Person and Family Centred Care in the ICU

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Summary
There is now support from both health care providers and policy makers that patients must be involved in the design of services within the NHS, to ensure safe, effective care is delivered to every patient. As a result, a multitude of models to deliver effective patient and family involvement have been described in the literature and policy. One model of patient involvement includes patient and family groups. These can come in many forms including small focus groups which address specific clinical areas and issues.

The staff at the Glasgow Royal Infirmary Intensive Care Unit (ICU) wished to develop a Patient and Family Advisory Council (PFAC) with the aim of creating a model of collaboration between patients, relatives and staff in the ICU. This project utilised a number of different facilitation and practice development methods throughout the progression of this 18 month project. These methods, which included the creation of a staff steering group, values clarification exercises and the adapted emotional touchpoint technique, were supported by the facilitator from the Foundation of Nursing Studies.

A total of 12 patients and family members were recruited to the PFAC. The council met for a total of six sessions and was co-chaired by a family member and a staff member. The discussions for each session were structured around the patient journey through the hospital and their experience at each point in their journey. This included, arriving at ICU, experience of ICU, transfer to the ward environment and discharge home. Discussions and key areas for improvement which were identified by the council included improved signage within the hospital; the creation of information poster and the improvement of ICU waiting area.

The creation of the PFAC in Glasgow has demonstrated the importance of co-production in the NHS. Furthermore, it has shown that allowing patients to drive the quality agenda does not mean massive changes or indeed costs to service providers. This group has shown that small changes, with relatively little costs involved, can have significant implications for the quality of care which patients and family members receive. Members of the project team have presented the key findings, including information on the creation of the Council, at national conferences.

This project was supported by the Foundation of Nursing Studies Patients First Programme in partnership with the Burdett Trust for Nursing.

Background
Person and Family Centred Care
The delivery of person-centred care (PCC) is central to current policy both nationally and internationally (Healthcare Improvement Scotland, 2011). In essence PCC is the delivery of healthcare that is responsive to individual personal preferences, needs and values (Timmins and Astin, 2009; Healthcare Improvement Scotland, 2011). This can be achieved in part by ensuring that patients and carers are involved in clinical decision making (Kelleher, 2006; McPeake, 2012).

A multitude of models to deliver effective patient and family involvement have been described in the literature and policy. These models differ and are defined by how the
patient is included and what they are involved in doing (Forbat et al., 2009). One model of patient and family participation involves active partnership with people who use specific services (Forbat et al., 2009). Within this model choices are made collectively about service organisation and delivery (Angood et al., 2010).

It is now firmly embedded in healthcare policy across the United Kingdom (UK) that patients must be involved in decision making with regards to service design and delivery (Scottish Government, 2010; NHS England, 2012). Undoubtedly with these political drivers, there has been increasing engagement with service users in healthcare design. However there is very little practical guidance to help clinicians and service providers enable this in practice. It is difficult to evaluate what patient involvement really means and most importantly, how it can be evaluated to ensure that it is a meaningful interaction.

Current ways of engaging patients in healthcare services

Patient involvement in design can take many shapes and it is important that the National Health Service (NHS) takes advantage of all forms that are available. Very simply, staff can ask patients and relatives for feedback on the service they received and indeed how the service can be improved. This is probably the most prominent and cost effective form of patient involvement in the UK at present, with most hospitals using structured questionnaires to obtain feedback. However, the feedback which is being received and the impact of this feedback on service delivery must be transparent if patients and service users are to have confidence in this approach. This can be in the form of simple ‘you said, we did boards’ in ward settings, or having accessible parts of organisation websites which are clear and unambiguous, about how services are being improved and changed as a result of patient feedback. It is also essential that patients are involved in the design of any feedback tools and questionnaires, as without this input feedback generated will ultimately be service driven.

Other forms of patient engagement include the use of patient panels and forums which sit within NHS trusts and health boards. These groups, which often represent large healthcare organisations, aim to influence decision making and healthcare design. Service improvement ideas from these groups should then feed seamlessly into management structures to ensure that healthcare delivery is person and family centred. However, an alternative model to these large overarching patient panels is to have smaller, more focused groups which address specific areas and issues (i.e. clinical speciality patient groups).

Although community engagement forums are a simple and often very effective model, staff charged with creating these models, must make certain that these groups do not become consultation forums. One way of achieving two way dialogue, is to encourage patients and family members to lead and facilitate groups either independently or with the support of healthcare professionals if necessary. This step ensures that the users direct the elements of care in which they wish to see an improvement. Additionally, it guarantees that the discussion is relevant and by definition person-centred.

When discussing patient and service user engagement, it is vitally important to describe how people have been selected for involvement. It is all too easy to purposively sample patients and family members who are willing to give healthcare managers the answers
which they are looking for. Healthcare professionals who wish to truly engage with patients and service users must be willing to be challenged and seek out patients who, for example, may have made complaints about services. Only by engaging with these groups of patients will service providers see an improvement in care.

_Glasgow Royal Infirmary Intensive Care Unit (ICU)_

The Glasgow Royal Infirmary (GRI) is a University Teaching Hospital within NHS Greater Glasgow and Clyde, Scotland. GRI is situated in an area of high socio economic deprivation, with 42% of the most deprived geographical areas in Scotland residing in this catchment area (Scottish Government, 2012). In addition, GRI is a tertiary referral centre for pancreatic care, burn care, esophageal surgery and some orthopaedic interventions. The Intensive Care Unit deals with the most seriously ill patients in the hospital and patients returning from large operations. Due to the diversity of the population admitted to the critical care unit, the length of stay of patients varies widely. However, on the whole, the average length of stay is approximately three days.

The ICU is staffed by 100 trained nurses and supported by ten nursing assistants. The majority of the trained nursing staff is made up of band five staff nurse. There are several band six senior staff nurses and charge nurses and three band seven ward managers. There are also twelve specialist medical consultants, two physiotherapists and two unit pharmacists.

The project team, which was comprised of three nurses and one member of medical staff, used a successful application to the Patients First Programme at the Foundation of Nursing Studies (FoNS) to provide support for the project.

**Aim**

The aim of this project was to develop and implement a patient and family advisory council (PFAC) to share their lived experiences of care within the intensive care unit (ICU).

**Objectives**

- Engage with key stakeholders in the project
- Gather information to guide the running of the patient and family advisory council
- Recruit patients and carers to the patient and family advisory council
- Understand the patient experience by actively listening and engaging with patients and carers on the council
- Use the patient experience to drive improvements in the quality and safety of care in the future
- Evaluate the patient and family advisory council

It was hoped that the PFAC would explore various topics and issues within the ICU and the information generated would feed into the staff steering group, who would then implement the changes in practice.
Key Activities and Outcomes

1. Engage with key stakeholders in the project

Creation of a Staff Steering Group

After the first FoNS workshop days in London and indeed the first visit from the FoNS facilitator to the ICU, it was decided to invite some key members of staff from ICU to work together to form a staff steering group. The project team used a DOODLE poll to coordinate a meeting and the following staff were invited and attended:

- The project lead and the other two nurses actively leading the project
- The consultant who was leading on the project from a medical perspective
- A senior charge nurse from the critical care unit
- The NHS Health Board’s Acute Nurse Director
- The Clinical Academic Lead for the unit
- A member of the domestic team
- The Lead Consultant for Quality Improvement in the unit

Values Clarification Exercise

At the first meeting the project team facilitated a Values Clarification Exercise with the steering group. A values clarification exercise is an approach frequently used within practice development for developing a common shared vision or goal (Manley, 1997). It is a useful tool when starting a journey which may involve a cultural change, or as way of developing a common vision. In terms of the PFAC, the values clarification exercise helped influence how both the steering group and the PFAC would be organised to ensure that it reflected the values that the steering group held (Manley, 1997). This exercise was facilitated by the project lead as a group exercise. Each person in the meeting was asked to consider their response to the following statements:

- I believe the purpose of a Patient and Family Advisory Council is …
- I believe this purpose can be achieved by…
- The factors that help this purpose are…
- The factors that hinder this purpose are…
- Other values and beliefs that are important to me are…

The responses to these statements were then shared within the meeting and common values and beliefs were identified collectively. The main values created from this exercise were that each member of the group wanted the PFAC not only to help understand the patient experience, but to also ensure that patients would have the opportunity to lead and develop the group in a way which helped future patients and groups. The staff steering group met on three occasions before the start of the PFAC and met at regular intervals throughout the duration of the project. Notes were taken on the outcomes of this exercise and at the start of each steering group, these values were revisited.

Dissemination to all ICU Staff

In addition to creating the steering group within the unit, the project team recognised the importance of ensuring dissemination of information and indeed entire unit involvement with the PFAC. In response to this, a notice board was created with information on the PFAC. A white board was also made available in the unit, to allow the team to keep all staff
in the ICU up to date with how the council was progressing. All staff were sent an email giving further information on the group (Appendix 1). Furthermore, the team presented information on the PFAC at the sister/consultants away day in the unit as well as at the nurse research group meeting which meets every few months. All staff were given the opportunity to feed in views and opinions about the council to the project team. On the whole, staff in the ICU were very positive about the remit and potential of the PFAC. This was demonstrated by feedback from all member of the multi disciplinary team.

2. Gather appropriate information to guide the running of the patient and family advisory council

*Attend Health Board Patients Panel*

Two of the project team attended the Health Board's Patient Panel, shadowing the Nurse Director (who was also part of the PFAC steering group). The purpose of this visit was to explore how patient groups such as these, are facilitated and to look at how the agenda is created and executed.

This was a worthwhile visit; the panel was made up of individuals from all different backgrounds. What was interesting was that a patient/service user co-facilitated the meeting with the chair person (the nurse director). This was a useful way of ensuring that the discussion was led by the patients.

At these meetings, staff from all around the Health Board presented new initiatives to the patient group. However, some of these presentations lasted over 20 minutes and it was clear that some of the participants did lose interest slightly. As a result the project team realised they needed to consider guidelines for presentations. The steering group decided to ask the PFAC to design these guidelines.

*Attend the Patient Experience Steering Group for NHS Greater Glasgow and Clyde*

One member of the project team was also asked to attend the Patient Experience Steering group in the Health Board. The Patient Experience group is made up of patients, NHS staff and local university staff to look at ways of improving the patient experience in the Health Board. This was a useful meeting to attend as it gave an overview of the different initiatives which were happening across the city in relation to improving the quality of care offered, as well as exploring the PCC agenda within the health board. Initiatives within the Health Board included visitor ratings boards and the use of patient stories to influence care.

3. Recruit patients and carers to the patient and family advisory council

*Engaging with previous patients and family members*

Engaging with previous patients and family members before the council started was vital to ensure that it would be appropriate and sensitive to the values and needs of individuals. This was achieved in several ways. Firstly, some of the team spent time discussing this project with two sets of family members and patients (some of who went on to become members of the council). These discussions focused on how best to ask patients and their family members about joining the council, when would be best for patients to attend and also how the project team could create an agenda for meetings.
Simple things were brought up in these meetings which the project team had not considered. For example, the project team had considered discussing different stages of the patient journey at each of the different council meetings. As staff we assumed that the first point in the patient journey was arriving in the ICU. However, by having these discussions it became apparent that the journey for most patients and family members, starts long before arriving in the ICU and this was important for them to discuss within the council.

Engaging with current patients and family members on the unit
The project team were also motivated about engaging with current patients and relatives on the ICU. To achieve this, the project team asked the medical illustrations department to design a poster advertising the group (Appendix 2). Additionally, a suggestions box was placed in the ICU waiting area with suggestions cards. This was monitored weekly by a member of the steering group. Suggestions for areas of discussion were then fed directly into the group.

Recruitment to the council
Initially the project team invited previous patients who had expressed an interest in the project, or patients who were thought to be interested in taking part in the project. The project team also actively recruited patients or family members who had been unhappy with an element of their care. Although, this felt a little uncomfortable for the project team, it was felt that it was important to listen to the patient and carer perspective. The team also sought patients who felt that their journey through the hospital went well. The team felt that learning from patients who had, what they felt was an 'executive service', was just as important as those who have made a complaint.

The project team sent letters of invitations to all potential participants and their family members. Along with this invitation was an information sheet about the council and a contact form. This contact form was sent back to the project team (a stamp addressed envelope was included with the initial letter of invitation) by the potential participant. This allowed the team to then contact the patient and family member to discuss details of attendance. Seven previous patients and their family members were invited to the PFAC. One patient declined, as she felt the group may be too upsetting for her. The other six patients and their family members were happy to be involved. This group represented different individuals with varying backgrounds and reasons for admission to ICU.

4. Understand the patient experience by actively listening and engaging with patients and carers on the PFAC
The next section of this report will discuss how the project team implemented the PFAC in the ICU.

Emotional Touchpoint Technique
The team explored the use of the emotional touchpoint method and how this could potentially be used by the PFAC to create discussion. Emotional touchpoints represent the key moments or events that stand out for individuals and which were crucial to their experience of receiving or delivering a service (Dewar et al., 2009). The emotional touchpoints kit was considered for use; however, it was decided after discussions with
patients and the FoNS facilitator, that this method should be adapted to a format that would guide the council meetings. The aim of the PFAC was to construct a discussion around the critical care journey which was meaningful to the members.

**Ethics and Research and Development**

It is a mandatory part of the research governance structure within the Health Board for all projects involving patients to seek ethical approval. The project team contacted the Health Board academic coordinator for research and development and then the scientific manager. From these discussions, the project team were advised that the project was considered to be a service evaluation rather than a research project. Therefore formal ethics approval was not required. However, good ethical principles were adopted and some standard documents for the group were created including: a consent form; a participant information sheet; a ‘consent to contact’ form and a standard letter of invitation. All of these documents were reviewed by the steering group and a patient representative before they were sent to any potential patients/family members. Additionally, this consent form included consent to audio record and take pictures.

**Planning of the Meetings**

The initial meeting was planned for a Monday night. However, it was clear from discussions with potential participants that this was not necessarily the best time for every meeting. It was decided within the staff steering group that the patients and family members could decide when best to have the PFAC meetings in terms of both dates and times. This would be discussed at the first PFAC meeting. All members of the project team helped plan the meeting and all were there for the first meeting.

**Collaboration vs. Consultation**

The aim of this project was to move beyond the traditional model of patient consultation to a model of patient collaboration. To achieve this, the project team undertook several strategies. These included:

- Asking a patient or family member to co-chair/facilitate the meetings with a member of staff. Staff would also support this chair in undertaking a values clarification exercise with the council on the initial meeting. The co-chair/facilitator would rotate and all members of the council would be given the opportunity to undertake this role.

- Initially, the project team had thought that staff would create the agenda/topic guide for each of the meetings (see previous section on the emotional touchpoint kit). However, to ensure that this piece of work was moving beyond the traditional consultation model with the professional creating the agenda, which is in essence a service driven approach to involving patients, the project team created a loose framework using the adapted emotional touchpoint method that reflected the care journey of a patient through the ICU (Dewar et al., 2009). And the patient and family members dictated how the meeting ran and what was discussed within these.

**First Meeting**

In total 12 participants (patients and family members) were recruited to the PFAC through letters of invitation. Invitations to the PFAC were also followed up by an informal phone call
from a member of the project team to discuss any questions or concerns that potential participants may have with attending and taking part in the PFAC.

The first meeting was co-chaired by a member of the project team and a family member. The group started firstly with an ice breaker exercise to help everyone relax and also to ensure that everyone could say something they felt comfortable about. The meeting then moved to a values clarification exercise to help understand what the collective group aims were. The values clarification exercise was undertaken by the family member co-chairing the group. The project team had discussed this with her before the meeting and sent her the framework in advance. She asked the key questions (the same as discussed by the staff steering group) within the tool. Discussion around this was facilitated by the project lead and notes made on a flip chart. The main themes which emerged from the values clarification exercise were that the group aspired to be positive about changes and not just dwell on problems. Further, the group aimed to focus on solutions. The group also discussed valuing others' opinions and being sensitive about approaching personal information (for example, medical information about individual patients). This also ensured that, to a certain extent, a loose set of 'ground rules' were put in place, about how the group would run. Additionally the members agreed to review how the staff steering group implemented changes as a result of the PFAC feedback.

**Structure of Meetings**
The first meeting took place on a Monday night. However, the PFAC decided that this was not actually the most suitable time and that Saturday mornings would be the most effective time to have council meetings. The PFAC also decided on what the topic of each meeting should be. They decided to look at the patient journey through the hospital and their experience of each of the points in their journey. These were:

- Arriving in ICU
- Experience of ICU
- Transfer to the ward environment
- Discharge home

5. Use the patient experience to drive improvements in the quality and safety of care in the future

**Arriving in the ICU**
Participants spoke at great length about the anxiety of arriving in the ICU and getting to the ICU for the first time. This part of the discussion was predominantly led by the family members in the group. There were three main issues which came up during this discussion:

- Family members not being prepared for what they were about to see
- Family members not actually being able to find the ICU due to poor signage around the hospital
- Family members not being able to recognise who their loved ones were when arriving in the ICU, due to the vast amount of machinery and how different individuals look when in the ICU

As a result of this discussion, several changes have been made in the ICU. Firstly, staff in the unit have designed a poster, which explains the different equipment used in the ICU. This poster, which is placed in the waiting area for relatives to look at before coming into ICU,
aims to prepare individuals for what they are about to see. However, when the council reviewed the draft poster, it was clear that it had been created with a service focus, rather than a person and family focus. Two major changes were advised as a result of feedback from the council. The first was to include a nurse in the poster with the patient and give a brief understanding of the role of the nurse in the ICU. The second change was to include a family member in the picture, to help family members feel more comfortable about being with their relative.

Another major issue which arose from the group discussion was how difficult it was to actually get to the unit and the PFAC members also described how difficult it was to follow signage to the ICU for the meeting! Following this discussion, two members of the project team met with the Trust Chief Executive with direct feedback from the members of the council. With the support of the estates manager, signs have been put up in the hospital at all points considered, apart from one area, which is under review by estates management (Appendix 3).

**Experience of the ICU**

Discussion around improvements and experiences within the ICU were quite challenging within the council, as it appeared that some members did not want to be seen to criticise the unit in front of the staff. However, the staff involved reassured the PFAC that no offence would be taken by any comments made.

Several issues about the family and visitors waiting area emerged. These included: the heat in the waiting area; lack of reading material about support for families and information about ICU in general; lack of ‘distractions’ and no access to food or hot drinks. Several strategies have now been put in place as a result of the discussions with the council.

Firstly, with the help of the council, it was decided that putting a TV in the waiting area was not appropriate and would not be of use. However, the council were keen on having access to free Wi-Fi. Most hospitals do have free access to Wi-Fi, however, most are password protected. This password is usually changed on a regular basis. One of the unit secretaries has now taken on the role of updating the Wi-Fi code weekly.

A food and hot drinks machine has now been placed outside the ICU. However, this has added to the issue that the waiting area is now very hot due to the fans from the machines! As a result, the unit is now trying to obtain funding to buy a fan which is approved by infection control which can be placed in the waiting area.

There was very little available for relatives to read in the waiting area. The PFAC discussed what information they would have like in the waiting area. There was a mixed response with some people looking for very detailed technical information about the ICU and other looking for information and advice about social changes and problems (i.e. information on where to seek advice on finance). Detailed information, which has been approved by the council, has now been placed in the waiting area including detailed ‘technical information’ as well as information about local Citizens Advice and Carers Centres. This information was obtained by contacting the organisations directly.
Transfer to the Ward Environment

Major issues were identified regarding transfer from the ICU to the ward environment, which is consistent with previous literature in the field of ICU (Field et al., 2008). Several key issues were discussed at this meeting; however, the key theme which emerged from this discussion was the challenge with communication in the ward environment. It is now well recognised that after transfer from intensive care, many patients have ongoing cognitive issues, including poor memory and concentration (Pandharipande et al., 2013). As a consequence patients found it difficult to retain information given to them by staff throughout the day. Relatives were then highly anxious when they were unsure of plans and progress, when they visited, the patient could no longer remember what had been discussed throughout the day. Due to the busy ward environments which patients were discharged to, it was then often difficult for relatives to discuss these matters with staff. This is in contrast to the ICU environment, where relatives are given information regularly by nursing and medical staff.

Guided by the PFAC, the project team have designed an information sheet which will be given to staff in the wards when a patient is transferred from ICU. The sheet, which is currently being internally scrutinised within the Health Board, gives ward staff information on some of the challenges which both the patient and the relatives are going through after transfer from ICU. This information sheet also includes information on the cognitive issues patients face when discharged home from hospital. We have yet to decide how this will be fully implemented in the ward environment, however, this work will continue beyond the Patients First Programme.

Discharge Home

A number of issues were discussed about discharge home from the hospital. Participants, both patients and family members, described the ongoing physical, social and psychological problems they encountered, which is consistent with previous work in this area (Herridge et al., 2011). The conversation also focussed considerably around financial matters and the impact that critical care can have on an individual's employment and income. As a result, the steering group have introduced Citizen's Advice into the ICU follow up service. Patients and carers can access information on benefits, housing and other financial matters which are important to them.

Discussion

This project demonstrated that the creation of a Patient and Family Advisory Council within the ICU environment is achievable and feasible.

A key finding from this project was that communication for both patients and family members could be improved at all stages of the patient journey. This is consistent with previous literature which has demonstrated that the recovering ICU patient often faces uncertainty (Field et al., 2008; Cox et al., 2009). As a result of this project, the ICU has implemented small changes at all stages of the patient journey to try and improve communication for both staff and family members. Changes include information sheets for ward staff and information for relatives during and after the ICU stay. We are presently evaluating the information sheets and reading materials with the support of the council.
Another key theme which was generated by the council was the need for improved facilities and support for family members during and after the intensive care stay. There is emerging evidence demonstrating the challenges which family members and carers of ICU patients face both during and in the months following ICU discharge (Haines, et al., 2015). Having a comfortable, practical and appropriately equipped visiting area was an issue for family members. These issues, such as those involving catering facilities, were also consistent with previous literature (Henrich et al., 2011). As a result of the PFAC, several strategies have been implemented to improve the family experience. These include: the provision of information before family members come into the ICU and a supported first visit. There have also been significant changes made to our waiting areas (Appendix 4). Furthermore, as a result of the council and their feedback, the ICU is now providing much more focussed support within the follow up clinic for family members.

The creation of the PFAC was not without its challenges with probably the most notable challenges being logistical issues such as dates of meetings and the provision of information before council meetings. The creation of a generic email address which the council could use has helped overcome part of this problem. This type of individualised email address is available throughout the NHS in the UK. Furthermore, accepting that not all patient and family members would be able to attend every meeting was the only way to overcome the challenge of booking dates for the council meetings. However, ensuring that patient and family members were involved in these conversations was key to ensuring no members became upset.

An interesting point which must be discussed in this section is the positive feedback the project team received from members of the PFAC about being involved in the council (Appendix 5). Many members discussed how happy they were to helping future patients and felt a positive influence on themselves about this, essentially, by taking part in a volunteering role. There is a small body evidence which focuses on the positive influence which volunteering can have on the volunteer’s health, especially in the elderly population. (Morrow-Howell et al., 2003). However, this finding should be explored further with the ICU population in future work. The project team is currently working with Medical Illustrations in the Health Board to create a filmed patient story in this area. Finally, the last meeting of the council took place in June and at this meeting the council planned how to improve the experience for council participants in the future.

Taking part in the Patients First Programme has also had a positive impact on the project team. All members of the team have grown in confidence with facilitating groups and in undertaking practice development exercises and techniques. Also, the opportunity for individuals from the project team to present the results and findings of the PFAC at national conferences (Appendix 6) has also increased confidence and developed skills. The support the project team has received from the FoNS facilitator and the ability to network with colleagues across the country at the workshop events has made individuals challenge assumptions about delivering person-centred care in clinical practice.

**Conclusion**

This project has successfully created and facilitated a Patient and Family Advisory Council. The creation of the PFAC in Glasgow has demonstrated the importance of collaboration in
the NHS. Furthermore, it has shown that allowing patients to drive the quality agenda does not mean massive changes or indeed costs to service providers. This council has shown that small changes, with relatively little costs involved can have massive implications for the quality of care which patients and family members receive.

**Recommendations**

From this project several recommendations for practice can be made:

- PFACs should be considered across the UK as a way of ensuring patient involvement in the delivery and design of services within the NHS
- Service providers must think critically about who they involve in co-production models
- It was clear from this project that patients and family members did not want massive changes to the structure of delivery of services. Instead, it was small changes to the patient experience which made the biggest difference

**References**


Appendix One: Staff information

The ICU Patient and Family Council

What is the Patient and Family Council?

As many of you are aware, a new patient and family group will be starting shortly in the unit. The purpose of the Patient and Family Advisory Council (PFAC) is to provide a forum for patients and carers, who have experienced the ICU journey firsthand, to suggest improvements in the quality and safety of care we deliver.

What will it involve?

The PAFC will involve approximately 10-12 previous patients and carers. The group will meet every two months. We expect a range of topics will be discussed.

What will we discuss?

There will be a specific ‘topic guide’ for each group based on the patient and family journey. For example, one of the meetings may focus on recovery from ICU. We would also like the group to give feedback on current projects in the unit. For example, some of the work around person centred care or the work currently being undertaken in the waiting area.

Why are the benefits to the unit?

We would hope that the feedback we receive from the group will feed directly into care in the unit, and more importantly, improve the care we provide to patients and families.

How can I get involved?

There are lots of ways you can get involved. If you have a project you would like the PFAC to discuss, let us know and we can perhaps arrange for you to speak to the group. Also, there will be a suggestion box in the waiting area appearing in the next few weeks. Please encourage family members to leave comments or suggestions for the group. In addition, if you know of any patients or family members who you think would be ideal for the group, please let us know. We are in the process of recruiting for the PFAC.

Who do I contact if I want to know or learn more about the group?

Please contact Joanne McPeake (joanne.mcpeake@glasgow.ac.uk) or Tara Quasim (Taraquasim@nhs.net) if you would like any further information. In addition, Murray and Gemma are also leading on the project.
Patient and Family Advisory Council

The critical care unit at Glasgow Royal Infirmary has a Patient and Family Advisory Council made up of former patients and family members.

The Council discuss topics from patient’s and family representatives. They then forward any thoughts and feelings about how to improve the critical care unit to the staff.

If you have any topics, ideas or questions for the council, or would like to become involved with the council, please leave a suggestion or information in the box below, speak to a member of staff or email: gg-uhb.icugripatient@nhs.net.

Appendix Three: Pictures of the new signs in the hospital
Appendix Four: Before and after pictures of the waiting area

Before

Empty white Boards

No drinks/refreshments available
After

New Drinks/refreshments machines in place
Appendix Five: Glasgow Royal Infirmary Patient and Family Advisory Council
Appendix Six: Presentations related to the Patient and Family Advisory Council:

McPeake, J. Daniel, M. Sheriff Short, M. Smart, G. Kinsella, J. Quasim, T. (May 2014) Systematic approaches to listening: using the voice of lived experience to lead and drive improvement. NHSScotland, Person Centred Care Learning Session,