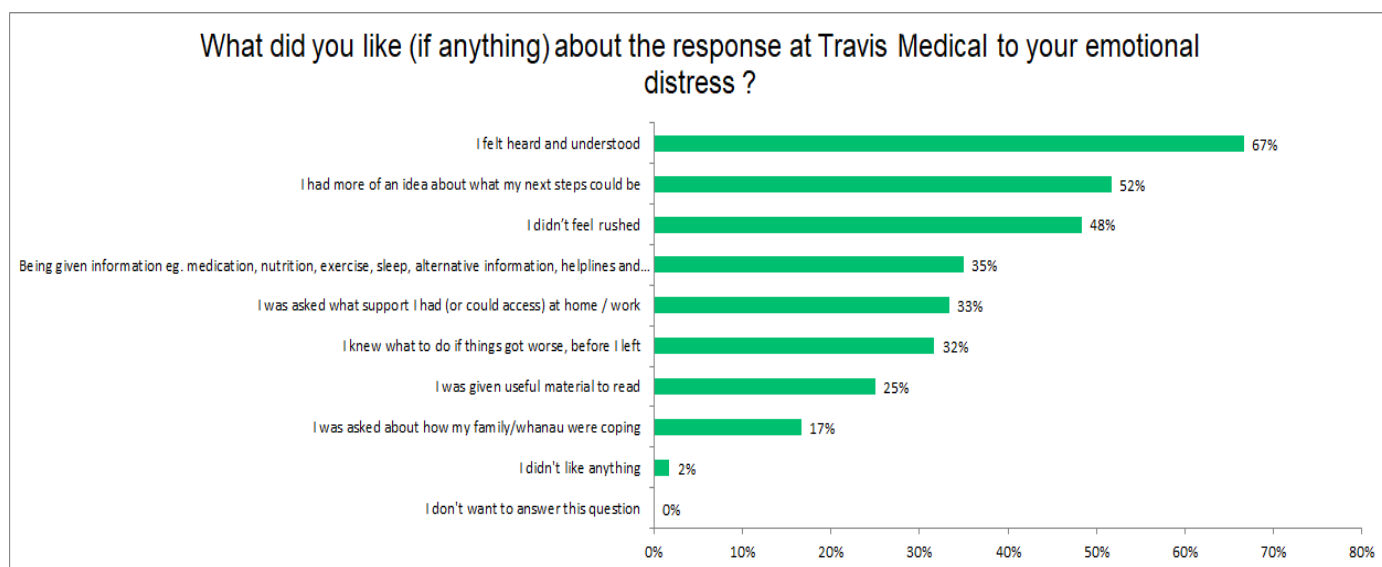
Of the cohort of 160 patients who were referred to the BIC service, we were able to contact 100 people over a 23-hour period. We did reflect on the point that the 60 people we were unable to contact may have been the most 'in need' group, and this means their experiences were not captured and did not form part of our learning within this project. Of the 100 people contacted, 99 agreed to complete the survey, and 60 returned completed surveys.

A second online survey exploring how patients felt as they went through each step of the process was completed by 17 of the 40 people who initially agreed to contribute. This aimed to elicit the emotional impact of the service processes on consumers, thus adding depth to the broader perspective gained from the initial survey.

Understand

From the 10-question survey, as well as gaining understanding about what could be better, we learned that there were things that participants liked about the practice's response to their emotional distress. For example, 65 percent of the 60 people who returned the survey felt 'heard and understood', and while there is a desire to improve, it is also helpful to understand that some needs had been adequately met.

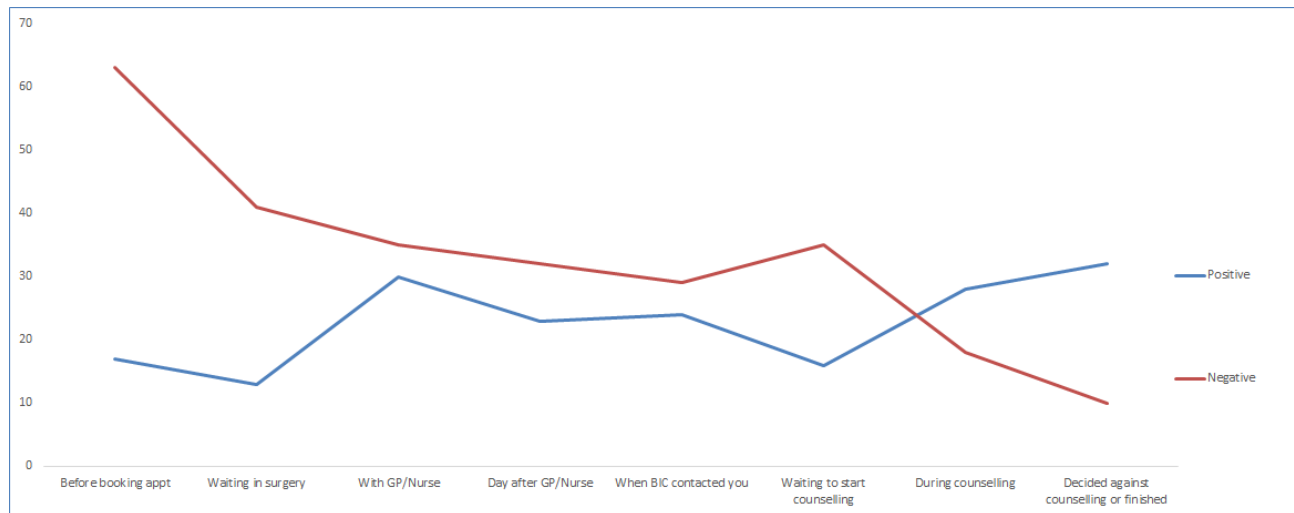
Figure 2: Patient responses to how the medical centre managed their emotional distress before changes



The experience survey was a more in-depth consideration of the step-by-step emotional impact of the experience from initial consultation to eventual access to specialist counselling.

Responses from the experience survey indicated an increase in negative emotions whilst waiting for counselling to start.

Figure 3: An illustration of the increase in negative experiences and decrease in positive experiences while the patient awaits their counselling appointment.



Consumers provided ongoing guidance that helped to develop a framework for the subsequent one-to-one conversation to obtain deeper and broader perspectives, to inform potential service improvements. From those who offered to contribute further, four people, ranging in gender, age and response to the counselling experience, were chosen.

The framework of ‘conversation-prompting’ questions was initially trialled with consumer project team members to identify any difficulties. After discussion, it was decided that consistency would be enhanced by this interview being performed by one team member. Recording the conversations aimed to minimise ‘interviewer bias’ when analysed.

Just two of the four face-to-face interviews were undertaken, as the other two patients did not respond to the calls and messages asking them to contact us, if they were still happy to take part in the interviews. The two one-on-one interviews highlighted that the care journey they experience is very personal, so the response needs to be personalised when they present with mental distress, and it is important that they are provided with an array of options to consider.

The involvement of consumers, both as project team members and participants, has provided broader perspectives than we would have achieved if we had only worked with providers, and the variation in suggestions offered reminded us that there is no universal way to meet everyone’s needs. However, there were some points that did resonate with everyone – for example, when communicating through any means, we need to pay attention to using language in a way to maximise understanding by as many people as possible.

The insight into the emotional impact of the consumer experience was really helpful. We noted that at each ‘touchpoint’ or interaction, either with a general practitioner (GP), nurse, or counsellor, there was a positive emotional response from the consumer. During gaps in contact with these service providers, we saw negative emotional responses. As a snapshot these responses on the experience survey do not provide insight into the degree to which the more positive emotion is sustained over time. Previous routine data collection processes have not tracked this, waiting instead for the return of symptoms to prompt a subsequent presentation.

Key points of learning, at this stage, include the following.

- The main positive aspects of the consumer's experience during the care journey were that they felt listened to and supported at the points of contact with either a GP/nurse or counsellor.
- The main negative emotions experienced throughout the care journey were related to feeling nervous and sad.
- Only 20 percent of consumers felt they were given good information about the counselling service, and at the time of the GP/nurse appointment they weren't given useful information or didn't know what to do if their emotional distress deteriorated.
- During the lengthy wait for counselling, some of the diverse reasons given by patients for not attending counselling sessions were 'getting better by themselves' (17%), 'the wait was too long' (15%), 'the emotional distress itself stopped me' (8%), 'got help elsewhere' (8%), and 'the input from doctor/nurse was enough' (7%). Other reasons given less frequently were 'life got too complicated', 'it was too hard to get there', 'it was the wrong time of day', 'I was too nervous', and 'poor interpersonal fit with the counselling person'.

Improve phase

In response to the ideas captured from the project so far, three service improvement elements have been selected to start with.

It was agreed to:

a) **Ensure up-to-date contact details are on both the patient management system and therefore the referral documentation**

In recognition of discovering that one third of our referrals had been sent with incorrect contact details on the system, all clinicians referring to BIC agreed to check with the patient that details are up to date. In addition, the patient's phone number and any preference they had about the best time for the BIC service to contact them, as well details of an alternate person who can be contacted, was to be included on the referral form along with details of their agreed personalised action plan. This more clearly indicates to the counselling service the content of their discussion with the referrer, demonstrating connection and continuity between providers.

b) **Provide greater support at the general practice surgery**

Patients being referred for counselling were given an information package, collated in consultation with consumer project team members and agreed by the surgery-based stakeholders, along with an individualised action plan. To date, we have identified that 35 percent of patients have received the information pack, and we are working towards increasing that figure to 65 percent in the next 12 weeks. We will also survey people who have been provided with the pack about their experience of it – for example, what was helpful, was there anything that was not helpful, what is missing and so on. The specialist BIC team were advised of the new material so that they knew what had been provided at the time of their surgery-based consultation and that it would form part of the 'measure' phase of the project.

c) **Make follow-up phone calls**

In an attempt to address the downward trend of negative emotional responses captured during the period between the surgery consultation and starting counselling, it was agreed that a follow-up phone call was to be made by the practice team to referred patients after a week.

Measurement of improvements

A weekly list of referrals provided by the data analyst comprised 30 patients over a 4-week period. This was used to capture and measure our improvements.

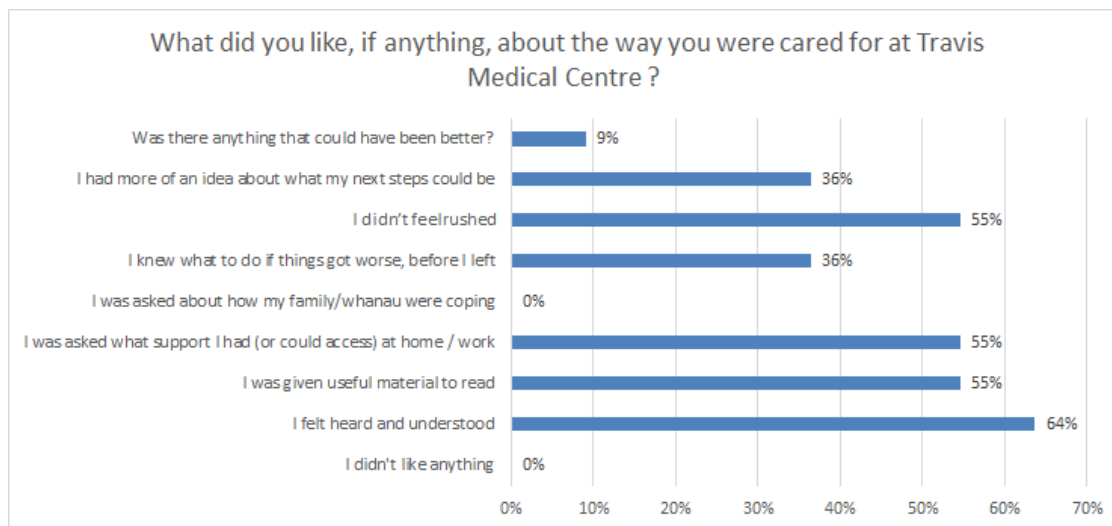
a) Contact details

Of the 30 patients, 24 received the resource information pack and were phoned after one week using their contact details, which had been checked. Having improved the accuracy of contact details should also lead to more success for the support services' attempts to make contact with the patient for counselling input.

b) Survey responses

Those contacted were invited to complete an 18-question online survey. The questions were similar to the initial survey, with questions added about the resource information pack and follow-up phone call. In an attempt to improve uptake, this survey also incorporated the previously used 'experience questionnaire' about emotional responses. Eleven patients returned completed surveys within the short timeframe of only 5 days.

Figure 4: Patient responses to how they were cared for at Travis medical post changes



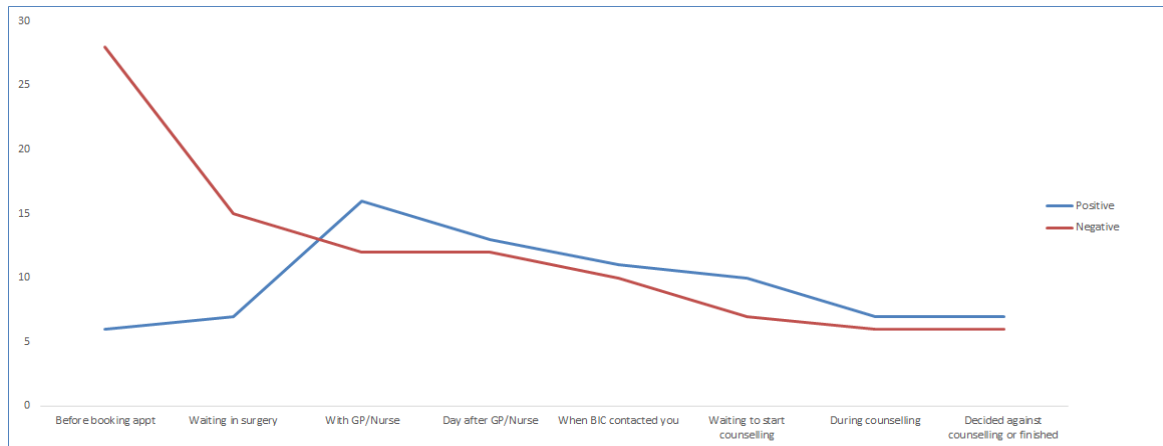
We were delighted to see that 8 of the 11 respondents (73 percent) felt their 'emotional distress was responded to' and 'felt involved in the decision to be referred for counselling'. While 45 percent (5) felt they were 'given good information about the referral', 18 percent (2) said that they were 'not really sure about what was being offered'. This is an aspect for further consideration.

The aspiration to improve the provision of an information pack to patients at the initial consultation from the original 35 percent to 65 percent after 3 months has been exceeded by reaching 80 percent after 1 month. In terms of value, 82 percent (9) said they received 'just the right amount of information', and 18 percent (2) said it was 'too much information'. There was an increase in those who felt 'the information was useful', from 25 percent in the first survey to 55 percent in the subsequent survey. There is now an intention to also use the information pack as a health literacy tool for self-help for consultations that do not necessarily require a referral to counselling, as well as offering it to other practices across the local primary care network.

c) Follow-up phone calls

The follow-up calls to patients did not refer to the service improvement project per se. The calls were made to check on their wellbeing, as the intended ongoing service standard.

Figure 5: Patients experiences along their journey post changes to service

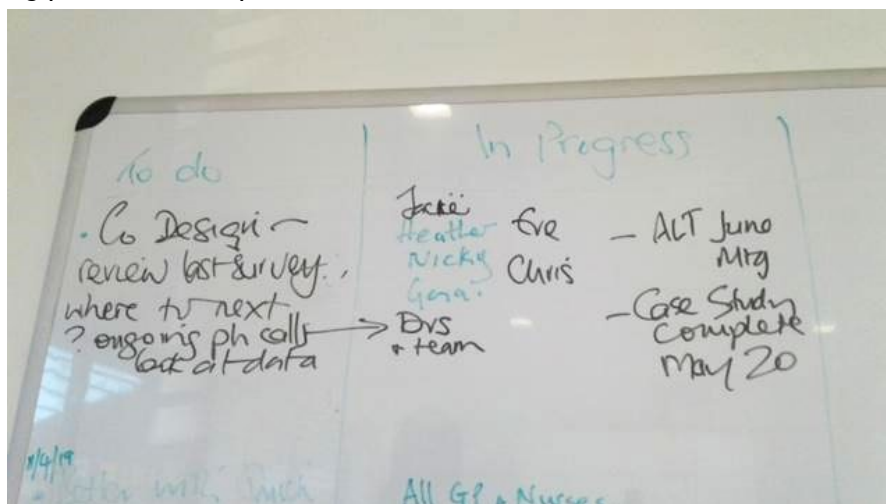


Even with a small number of responses (11), it was heartening to see the improvement on the previous survey responses, relating to the impact of the follow-up phone call at one week post-referral, showing a decrease in negative emotions and increase in positive emotions whilst the patients await their counselling appointment. Sixty percent (6) of the patients described getting the follow-up phone call one week after being seen at the surgery as 'very welcome and useful', and 30 percent (3) described it as 'very welcome but not useful'.

What went well

The project team members have established strong interpersonal connections and mutual respect, which has maximised use of the collective skill set. Team cohesion has been maintained, despite personal demands, and everyone has remained committed even if not available to attend every meeting in person. Joining meetings by telephone and using the shared platform for Google Docs has enabled all opinions to be considered and kept everyone in touch with developments.

Figure 6: Keeping practice staff up to date



A noticeboard in the staff room (Figure 6) kept staff in the practice up to date on where we were at, which helped to maintain engagement and service delivery cohesion throughout the project.

The project team also used a high impact approach to achieve greater stakeholder commitment. This involved purposely utilising the project team member who is a GP to present to GP peers, alongside one of the consumer team members, about the proposed service improvement. They represented both sides of the 'gains' (ie, provider and consumer). Their presentation described the 'why' of the project, in terms of both patient benefit and better scarce resource utilisation and

spoke specifically about the ease of the actions required. They used words like 'quick' and 'saves waste within and beyond the practice'.

Figure 7: Project team sharing findings with the practice team



Relationships with wider service providers (general practice team, Mental Health Advocacy & Peer Support, NGO team, PHO Pegasus) have been enhanced by this project. Wide interest has been generated, and it is clear that the co-design process is transferable to other aspects of care delivered by general practice teams.

Data analyst support secured for the project by one of the senior leaders and having a contact person and feedback from the BIC team have been invaluable, as has the timely and supportive input from the Health Quality & Safety Commission. It has been helpful also to learn from other co-design initiatives underway and those on the Health Quality & Safety Commission website.

The response rate to our initial invitations and the two online surveys has been very encouraging and enabled some meaningful analysis. Our approach was to gather information in a cumulative way with a second round of enquiry building on the first, and this has resulted in a richer and more cohesive data set.

What has been difficult

- We found that inaccurate patient contact details were being automatically loaded onto referral forms, leading to major barriers to accessing counselling.
- We found that the contact number on the system, for a young person, was actually their parents'.
- We didn't know that one contact number was for a deaf person – resolved by sending text invitation to participate.
- Using technological tools for project documentation has presented challenges for some project team members who were less familiar with them.
- Without any dedicated funding, the project has entirely relied on the goodwill of project team members.
- Meeting tight deadlines and allocating sufficient time, with the loss of momentum over Christmas, has been challenging.
- Maintaining the privacy of patient data meant that all contact had to be made from the medical centre, not allowing for any remote working.
- Unexpected life events for many of the project team have added pressure.
- Failing to identify ethnicity in our sampling meant we didn't consider any particular cultural barriers.

- The 'other' responses offered for some of our survey questions gave us too many variables, which then had to be grouped to fit within the other answers, and potentially skewed our percentages data.
- Whilst the counselling service provider team would have preferred us to use words like 'talking therapy' and 'clinicians', our project team consumers told us they didn't believe this would be comfortable for consumer respondents and that we should continue to use 'counselling' and 'counsellors' instead. In the spirit of co-design, we went with their opinion.
- Initial 'push back' from referrer stakeholders suggested that the revised process would be too time-consuming to include in an already stretched 15-minute consultation.

What has been learned along the way

- The recommended 'Plan, Do, Study, Act' framework provided a practical process to follow.
- Whilst there had previously been some provider interest in more involvement of consumers generally, and specifically exploring service improvements for people with mental health needs who find themselves in the space between general practice services, NGOs and a clearly overburdened specialist mental health service, the project has given this team greater awareness of an appreciative enquiry approach, as recommended by Lynne Maher.
- The project has provided a 'discover' stage, which has shifted the focus beyond a service provider perspective on service deficits to consider existing successes too. The provider-led 'dream' stage had not previously recognised the advantage of stepping aside and really hearing the consumer opinions about their 'dream' service. We recognise that without this co-design project, we could have gone down the wrong road of service delivery. We are more confident that in future we need to incorporate the influence of consumers into any 'design and deliver' improvements to service delivery.
- The initial anonymous survey, which asked for ongoing contributions from participants, had to be amended to request their contact details, as we realised we would otherwise not be able to take them up on their offer.
- The consumer dimension of service delivery is, so often, overlooked. Consumers' expertise both in their lived experience of 'the system' as well as the insights that they bring from their day-to-day realities, their own work background and family supports or lack of are all resources that should not be wasted.
- We learned the value of keeping senior leadership sponsors informed of project progress.
- As we reviewed our work we recognised that we had not been able to engage with all of the consumers that we would have liked to. Some consumers did not respond to our phone calls or messages and we needed to just move forward with the consumers who had responded. In retrospect, we know that these people would have provided valuable insights, and in future we would consider a different range of ways that might be more successful in the initial engagement/contact.
- Not all clinicians have the same skill/comfort/confidence levels in mental health care delivery, and there is variability in what an individual is asked about and provided with in any given consultation. Resource material and standardised tools for practice can address this.
- As highlighted by the Health Quality & Safety Commission's ongoing work around transitions between services, we are now more aware that a poor experience for people can have long-term negative impact for the person concerned, their family/whānau and providers of services, in terms of safe practice, resource management and sustainability.
- There are opportunities for local multidisciplinary professional education sessions relating to mental health care.
- It is important to consider access issues for allied clinical input. For example, closing times for the community pharmacy will impact on the patient's ability to start prescribed medication on the day of their consult if the doctor appointment is late on Friday afternoon.

- When the suggested process was considered ‘too difficult’ for referrers, editing of the proposed document and technologically auto-generating a task for the follow-up call in response to a referral submission, as well as negotiating a one-month trial then review of the impact, was sufficient to secure ‘buy-in’ to proceed.
- This project activity has highlighted the potential for a co-design approach to develop more culturally appropriate services when addressing other aspects of general practice service delivery.
- Using the follow-up phone call to check if the information pack was useful, as well as the intended tracking of access to counselling service and to provide additional personal contact, was a means of determining its value.

In summary, the project has provided a valuable opportunity to apply the principles of good communication and coordination, partnership, respect, teamwork, safety, value and being true to improve service delivery with a focus on both physical and emotional needs of a practice population.

Further considerations for ongoing service improvements in the future

The time constraints of this project leave further potential service improvements to be explored at practice level within the counselling service and beyond into the wider health service system.

At the practice level:

- It is hoped that, within 3 months, 65 percent of those referred are being given the information pack, compared with our initial survey results of only 35 percent. Collaboration with the counselling service to audit this and to find out if providing an alternative contact person has improved the Did not Engage (DNE) data would be necessary.
- The content of the information pack will need to be updated over time, in collaboration with the specialist team, to ensure consistency and currency.
- A template for a standardised crisis plan and consideration of who, in the general practice team, is best to assist with its completion needs to be considered alongside the existing electronic personalised care or acute plan options on the shared platform which is already accessed by both primary and secondary service providers.
- The follow-up phone call provided an additional, and unfunded, clinical consultation rather than its intended process tracking purpose. A means of resourcing the time and effort for such input to meet an apparent unmet need will need to be explored, as the call was not initiated by the patient, so they may not expect to be charged.

System-wide improvements to the integration and continuity of service delivery include the following.

- The counselling service could make a standard follow-up call, perhaps 3–4 weeks from unsuccessful contact. This would track whether the patient has got better, gone elsewhere, or felt too unwell initially but now wants to engage.
- The BIC service could include recommendations for alternative counselling/support options within the written ‘non-contact’ correspondence from the counselling service to patients and the referrer. This would provide useful ‘next steps’, thus improving system-wide health literacy.
- More consideration could be given to known low literacy levels, the limited postal system and the financial burden of cell phone costs for the usual communication process between service providers and patients.
- The counselling service could give a ‘heads up’ to the referrer in the event of x2 did not attend (DNA) before the discharge process is undertaken. This could enable the referrer to raise the issue at the next consult or by the general practice team contacting them to check what’s happening for them. It may then prevent the work involved, for everyone, in discharging and then potentially making a repeat referral.

- A motivation screening question could be included in the initial assessment before sending the referral. This could address any unintended sense that the referral is being imposed and they are then counted as a DNE/DNA statistic, often documented as a 'lack of motivation'.
- Visual aids could be developed to help with consumer feedback, such as smiley rating scales, emojis, images of various emotional states.
- A standardised template for encouraging consumer involvement, for all service development activities, could be developed for use across all Canterbury PHOs.

The project team

Name	Role	Organisation
Eve Nissen	Consumer	
Chris O'Donnell	Consumer	
Hannah Komatsu	Consumer/NGO (consulted 1st questionnaire)	Mental Health Advocacy & Peer Support (MHAPS)
Gena Orpwood	Social worker	Travis Medical Centre
Jackie Cooper	Service Integration Facilitator	Christchurch District Health Board
Nicky Scott	Practice Nurse/Project Leader	Travis Medical Centre
Paul Bridgford	PHO-based data analyst	Pegasus Health
Heather Peacock	General Practitioner/Senior Project Lead	Travis Medical Centre
Vince Barry	PHO CEO/Senior Project Lead	Pegasus Health

The project was consistently guided by regular consultation with Lynne Maher (Innovation and Improvement Clinical Director at Ko Awatea I Health System Innovation and Improvement, University of Auckland).