

ERASMUS +

KA2: Cooperation for innovation and the exchange of good practices - Sector Skills Alliances



Project acronym: DISH

Agreement Number: 2018 - 3001 / 001 - 001

Project full title: Digital & Innovation Skills Helix in Health

Project Number: 601008-EPP-1-2018-1-DK-EPPKA2-SSA

Call identifier: EAC/A05/2017

D4.4: Implementation Report

Version: 1.0

Status: Final

Dissemination Level: Confidential

Due date of deliverable: 30/08/2021

Actual submission date: 15/03/2022

Work Package: WP 4 – Testing Concepts

Lead partner for this deliverable: NHS Liverpool CCG

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1. Background

The objective of WP4 was to ‘*test the usability, relevance and transferability of the concepts that were developed in WP3, through a close collaboration with 5 test sites in each participating country.*’

Each Triple Helix developed their own testing plan, based on a standard template, with questions designed to help regional HELIX partners understand and support the testing of DISH concepts. The template was later revised to make it easier to complete (See [Appendix A: Test Site Initiation Template v1](#) and [Appendix B: Revised Test Site Initiation Template](#)). The Triple Helixes then implemented that plan.

Throughout implementation, regular progress and feedback reports ([See Appendix C: Test Site Progress & Feedback Report Template](#)) were completed, up to seven per Helix, which were summarised and fed back to the partners. This served as an update on implementation progress, and allowed the concept development teams (WP3) to use this feedback to update and finalise the three process concepts.

All Helixes also completed a final template, with input from all their test sites, to inform this implementation report (See [Appendix D: WP4 Final Triple Helix Reports](#)).

Constraints

The implementation phase was scheduled to start in January 2020. Due to the effects of the Covid-19 pandemic on the ability to meet colleagues and to deliver training, the project was delayed, and prolongation was agreed with EU project management, with this report becoming due at the end of August 2021 – an additional six months. However, there were further unavoidable implementation delays and alterations to delivery plans as the pandemic has continued, and which meant that some Helixes were unable to report their implementation findings until the end of January 2022, which has subsequently led to the late publication of this report.

Note on terminology

The three concepts of the DISH framework have now been finalised, however they may be referred to by previous names in earlier reports and templates:

- Preparation Tool for Innovation and Digital Skills Adaption (IDSA) – was Learning Innovation Unit (LIU)
- Process Tool for On-The-Job Training (OTJT) – was On the Job Training (OtJ, OTJ, OtJT)
- Process Tool for Assessment and Recognition (A&R) – was Assessment

2. Implementation Overview

The initial aim of the project was for each of the six Triple Helixes to establish five test sites, and train 100 people in each country, giving a total of 30 test sites, and 600 people trained.

Triple Helix/Country	LIUs implemented	Test sites implemented	Number of people trained
Denmark	14	19	357
Germany	5	11	178
Norway	6	6	120
Poland	5	5	88
Spain	1	3	96
UK	1	1	0
Total	32	45	839

Although the targets were met overall, these numbers reflect the constraints listed in the section above. Each Triple Helix adapted its plan to reflect the circumstances, implementing delivery in flexible ways, with those able to access health and care staff more readily delivering more of the training.

2.1. Test Sites

The implementation varied across different Triple Helixes, with a wide variety of situations and delivery types, giving a broad range of experiences on which to give feedback.

Triple Helix	Test Sites
Denmark	<ul style="list-style-type: none"> <i>Cetrea (Digital Patient Logistic Boards)</i>, delivered in 8 test sites - simulation training of hospital staff in skills related to this patient flow management software
	<ul style="list-style-type: none"> <i>Cisco Meeting Server (CMS)</i>, delivered in 10 test sites - training to enhance skills in using technology when a patient is discharged from the hospital to the municipality, particularly vulnerable patients and patients with complex diseases.
	<ul style="list-style-type: none"> <i>Cisco Webex Meeting (CWM)</i>, delivered in 1 test site - international webinar for obstetricians and midwives, to show the benefits of having online meetings/teaching/learning, and to increase knowledge and competencies of digital and technological tools for teaching and learning..
Germany	<ul style="list-style-type: none"> <i>University zu Lübeck: HelpChat-App</i> – training for nurses in using an online survey tool and the set up of the app for patient requests and connection with nursing staff
	<ul style="list-style-type: none"> <i>University Medicine Rostock: HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward.
	<ul style="list-style-type: none"> <i>Bodden Klinik, Ribnitz-Damgarten: HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward.
	<ul style="list-style-type: none"> <i>Malteser Klinikum St. Franziskus, Flensburg: HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward.
	<ul style="list-style-type: none"> <i>Klinikum Nordfriesland, Inselklinikum Föhr: HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward.

Triple Helix	Test Sites
	<ul style="list-style-type: none"> University Medical Center Schleswig-Holstein (UKSH), Campus Lübeck: qSOFA - training in implementation of a digital recorded and documented Sepsis Score (qSOFA). University Medicine Rostock: <i>HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward. Bodden Klinik, Ribnitz-Damgarten: <i>HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward. Malteser Klinikum St. Franziskus, Flensburg: <i>HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward. Klinikum Nordfriesland, Inselklinikum Föhr: <i>HelpChat-App</i> - training for nurses in setting up and using app for communication of hospitalized patients with the nurses on the ward. The University of Lübeck: <i>Lime Survey</i> – training student nurses in use of digital online questionnaire instrument.
Norway	<ul style="list-style-type: none"> Bjørnafjorden Municipality: <i>Home care service</i> – training health care staff in the use of electronic medical dispensers for medicines Bjørnafjorden Municipality: <i>Nursing home</i> – training health care staff in the use of remote monitoring patient warning system. Vaksdal Municipality: <i>Home care service</i> – training home care staff in the use of electronic door locks (e-locks)
Poland	<ul style="list-style-type: none"> Military Hospital - Department of Intensive Therapy and Anaesthesiology – training in advanced search and verification of medical information Military Hospital - Clinical Ophthalmology Department with the Ophthalmology Clinic – training in advanced search and verification of medical information Centrum Kształcenia Dorosłych - training for Remote work in healthcare, particularly in elements of Excel and cybersecurity Centrum Kształcenia Dorosłych - training in general digital competences for carers of the elderly and people with disabilities Podhale Specialist Hospital John Paul II in Nowy Targ – training in cybersecurity in healthcare
Spain	<ul style="list-style-type: none"> <i>Online training platform (Moodle)</i> - provided reinforcement for those healthcare professionals who did not have extensive experience in non-face-to-face training, and to ensure that those who did had the opportunity to carry out the course. <i>Prescription of digital resources to patients</i> – training professionals to be able to provide their patients with secure information which they could reach/access in case they had concerns outside the office. <i>Type II Diabetes Mellitus dashboard</i> - provided healthcare professionals with training in a new tool that will be implemented in the near future in hospitals, so that they have an average knowledge from which to start using it.
UK	<ul style="list-style-type: none"> <i>ORCHA library of Apps</i> – training via an online workbook for health practitioners in using the app, what to look for, and how to check the medical suitability before they make recommendations.

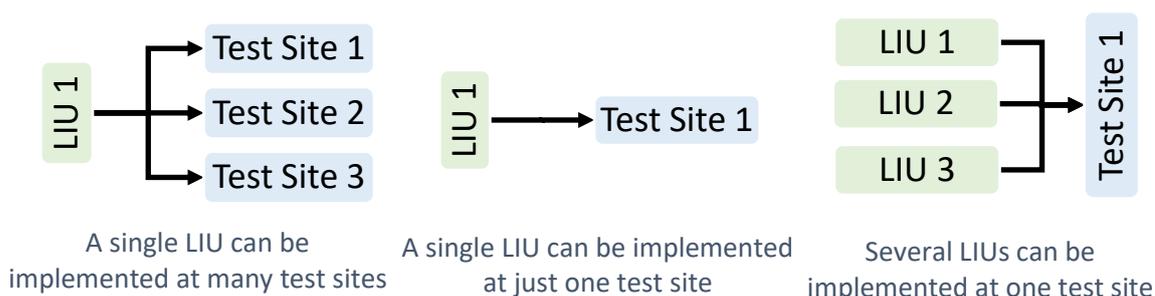
3. Using the Dish Concepts

3.1. Agreeing test sites and setting up LIUs

To clarify terms:

- A Test Site is a location or setting where an LIU is implemented
- An LIU is developed for a single technology implementation, and the training that goes with it.

LIU/Test Site relationship models:



In order to identify and initiate their LIUs and test sites, the Triple helixes made use of their existing networks, clusters and contacts, and those they had been in collaborative projects with previously. Partners also used their knowledge of existing and coming technology innovations that were being introduced in their regions and organisations, and this was often through the health providers involved in the Triple Helix, and meeting their internal training needs.

For example, the representative of the health care provider (a nursing manager) in the German Triple Helix was already involved in a multi-professional working group "Sepsis", which included medical staff (nurses and physicians), nursing manager, the UKSH Society for IT Services mbH, the Department for Quality and Risk Management and Patient Safety, the Revenue and Care Complex Measures Score Management of the UKSH and the Department of Digital Transformation of the UKSH Academy. In consultation with the Director of Nursing and the lead of the Department for Quality and Risk Management and Patient Safety, the working group formed the basis for the LIU.

The Danish Triple Helix took the additional step of adapting the DISH concepts to a Danish setting, by amending the wording to facilitate Danish understanding, describing guidelines for the three concepts of the DISH project adapted to the Danish health care setting.

Once contact and interest had been established, partners started discussions about which training and technology needs would be addressed, and the context for the training. They gathered together key stakeholders from the LIU, where the training was planned. In some countries one LIU covered more than one test site, in others, a separate LIU was needed for different test sites, particularly where different technologies were being introduced within a single Triple Helix.

There were diverse ways in which test sites and LIUs were established, dependent on the situation of the organisations involved in the Triple Helix. Some Triple Helixes started from the position of a technology innovation that was to be newly introduced, and what training would be needed to ensure staff were able to use it effectively. Others started from an existing, or general technology and looked at what the training needs were for a particular group of staff. Poland were an example of this, where institutions interested in training their staff carried out individual training needs analysis, and training was tailored for each institution.

Typical people involved in LIUs included:

- Hospital medical staff - nurses at all levels, and physicians
- Other health professionals
- Hospital managers, including Nursing Manager
- Hospital administrative staff
- Senior managers with responsibility for:
 - Clinical staff management, such as Director of Nursing
 - Quality and Patient Safety
 - Digital Research & Innovation, such as Senior Digital Transformation Lead
 - Digital Assurance
 - E-health
- Hospital IT staff
- Regional Managers of health and planning
- Nursing home leaders and department managers
- Home care service department managers
- External technology providers and experts
- Education and training managers
- Teachers and Trainers
- Academic partners and staff, including senior lecturers and Heads of Medical School
- Triple Helix coordinators

After each LIU membership was agreed, each Triple Helix established a schedule of meetings, ranging from biweekly to bimonthly. These were led by LIU representatives, and the LIU framework was used to steer the discussion and decisions of the LIU stakeholder group. In most cases the group did not use all questions, but handpicked those that were relevant to their situation and worked through these. During these meetings the LIU group defined the needs of the healthcare personnel, the training required, the objectives of this training, the way in which it was to be provided, and how it was to be evaluated, resulting in an overarching plan for the rest of the training.

3.2. Arranging and carrying out OTJT

The OTJT concept was followed to different degrees, depending on the requirements and situation within the test sites:

- Denmark used the OTJT concept and checklist extensively, finding that the focus on hands-on training suited their situation well.
- The German Triple Helix produced an integrated project management system (PMS) that encompassed all three concepts and allowed the team to work interactively through the tasks and pick only those tasks that were appropriate for their situation. Using this they followed the OTJT checklist in a manner that allowed them to devise effective training, as well as feeding back easily to the LUI group.
- Norway followed the OTJT concept, adapting it for different situations as necessary.
- In Poland trainers were contracted to follow the OTJT principles and prepare training and teaching materials that fitted the individual groups needs, and then to carry out the training.
- Spain followed the OTJT checklist and devised training which included both practical and theoretical aspects. This training was adapted, using the OTJT concept, to online training when face-to-face delivery was no longer possible.
- The UK used the principles of the OTJT to develop a bespoke on-line training package in the form of a workbook and a reflective portfolio, although the OTJT checklist did not fit directly with the training package they planned.

There were a wide variety of training methods deployed in different Triple Helixes, and within Triple Helixes:

- Ad hoc practical hands-on, 1:1 & small group: Norway
- Face-to-face, group: Germany, Spain (planned only), Norway,
- Mixed simulated hands on & presentation, group: Denmark
- Online, group: Poland, Spain, Norway
- Online self-directed learning, individual: UK
- On site hands-on, group: Denmark
- Role play, group: Germany

Several Triple Helixes reported that, after a pause in delivery when the Covid-19 pandemic restrictions were first put in place, health professionals and their managers recognized that there was an urgent requirement for training to address new needs that had come to light, and to fill gaps in provision. These people directly approached the Triple Helix to provide that training.

For example, in Spain, primary care physicians and hospital endocrinologists told them that the need for training and implementation of the Type II Diabetes Mellitus (IIDM) dashboard technology was crucial; the follow-up of patients suffering from this disease had become complex and had become out of control during the most complicated months of the pandemic (patients were unable to attend their follow-up visits and only indispensable

laboratory visits/tests were performed, or they were afraid because of COVID-19 and did not attend, etc.). The Spanish Triple Helix restructured their training and delivered an online course.

Both Denmark and Norway Triple Helixes said they had found it important to support learning with workbooks, manuals and follow-up support. The latter took the form of 'refresher' training sessions, trainer availability for immediate questions in a hands-on situation, trainer availability for email questions, and training superusers who could help other healthcare staff. It was suggested that supplementing training with e-learning, video guides and distance teaching was a good strategy for the future. Norway said *"The follow-up training after the course was the most important part of the training. Follow-up training, availability, superusers, and manuals are key ingredients."*

3.3. Assessment and certification

Assessment

A diverse range of testing methods were used, to fit a variety of training situations. Some of these were formal and then formally assessed, others were more informal, and based on the demonstration of knowledge and skills, both in the workplace and the training room. A small number of tests sites did not assess the learners.

Assessment techniques used included:

- Written self-assessment questionnaire
- Group follow-up – questioning and demonstrating tasks
- Assignment tasks demonstrating understanding and knowledge
- Reflective written exercise
- Observation of practical skills being used
- Written exercises
- Pre- and post- testing

Triple Helixes were careful to ensure that the assessment of learners was appropriate for the level and length of training that was delivered, that it was not disproportionate to the type or time taken, and that it did not form a barrier to take-up for future learning.

A few test sites were able to use were able to use existing assessments, while others devised their own. For example, due to a lack of an exiting valid and suitable assessment, one German Triple Helix partner developed an assessment for the domains: digital competencies, technical affinity, technology knowledge, as well as assessing the knowledge gained of the digital application.

Certification

Accreditation and certification proved to be the aspect of the three concepts with the most diversity in its implementation.

Some test sites issued certificates on completion of the training, others issued certificates when learners had successfully completed set assignments that were assessed by the training team or other appropriate professionals. In some cases, accreditation was tied to national standards, and certification was by a recognized external institution. For example, the UK Triple Helix gained recognition for the assessed learners' reflective exercise as an element of their required Professional Continuing Development portfolio, as well as providing certification for the module from the academic partner.

In some cases, while they were assessed, learners did not receive certification. This might not have been available, or not relevant, or their assessment is part of a larger qualification that will be awarded after further successful assessment.

3.4. Is there anything you would have done differently?

The effect of restrictions during the Covid-19 pandemic led to rearranging plans and delivery in most of the Triple Helixes, which in turn slowed down the implementation and testing phase overall. A lack of face-to-face training was seen as a big disadvantage for the effectiveness of delivery.

The Norway Triple Helix said that they would have translated the DISH materials from English before presenting them to managers at the test sites, to enhance understanding, and would also have amended the terms used to fit with the existing tools in their National Welfare Technology Program.

The UK Triple Helix mentioned that they would have included more of the relevant Digital related teams from within the health service from the start of the project, and stressed the importance of ensuring that LIU membership included representatives across all relevant teams and levels.

4. Feedback on the Concepts

4.1. As a DISH partner, what did you think about the DISH concepts?

All Triple Helixes agreed that all three concepts were essential in order to maximise the chances of implementing successful training, each contributing an essential aspect to a training program.

There was also agreement that they are aligned and worked well together, and it was easy to move smoothly from one to the next. Several Triple Helixes mentioned that the transition from LIU to OTJT in particular worked very well.

Early iterations of the DISH documentation were seen by some to be very text based and inflexible in its application, not process-oriented, and in different styles across the concepts. Some of the wording was seen as difficult, particularly specific terminology.

Almost all triple Helixes had some concerns over the number of questions in the LIU documentation, finding it too comprehensive, and often not appropriate for their situation. Following this aspect also put additional time pressures on busy staff and managers in the LIU group. It was noted that the LIU concept needed a short introduction about how best to use it.

It was soon clarified that the LIU template was a list that should be picked from, depending on the particular situation in a test site. By picking the most relevant questions from the template, Helixes were able to gather the most appropriate information for their test sites.

As the project progressed, feedback was received and the concepts streamlined and simplified, the concept documentation became easier to apply. In addition, after being translated – both language and terms – for each country, the documentation became easier to understand.

It was thought by most Triple Helixes that setting up an LIU group and following the concept template definitely facilitated the planning process, allowed for a more thorough reflection and planning of the entire process, and also forced a more in-depth diagnosis of the needs of the training participants. There was a lot of emphasis on the importance of making sure that the LIU was established effectively from the start, included a wide range of people, and that all the appropriate people were included. It also was useful in bringing to the front any technological issues, which could then be addressed before they affected the training.

Involving people in the LIU in particular not only helped in initiating and designing the training, but also facilitated the uptake of the digital solutions, with those involved 'championing' the training, and promoting the digital solution.

The Norway Triple Helix reported that, by using the DISH concepts, the training was given a higher priority and more attention, and feedback from the German Triple Helix was that the DISH concepts were very well received by the participants and successfully facilitated the process of implementing a new digital application.

There was a general call for the DISH framework to be more process-oriented, providing an easy-to follow 'road map' through the process. It was felt that this would make the use of the framework easier and its take-up more likely, and that an interactive online tool that allows a team to work together would be most helpful.

As an example, to assist with following the DISH framework, the German Triple Helix integrated all three concepts, LIU, OtJT and assessment in an online project management System (PMS), which allows a team to interactively work through all the tasks and makes it easy to delete tasks that are not needed in a particular situation.

Overall, the Triple Helixes were very positive about the DISH concepts in principle. The German Triple Helix commented that the division of the DISH framework into three concepts *"is very suitable as a process that closes the gap between innovation readiness-digital competence-change management and health care in a sustainable way."*

It was agreed that the concepts provide a good overview of the topic of introducing a digital innovation in a health care setting and offer a good toolbox of methods.

4.2. Promoting factors

National and regional policies – Many of the countries involved are now developing, or have recently developed, policies for their health and care services which include technology and digital competency requirements and the relevant training to ensure that health care practitioners have these competencies. This has been a positive factor in promoting the DISH material, particularly as senior levels within organisations, and stands the DISH framework in good stead for the future. Examples of these include:

- Germany: the DISH concepts were taken up by the *"Masterplan Gesundheitswirtschaft Mecklenburg-Vorpommern 2030 (MPGW-MV 2030, Masterplan Health Economy 2030 of the Federal State Mecklenburg-Vorpommern)* in the cross-sectional area *"Digital Transformation"*.
- Norway: In 2014 Norwegian government launched the *"National Welfare Technology Program"*, and since 2020, 20 municipalities and organisations are part of *E-helse Vestland (Westcoast eHealth)*, a collaborative project for collecting, building, and sharing knowledge and experience that are critical to implementing eHealth solutions in municipalities.
- Poland: the government is currently working on a public policy entitled *"Healthy future. Strategic framework for the development of the health care system for 2021-2027, with a perspective until 2030"*
- UK: since 2020, digital technology introduction and training have been included in the NHSX, NHS Digital and NHS England and NHS Improvement *"Digital Clinical Safety Strategy"*, the NHSX *"What Good Looks Like"* Framework for digital transformation, and the NHS Digital *"Digital inclusion for health and social care"* Guide

High level involvement and commitment – Several Triple Helixes reported that the involvement of high-level managers and decision makers, such as managing directors, other board of director members, senior clinical staff and senior training managers was one of the main drivers for implementing the DISH concepts. Their commitment as LIU participants, particularly those responsible for the implementation and promotion of digital innovation was seen as crucial to those helixes successfully implementing the DISH framework. One example was Denmark, where “An overall decision from the managing directors at the hospital to optimize the use of the patient logistics boards gave an incentive cause to establish contact with the Learning – and Research Centre and promoted the use of the DISH concepts.”

Innovation driven by the Covid-19 pandemic – Several Triple Helixes reported that challenges that the Covid-19 pandemic has presented have meant that development and implementation of new strategies has accelerated, and there has been an increased recognition of the need for digital solutions both in health situations and in management, for instance where health care professionals looked for alternative options to have meetings. This has meant that the Covid-19 pandemic had led to a speeding up of implementation and had an overall positive effect on digitalisation in the health and care sector. Norway reported one partner said: *“In 14 days we managed to do as much as we have spent several years on doing when it comes to eHealth solutions”*.

As Triple Helixes had already started their DISH concept delivery, it was easy for them to get started again after the “COVID-19 pause” - test sites did not have to start all over again. In some cases, the restrictions imposed during the pandemic meant that physical training was held in smaller groups due to social distancing, which meant that training could be more effective.

4.3. Limitations

Covid-19 pandemic - Without doubt the single most limiting factor for all implementation of the DISH concepts in all the Triple Helixes was the impact of the Covid-19 pandemic. The effects of this can be summarised as:

- Health care professionals not having time to engage with the project, at all levels stages, due to increased work pressures and staff shortages due to increased work load, staff illness and self-isolation. In some cases there were restrictions places on health and care staff on taking part in anything other than vital training.
- National restrictions on gathering, sizes of gathering, and unnecessary entry into health and care facilities has meant that many planning, training and assessment activities could not take place. Some Triple Helixes were able to switch to online meetings and training, however this took time to be implemented, as all organisations struggled to re-organise.

Existing training programmes - Some countries already have national training programmes, such as Norway, with the *National Welfare Technology Program* and the United Kingdom with *Health Education England*, and these are generally the 'preferred suppliers' for many health service providers. These offer existing tools that cover most or all of the functions in the DISH concepts, making it challenging to come up with new tools, or reasons for changing current practices.

National organisation and cultural barriers – Some countries have difficulty implementing national programmes due to their internal organisation of health and care services. In Germany, for example health and education are under the sovereignty of the Federal States, and it is therefore difficult to roll out a concept all over the whole country.

Lack of requirements for technology competencies in health and care staff –Some countries do not have required technology skills standards for health and care staff, in others these are just being introduced. This has had the effect of de-emphasising their importance, particularly when there is more urgent training to be implemented and training time is restricted.

Appendix A: Test Site Initiation Template v1

ERASMUS +
KA2: Cooperation for innovation and the exchange of good practices - Sector Skills Alliances



Project acronym: DISH
Agreement Number: 2018 - 3001 / 001 - 001
Project full title: Digital & Innovation Skills Helix in Health
Project Number: 601008-EPP-1-2018-1-DK-EPPKA2-SSA
Call identifier: EAC/A05/2017

Template 4.1: Implementing & Testing Concepts

Test Site Initiation Template

Version: 3.0
Status: Final
Dissemination Level: Confidential
Due date of deliverable: M16 (March 2020)
Actual submission date: 16/01/20
Work Package: WP 4 - Testing Concepts
Lead partner for this deliverable: NHS Liverpool CCG
Partner(s) contributing: Edge Hill University + LCR eHealth Cluster

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Appendix B: Revised Test Site Initiation Template

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Project Number: 601008-EPP-1-2018-1-DK-EPPKA2-SSA
Call identifier: EAC/A05/2017

Template 4.1: Implementing & Testing Concepts

Test Site Initiation Template Update January 2021

Version: 4.0
Status: DRAFT Update 01-21
Dissemination Level: Confidential
Due date of deliverable: N/A
Actual submission date: N/A
Work Package: WP 4 - Testing Concepts
Lead partner for this deliverable: NHS Liverpool CCG
Partner(s) contributing: Edge Hill University + LCR eHealth Cluster

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Appendix C: Test Site Progress & Feedback Report Template

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Project Number: 601008-EPP-1-2018-1-DK-EPPKA2-SSA
Call identifier: EAC/A05/2017

Template 4.2: Implementing & Testing Concepts

Test Site Progress & Feedback Report Template

Version: 2.0
Status: Final
Dissemination Level: Confidential
Due date of deliverable: M16 (March 2020)
Actual submission date: 16/01/20
Work Package: WP 4 - Testing Concepts
Lead partner for this deliverable: NHS Liverpool CCG
Partner(s) contributing: Edge Hill University + LCR eHealth Cluster

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Appendix D: WP4 Final Triple Helix Reports



WP4:Final Helix Reports

Denmark

1. Overview of Implementation in your Helix	
1.1. How many LIUs did you implement?	14
1.2. How many test sites did you implement?	19
1.3. How many people were trained?	357
1.4. Brief description of Test Sites: Explain for each test site the following; 1) What kind of health provider did you work with? 2) What kind of challenge did the test site face? 3) What kind of technology did the test site want to develop and / or implement? 4) What was the objective for the test site?	
<p><i>What kind of technology did the test site want to develop and/or implement?</i></p> <p>We had several test sites:</p> <p>Technology 1: Cetrea (Digital Patient Logistic Boards) with 8 LIU, 8 test sites and 231 learners. The company delivers technological solutions focusing on patient flow management to hospitals. The training focused on simulation training of hospital staff in skills related to Cetrea (Digital Patient Logistic Boards). The participants/learners were staff and managers from the regional hospital in South Denmark (Sygehus Sønderjylland/SHS). The system was already integrated at the hospital but not used in full-scale; the objective then was to increase usage of the system to full-scale. Therefore, the board of directors declared a must-do task for the hospital</p> <p>Technology 2: Cisco Meeting Server (CMS) with 4 LIU, 10 test sites and 94 participants. A regional decision to strengthen the multidisciplinary collaboration in the region of southern Denmark through the use of technology. To promote skills in using technology when a patient is discharged from the hospital to the municipality. Especially vulnerable patients and patients with complex diseases.</p> <p>Technology 3: Cisco Webex Meeting (CWM) with 1 LIU, 1 test sites and 32 participants. One international webinar for obstetricians and midwives using Cisco Webex Meeting (CWM). The objective was to provide a different alternative to physical meetings (due to Corona restrictions). To show the benefits of having online meetings/teaching/learning. To increase knowledge and competencies of digital and technological tools for teaching and learning.</p> <p><i>Summary of what kind of challenge did the test site face?</i></p> <p>Each training starts with an LIU meeting. OTJ training and Assessment follow the LIU meeting. The answers below are therefore organized according to this.</p> <p>LIU:</p> <p>The whole LIU concept is too comprehensive and has too many areas and too many questions/tasks included. Therefore, as also recommended in the concept, we use it as a template from which we can handpick relevant questions for each LIU meeting.</p> <p>The LIU concept is when an appropriate and qualified guide is modified for preparing the training. When not all professions relevant for the training are present at the LIU, it is challenging to conduct a constructive discussion about the expectations and learning aims, both overall and specifically related to each profession; related to LIU's domains; and related to the technical solution (Cetrea). In addition, professions use the Logistic Board differently, and with this technology, it did not seem accessible to mainstream training across professions.</p> <p>On the job-training:</p> <p>Not all 'on-the-job' locations have been suitable for training "on-site"/at the ward. For example, a hospital ward moved to new facilities and requested the training at the new location. But lightning and heating were still to be</p>	