# Winston Churchill Fellowship Report

## To Study Effective Implementation, Embedding and Evaluation Methods of Person Centred Health Care approaches and the Outcomes of these approaches in the UK.

**He aha te mea nui o te ao**
**He tangata, he tangata, he tangata**
Māori proverb

*What is the most important thing in the world?*
*It is the people, it is the people, it is the people*

# Acknowledgements

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## Executive Summary

The value of person centred care is increasingly recognized as an approach that puts people and their families at the centre of their healthcare and wellbeing. (Elywn, Frosch, Thomson, Joseph-Williams, Lloyd, Kinnersley, Cording, Tomson, Dodd, Rollnick, Edwards & Barry, 2012; Kings Fund, 2010; Health Foundation, 2014)

Whether it is termed relationship centred practice, cocreating health or health coaching - the approach is the same – it is about training staff to develop genuine partnerships with people and their whanau. Finding out not 'what is the matter with them' but rather 'what matter's to them' developing a shared agenda and working collaboratively towards the patient's health goal. The approach supports people to take a more active role in managing their health, by building their confidence, knowledge and skills to make shared decisions about their health and ultimately self-manage. Evidence suggests that for those with chronic conditions or who have long term disabilities this approach can improve health outcomes.

In 2017 the author took a study trip to the UK to look at co-creating health and health coaching programmes. In particular, the author focused on the process for implementing these programmmes, the lessons learned, the qualitative and quantative outcomes and sustainability.

Visiting a variety of programmes and organisations in the UK has assisted me in reflecting on and gaining greater clarity on how to create and embed sustainable Relationship Centred Practice behavioural change in health care organisations in New Zealand.

One of the main lessons learned was that rolling out training packages without robust processes and structures being in place to support those behavioural changes, sets it up to fail. From the outset, management and senior clinician buy-in is critical from the initial stages, as is having a few champions to assist it gaining momentum - both these factors are imperative. Simultaneously, having human resource systems and clinical processes that supports this Relationship Centred Practice partnership model is essential to the ongoing embedding in and continuity of clinician behavioural change.

The central learning from this report is that, in embedding in any sustainable person/whanau centred care model in health care in New Zealand, it is imperative not to do so in isolation. Any training or education initiative in this

area needs to be supported by processes and an organization structure that supports this behavioural change. In addition, there needs to be robust built-in evaluation methods that measure outcomes to provide the evidence required for both Managers and funders to validate the outcomes and thereby the continuation of the programme/s. And finally, any behavioural change needs to be embedded in and adopted by Senior Managers and Clinicians in order for transformational behavioural change to occur.

## Introduction

Relationship Centred Practice (RCP) is based on effective engagement through a partnership model with the patient/client, rather than an expert/telling bio-medical model and has increasing recognition and evidence base as a transformative approach to delivering health care for those with chronic conditions or who have long term disabilities. (Kings Fund, 2010; Gottlieb, Sylvester, & Eby, 2008: Hibbert & Gilbert, 2014; Phillips, 2015; Seers, 2015; Walter, 2014).

It is a framework that supports people to take a more active role in managing their health, by building their confidence, knowledge and skills to make shared decisions about their health and ultimately self-manage. For a partnership model to work effectively it needs to be supported by changes in clinical practice and service delivery. As well as having a lasting impact on people's quality of life and wider health outcomes, relationship centred practice can lead to improved health outcomes and improved levels of patient activation. I have worked under the guidance of my Relationship Centred Practice Steering Group and Māori Health Unit to develop RCP in the NZ cultural context - the Hui Model is a key enabler central to the RCP Model. This RCP Model aligns with the NZ Health Strategy released in April 2016 and 'People Powered' Health.

## Project Purpose

To inform the development of a NZ co-creating health or relationship centred practice model, that will assist in training clinicians in a partnership model of health delivery that enables patients to feel more connected, confident and engaged to take ownership and responsibility of health issues. It is a framework that promotes health equity and improved health outcomes, and is congruent with the NZ Health Strategy and the NZ Disability Strategy rolled out in early 2016. The purpose is to further research and develop a training model that supports clinicians to address patient's confidence, ambivalence and motivation through shared decision-making to make health decisions, health goals and sustainable changes to enable better health outcomes. It was also to look at how to embed in and make sustainable this behavioural change, with clinicians.

## Research Themes and Questions

There are well developed pockets and programmes that have been run in the UK on co-creating health, person centred care and health coaching for the last 12 or so years and so getting a more in-depth understanding of the challenges, successes and lessons learnt from implementing and embedding this framework into health care organisations in the UK, will assist ongoing development in New Zealand.

The key themes of the study Fellowship are around gaining a more in-depth understanding of: -

- co-creating health and health coaching approaches
- how it has been disseminated
- the challenges and successes & lessons learnt from putting this framework into health care organisations
- how best to get champions on board
- how to get allied health professionals, nurses and doctors on board
- look at other models of shared decision making
- looking at some of the successful self-management programmes
- how to sustain the programmes
- evaluation methods

### Co-creating Health and Health Coaching

There are many challenges facing healthcare around the world in terms of increased technology ad advancement and a growing number of older people and people living longer with long term conditions and disabilities. Many health systems, including the NHS are under increasing pressure to improve outcomes and reduce costs.

Evidence-based research has shown that supporting people to self-manage their condition improves their quality of life and helps to save costs.

The Co-creating Health programme introduced in the UK 8 years ago, aimed to embed self-management support within mainstream health services across the UK and equip individuals and clinicians to work in partnership to achieve better outcomes.

The programme focused on three equally important factors which determine how much individuals are able to play an active role in managing their own health:

- Giving **people with long-term conditions** the skills, confidence and support to self-manage.
- Helping **clinicians** to develop the skills, knowledge and attitude to support and motivate people with long-term conditions.

- Changing **health systems** so that they encourage and facilitate self-management.

  Programmes such as 'Realising the Value', & '1000 Lives' & Co-Creating/Co-production Health initiatives are a few of the programmes that were rolled out.

## Health Coaching

Assists people/clients/patients to gain the knowledge, skills, tools and confidence to become active partners in their care so that they can reach the health goals they have identified together with their health care professional.

Evidence shows that by health professionals working with people to identify what's most important to them, and assisting them to focus on their own internal motivators, can helps them move forward and take more self-responsibility for their health and leads to better health outcomes.

Health coaching is a patient-centred process that assists people to focus on their current situation and the health and well-being goals that they want to achieve. It builds on working with the client to support them though building knowledge, motivation and resilience. It is a shared decision making approach that promotes collaborative partnership while also providing support and an accountability mechanism.

Health Conversations and Health Coaching Programmes have been rolled out in various areas in the UK over the last 5 years.

Evaluation of outcomes was central to the study to see if changing clinician behavior made a difference and what effect that had on patient self-management, patient's health and patient satisfaction. I wanted to look at the qualitative and quantitative outcome measures and any reported outcomes that the programmes had. This is imperative to provide evidence to funders and Senior managers that health coaching or co-creating health was making an essential difference to healthcare.

The most commonly used measure is the validated Patient Activation Measure – or PAM for short – an internationally-used and validated patient questionnaire, which measures the level of activation. This is the skills, knowledge and confidence that a person has to manage their own health.

The Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) are also commonly used.

## Fellowship Findings

### Abertawe Bro Morgannwg University Health Board (ABMU)

Abertawe Bro Morgannwg University Health Board covers a population of approximately 500,000 people and employs approximately 16,000 members of staff, 70% of whom are involved in direct patient care.

The Health Board has four acute hospitals providing a range of services and a number of smaller community hospital primary care resource centres providing services to the residents outside of the four main acute hospital settings.


**David Hughes, Head Podiatrist and Co-production Health Lead at Abertawe Bro Morgannwg University Health Board , Port Talbot, Wales**

ABMU introduced Co-production training (health coaching) in 2012 and over a four year period, 900+ staff attended the 2 day co-production training workshops, facilitated by an external trainer. There was real management buy-in with the Director of Therapies and others across ABMU supporting this initiative.

A comprehensive work plan was developed to ensure that staff across ABMU were trained, Resource materials were developed in the form of a training and promotion video and e-learning modules. Therapy staff rolled-out 'Making Every Contact Count' (MECC) training and collaborated with Public Health Wales to incorporate this training within the co-production plan as a means of first line self-management support. Co-production PROMS were developed and shared nationally by podiatry staff.

Discussion. There are pockets of excellent co-production work being done across the ABMU sites, with qualitative and anecdotal positive outcomes being reported. However, it appeared that this information was not being correlated and reported on in a consistent and collective way. Further to this, the two of the main Co-production champions at a Senior Management Level have both left ABMU, and this, coupled with the pressures on the limited health dollar had seen the prioritisation for co-production training become compromised.

The contract for the external training was rescinded in early 2017. There are pockets of excellence in different areas, across ABMU like in the physiotherapy, occupational therapy and podiatry departments. However, embedding the programme and the future sustainability of the model of care was an ongoing issue. Staff turnover in various areas meant some staff had been trained in the model and others had not, co-production champions at a Senior Management Level had left, there was no resource or central point to evaluate the impact of outcomes achieved.

David Hughes, the Lead for Co-Production, who also Manages the Podiatry, Orthotic and Chronic Pain Team, is in the process of putting a business case to the board to roll-out more co-production training and also couple with Swansea University to evaluate outcomes of working in a co-production model, to ensure evidence was correlated to sustain the programme.

**Penny Brohn Cancer Services - Bristol**

Penny Brohn UK is a charity organization focusing on helping people live well with cancer, with emphasis on self-management in terms of supporting, enabling and empowering people on their journey through cancer. They are a non-government organization and rely on funding grants and contracts to run their services.

Their services are designed around a holistic, whole person approach known as the Bristol Whole Life Approach . Living Well is their flagship course, that is a self-management course that explores the various aspects of the this

approach and how it can help a person live as well as possible, for as long as possible with the impacts of cancer. They were successful in winning the contract to expand their Living Well services to locations throughout the UK, as they were determined to reach as many people as possible with their life-affirming message.

Other services Penny Brohn offers include Introductory Courses, GP Consultations, Nutritional Sessions, Cooking Classes, Acupuncture, Counselling, Meditation, Qigong, Tai Chi, Nordic Walking Classes, and treatment support clinics for those undergoing or recovering from chemo or radio therapy

**Dr Helen Seers, Research and Evaluation Lead, Penny Brohn UK**

Penny Brohn has embedded co-creating health principles and self-management courses as their fundamental core business in assisting people to live well with cancer. Moreover, they have created a sustainable model by actively quantitatively and qualitatively evaluating patient outcomes.

Five years ago, they employed a lead evaluator, Dr Helen Seers to provide the evaluation required to assess if their services were making a difference in people's lives. Penny Brohn utilise the Patient Activation Measure (PAM), which measures the level of activation around the skills, knowledge and confidence that a person has to manage their own health before and after the involvement with Penny Brohn services.

They also utilize the MyCaW (Measure yourself Concerns and Wellbeing) which is a validated, person-centred outcome measure, designed specifically for the evaluation of cancer support services. The MYCaW questionnaire measures

the impact of cancer support services on the severity of each client's cancer-related concerns and wellbeing. Penny Brohn has helped to develop MYCaW over many years, including the accompanying qualitative coding guidelines. (Penny Brohn; 2017)

In addition, they also use the Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) tailored to each of their services.

In June 2016, Penny Brohn published their latest evidence – an evaluation report on their Wellness Package, which included their Living Well course, plus 12 months of their follow-up support. The package was funded by the Department of Health, reaching 519 people over 18 months. The main findings showed that most participants on the course experienced

- Reduced cancer-related worry and stress
- Improved wellbeing
- Increased Patient Activation
- Improved lifestyle – meaning better diet, increased exercise and stress management
- Improved relationships
- Better self-management of health: reduced reliance on GPs and NHS services

The validated outcomes have meant that Penny Brohn can evidence patient satisfaction, patient management and better health outcomes, which has in turn assisted them to be successful in winning more funding and future contracts. This has meant that the co-creating health and patient management model has become a sustainable and has been firmly embedded as a successful model of care.

Six weeks after the living well programme 86% of clients reported that the course had enabled them to self-manage their health more effectively. The patient Activation Measure (PAM) that measures the level of a person's activation around the knowledge, skills and confidence to manage one's health showed a small but significant improvement at the six week follow-up with 42% having a clinically relevant improvement. After the course there were less low activated clients and a greater number of higher activated patients.

At the 12 month follow-up 45% of clients said the 'Wellness Package' had changed the way they access medical services – reduced number of GP visits, cancer team visits and other NHS services.

In 2016, Penny Brohn became part of the Realising the Value Project led by Nest and the Health Foundation, who conducted a thorough analysis of the evidence for person centred approaches.

The economic modelling of the Realising the Value Project showed that the impact of self-management and person-centred care initiatives could save the UK £950 m and the social benefit generated from each 'Living Well' participant at Penny Brohn was around £13,700.

## Vanguard - Symphony Healthcare Services

### Background

NHS England announced the launch of new 'vanguard' sites across the country in late 2015, where new funding would be used to support the development and roll out of the new care programmes. Today, 50 different vanguard sites exist across the country, all tasked with developing and testing new ways of delivering healthcare services to create the most effective model.

South Somerset was experiencing the same challenges as much of primary care across the UK, with GPs struggling to deal with increasing workloads, as well as rising numbers of GPs eligible for retirement and difficulties in filling GP training positions. Patient demand is continuing to grow, along with rising patient list sizes for practices and the number of patients who have increasingly complex long-term health conditions

In April 2016, a brand new NHS healthcare organisation; Symphony Healthcare Services – through a unique partnership between Yeovil Hospital and GP practices in south Somerset was formed. The main purpose was on integrating primary and acute care services, developing improved ways of delivering healthcare services; which would not only help to improve a patient's experience, but use NHS funding efficiently and effectively. The purpose of this new organisation was to provide 'the right care in the right place' for patients and to support primary care to be able to provide a sustainable way of providing high quality healthcare services both now and into the future.

Symphony Healthcare services a population that has 135,000 people with an older age profile and 30,000 having long term conditions. There are 19 GP practices and 2 community hospitals and one general hospital.


South Somerset Health District

The Symphony Programme vanguard is managed through a Programme Board where representatives from all key healthcare organisations across south Somerset meet to discuss ideas, innovative ways of working, addressing any issues that may arise and ensuring key development milestones are met.

The Symphony Programme supports the implementation of new models of care within primary care and Yeovil Hospital to ensure that patients with the most complex needs are supported to live independent and healthy lives. Enhanced Primary Care practices are using the 'huddle' model of care practices and new health coach roles have been created to improve access and decision-making, while Complex Care Hubs, with their teams of Key Workers, Care Coordinators and Extensivist GPs, are revolutionising the way those with multiple conditions are being supported.

The aim was less duplication of appointments and information, fewer delays in getting the right care, and more proactive, preventative services. Those with multiple conditions receive extra care and support to help them manage their health, remain independent and enjoy quality of life

By eroding the boundaries between acute, primary and community care they have created a more sustainable healthcare system.

Considerable progress has been made since the vanguards were launched in 2015 and there is emerging evidence that the new models of care are making significant improvements at a local level. This includes reducing pressure on busy GP and A&E services.

Ian Creek was appointed Head of Projects, Jeremy Martin Programme Director and Deborah Neale the Symphony Training and Evaluation Lead.

Mobile Older Persons Complex Care teams consisting of Extensivist GPs, Care Coordinator and nurses were introduced who are employed by the hospital, but work in a seamless way across the primary sector.
Each of the GP practices employed health coaches – roughly the ratio was one health coach to 1 FTE GP. 43 Health Coaches have been employed across 17 GP Practices in South Somerset.

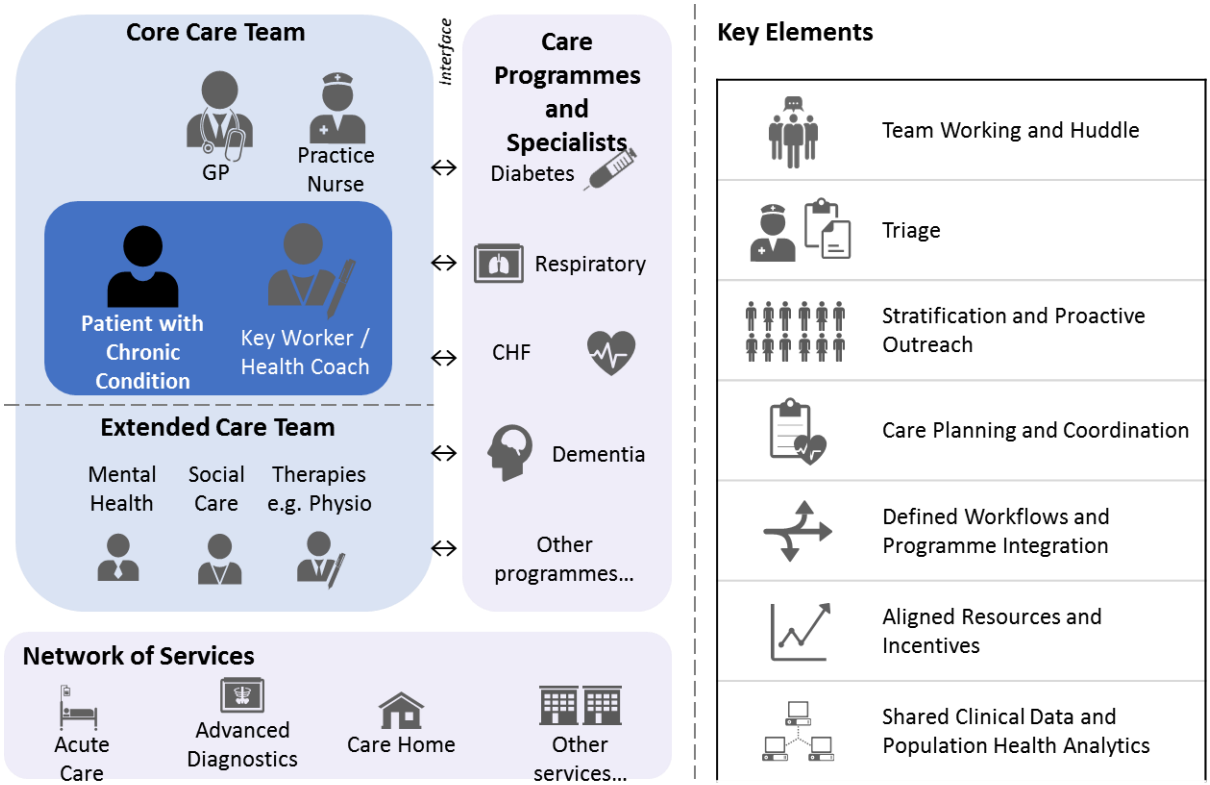
The three main tasks of health coaches are:-

1./ Coordinating care and sign-posting people in the right direction. Within this building links with the community, linking in with community groups and developing groups where there are gaps.

2./ Health Coaching – Coaching for change

3./An active member of the Primary Care Practice – being part of the huddle, using initiative, ensuring sustainability and working "to the top of their licence" – trained to do blood pressures etc.

The GP Practice Model
The patient and health coach are supported by the wider care team and a number of care programmes and services




*Source: Jeremy Martin, Symphony Programme lead Presentation, Oct 2017*

**Ryalls Park Medical Centre, Marsh Lane, Yeovil**
- 5000 registered patients


**Jeremy Martin, Symphony Programme Lead and Dr Catherine Patrick, Ryalls Park GP & Director of Primary Care for Yeovil Hospital**.

Programme Outline –

Every day a multidisciplinary team meeting occurs at each GP Practice (called a huddle) with at least one GP, Practice Manager, Health Coaches, Health Visitors, practice nurses, health care assistant and others like muscular skeletal physiotherapist, community pharmacist, nutritionist, hospice nurse, district nurse, social worker etc. there on an as needed basis.

The huddle purpose is to: -
Review all hospital discharges in the previous 24 hours
Review all hospital admissions in previous 24 hours (putting these on huddle list to review in a week to ensure primary follow-up)
Address any patient concerns that any member of the huddle/or practice may have

The huddle can last anywhere between half an hour to an hour depending on the number of cases to be discussed.

Once a week the Mobile Complex Care team attend the GP Practice Huddle to discuss the more complex cases. A combined decision on which of the more complex cases should be managed by the Complex Care Team – these cases are

managed by the Extensivist GP and the Complex care team, until the patient is stabilized and a plan in place then handed back to the GP practice.


*The Huddle - Source*

A central element to the Symphony Programme is the screening done at the initial phone call to the GP practice by the administrator or health coach. Screening questions such as:-
What are your concerns?
How long have you been concerned about this?
What are the reasons you are ringing for an appointment now?

To manage expectations and change patient culture around this the 'holding' message on the GP's answer phone tells the caller that the admin person will be asking some screening questions to assist in directing the patient in the right direction.

The answers to these are documented and expectations are managed as a GP might not be able to phone or see them till later that day –a health coach will ring or go out in the interim (if necessary) and often the need to see a GP becomes not necessary.

The answers to the screening questions can assist the GP or the Health Coach to hone in on the issue that the patient is really concerned about – "So Mrs Fussell, you are really concerned about the ulcer on your leg" – the advantages of this is it not only makes the patient feel listened to, but allows the GP/Health Coach to focus quickly on the patient's central concern, thus saving time trying to ascertain the patient's most important concern.

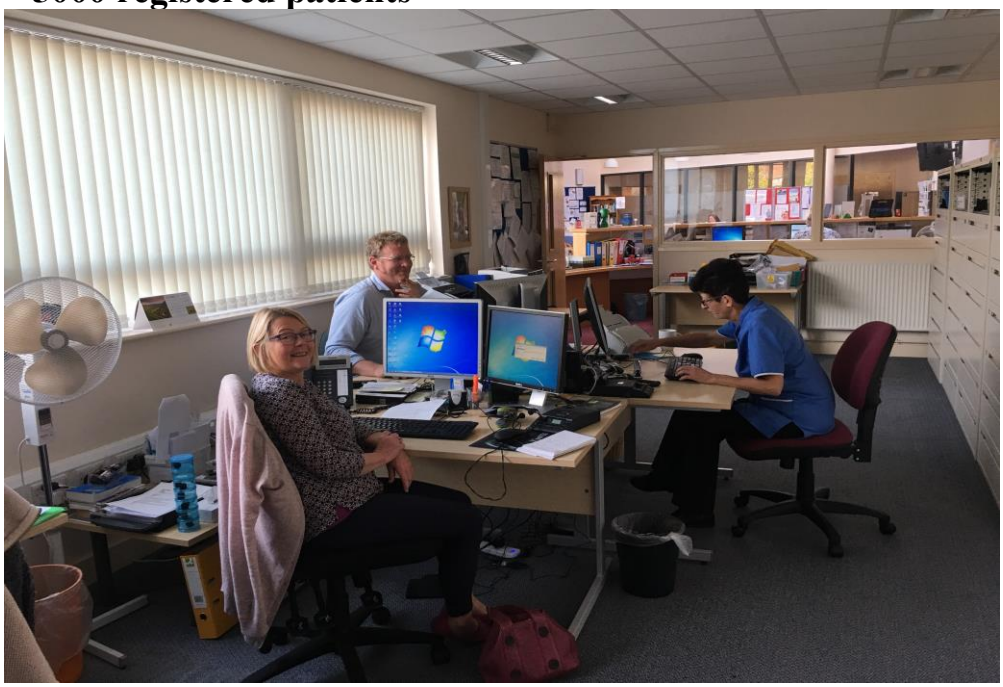
The GPs have times in their day scheduled for any Urgent Appointments, Urgent Phone Calls then an GP Phone Call Over Flow List.

The screening questions manage expectations, and in many cases can alleviate the need to see the GP. In the case of mental health issues, there will always be the need for more urgent prioritized appointments but many with milder mental health issues, have explained to them that the GP will ring them later in the day (during their Urgent Phone Calls time or on the GP Phone Call Over Flow List slot), but at same time they are signposted to the "Good Samaritans" or "Helpline" phone number to ring in the meantime, if they so wish. Qualitative analysis has shown that half of those with mild mental health issues, have had their short term needs met by a Mental Health Support line.

At Ryalls Park the qualitative benefits of the Symphony Model of Care change have been threefold:-

1. Better patient care working with the Allied Health & Complex Care Teams
2. Keeping people out of hospital – for example Type 2 diabetes managed much more effectively/ hypertension managed together by patient and health coach
3. GP Workforce Crisis alleviated – GPs are feeling far less pressure, job satisfaction and work life balance has returned, (anecdotal evidence – Dr Catherine Patrick, Ryall Park Practice : 12 October 2017)

## Millbrook Surgery, Millbrook Gardens, Castle Cary – 5000 registered patients



Dr Steve Edgar & Health Coaches – Steph Agbo, Mandy Lynch,
Bev Vincent & Helen Littell

I attended a huddle with the Millbrook Surgery Team – who work in a similar way to the Ryall Park Huddle.

The Symphony Model has allowed the practice to work in a completely different way and make a real difference to patient care and allowed people to be more in charge of their health care. It has allowed the practice to move boundaries so the patient can get more service in the right place (their homes) from the right people. According to Dr Steve Edgar, there have been real changes in hypertension management, diabetes management, and in the frail elderly, dementia and there is more service from the right people in the right place. With the TEP and Care Plans the end of life patients people are dying where they want to.

Modelled on the NUKA and the IORA Models Dr Edgar and the team at Millbrook GP Surgery work in a shared open-plan shared work area when not seeing patients on a one to one basis. This way they can share patient information and use collective best practice knowledge in a collective and inclusive way.

Health Coaches in the Millbrook Surgery have been employed from Health Care backgrounds – one from a transplant care ward and one from a dementia care ward, but do not have professional health qualifications per se. They have undertaken the two-day Health Coach Training & the two day 'House of Care' Training.

A fair amount of the time the Health Coaches at Millbrook work in their roles as a health navigator and only work as a health coach when lifestyle changes are part of the patient's goal.

Tasks

1. Discharges from hospital – phone call and/or visit to look at medications, complete care plans, look at any lifestyle changes together with person and to administer Patient Activation Measure
2. Make 3-day post discharge calls with people who have had 'out of hours' care twice a week on a Tues & Thursday
3. Follow up on any referrals from the GPs – Blood Pressure or Statin concerns
4. Prepare and input the patient information to be screened for the daily huddle (under the headings Name/Age/Status/Team Lead/Location/Brief Context/Goals/GP/Date to be Reviewed Next)

5. Follow-up on any referrals generated by the daily Huddle discussion
6. Run ‘Happy & Healthy’ Lifestyle Groups 1 X a week, link into Community Groups running ‘Health Walks’, 1 X a month provide educative talks on stroke, diabetes etc.
7. Undertake Care Plans with people when status changes and review what they would like to happen next time a similar situation occurs. The health coaches are required to review these care plans with the patient after 6 months –
8. Complete TEP Plans (End of Life Plans) with patients

A daily Huddle At Millbrook Surgery at Castle Cary

<u>Symphony Programme - Overall Lessons Learnt</u>

Challenges

The culture shift has been a challenge for the Symphony Project and initially this was fairly reactive and a lot of firefighting needed to be done to work upstream. The inter-relationship between GPs and the Secondary Care Specialists has been another challenge – the contracting system rewards GPs for keeping people out of hospital and rewards the hospital for keeping people in hospital (i.e. pays for patient bed days)

An added challenge was that the GP practices were individual businesses so they were not used to working collaboratively.

March 2018 and beyond

Over time it has been proven that working on the wider determinants of health has impacted favorably on the GP practice workload.

Some practices will continue as health coaching works well and is a lot cheaper than a locum GP.
The thought was that the proven downstream saving in hospital bed days would fund ongoing health coaching initiatives, however the contracting requirements have not changed to allow this shift in funding to occur. The Sustain & Transform Programme lends support that the Symphony Programme is a good model of care and should be rolled out across Somerset, but the contracting model does not support this – so constricts any possible changes at this point in time.

Health Coaches use E-Bikes to visit local patients

What Benefits Have Been Achieved

Evaluation of the outcomes is currently in process.
In diabetes

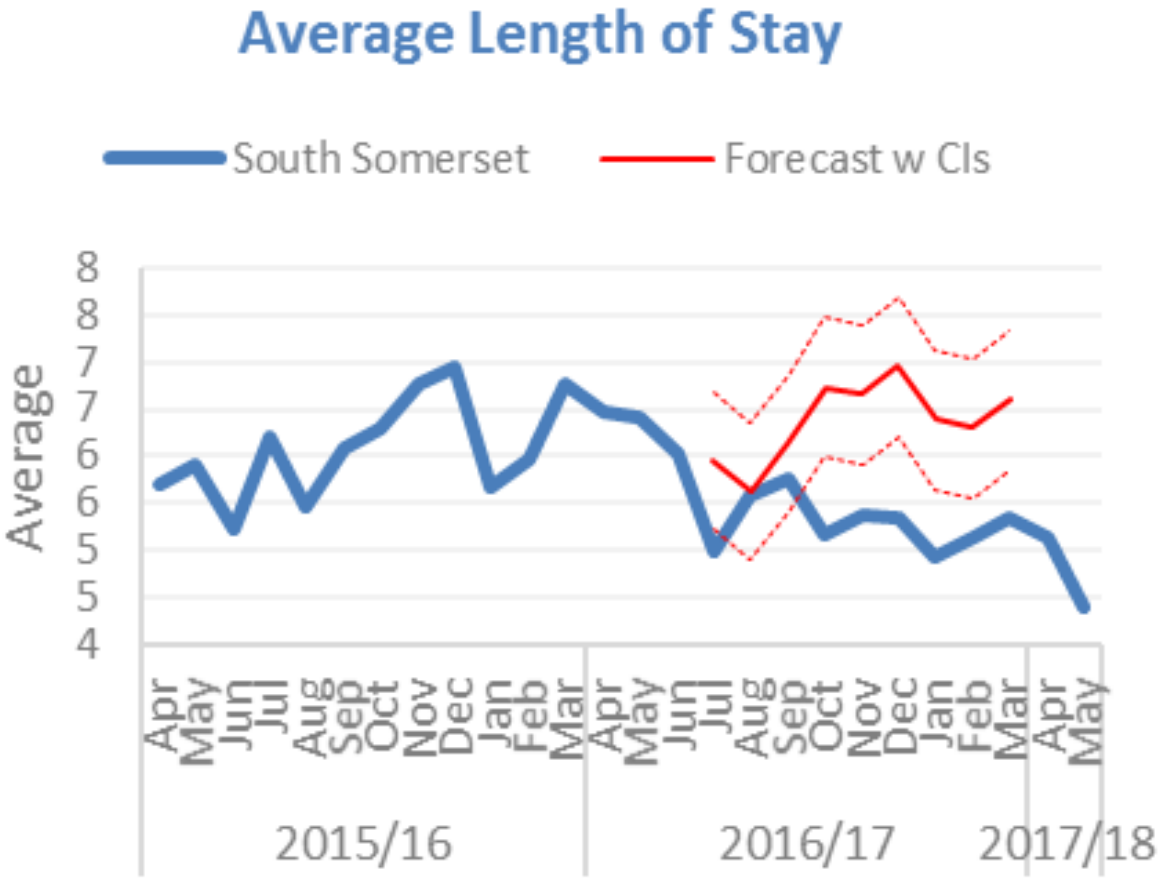
- Reduction in 75%of tier 2 & 3 referrals would lead to an income saving of £99k1
- If a 50% reduction achieved, then income saving will be £66k1
- Skype clinics have led to 14 saved clinic appointments leading to time savings for consultants

In gastro

- 30% reduction in follow ups based on 16/17 referrals to gastro, gives annual saving of £43k
- Consultant Connect likely to result in 30 – 40% reduction in referrals

Overall

- 25% reduction in outpatient follow ups equates to £20k income reduction
- Average length of stay at Yeovil Hospital has dropped with a direct correlation to the transparency and seamless transition between secondary and primary and the health coached working as health navigators.




***Source; Symphony Programme Findings, 2017***

**West Suffolk NHS Foundation Trust**

West Suffolk NHS Foundation Trust (WSFT) provides hospital and some community health care services to the population of West Suffolk and is an associate teaching hospital of the University of Cambridge. They serve a predominantly rural geographical area of roughly 600 square miles with a population of around 280,000.

At the main site, West Suffolk Hospital, is a 430-bed hospital that was a purpose-built Macmillan Unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit where children and adults are treated. Access to specialist services is offered to local residents by networking with tertiary centres, most notably Addenbrooke's hospital in Cambridge. The Trust has a turnover of £200 million and employs just over 3,000 staff.

Health Coaching in West Suffolk NHS was initiated as part of the East of England Health Coaching Programme. Trainers were accredited under Licence Agreement with TPC in November 2014, and a pilot commenced in March 2015.


Trainers Nina Frimley &Trudy Dunn are physios and work one day a week as health coach trainers

Initially training was offered to clinicians in Band 4 and above – Allied Health Professional's, nurses, Doctors and midwives across the acute trust divisions and then later to community staff, when the trust gained the tender to roll-out the training to Community Services. Training is offered once a month and so far training has been rolled out to 240 Clinicians.

Absolutely critical in the success of the roll out was the support of line management and senior management. Also was the close geographical working of the two trainers, the shared values, belief and commitment in the approach and to the task of rolling out health coaching. Word of mouth from clinicians trained around the organisation was the best marketing tool.

Health Coaching Workshop at West Suffolk

Lessons learned

The trainers found several challenges in rolling out the training – initially very little support from the Training Department in taking bookings, availability of training venues, the under-estimated time that administration associated with the workshops would take, the extensive marketing required.

Added to this the ability to fill the courses due to the pressing workloads of clinicians. Added to this the qualitative data made it difficult to prove the cost effectiveness of the programme to the finance team.

Evaluation was done at the very end of the workshop – post training and again 6 weeks later. Also, narrative case studies are collected from clinicians.

Evaluation data
97% strong or very strong mindset shift
98% would recommend the training to others
100% feel that the training is useful for working with people with Long Term Conditions
100% feel that clinicians would benefit from using coaching with their patients.

A 2 hour Continued Professional Development Session is also offered 6 weeks post training, but these are not well attended.

**Co-creating Health Framework**

Petrea Fagan was one of the lead developers and trainers for the Co-creating health movement.

Petrea Fagan, lead developers and facilitator, Co-creating health movement

The Co-creating Health model incorporates self-management training for people with long-term conditions, training in self-management support skills for clinicians, and a service improvement programme to put systems and processes in place to support patients and clinicians in their self-management activities. It builds collaboration between clinicians and patients, who deliver training together. At its heart is the combination therapy of shared agenda setting,

collaborative goal setting and clinical follow up. As in combination therapy, where a single drug is not sufficient, so here all three interventions need to be delivered in a co-ordinated way.

The evaluation of the first phase showed there are three critical strands to consider:

- Staff development
- Patient self-management education and development
- Service delivery and evaluation

Lessons learnt suggest that without these three critical stands, embedding health coaching is not sustainable.

In 2017 a Core Skills and Education Framework was published to assist workforce leads and developers to understand the knowledge, skills and training required to develop a person-centred workforce. The project team consulted widely with 300 different practitioners, health professionals and stakeholders working in this field and brought together the common threads and synergies of creating effective and sustainable person- centred practice. (Health Education England, 2017)
The aim of the Framework was on how to develop and support the workforce to work in a person-centred way. The core components of the framework focused around the underpinning values, core communication and relationship-building skills and key enablers for embedding a person centred approach.


It is essential that training encompasses the core values, communication,& relationship-building skills and takes place in the context of 'enablers' provided and supported by the system & organisation
*Source: Health Education England, Skills for Health and Skiills for Care, 2017*

It is clear from the framework that it is critical to have a three pronged approach to successfully embed in the culture change – staff training enablers, patient self-management education/programmes and structures that support the change including service delivery processes and evaluation. All three components need to exist in order to embed in patient centred care behaviour change and ensure ongoing sustainability.

It is not enough to teach health coaching, key enablers stratifying and pathways to activation without organisational structures that support this.

**Dr Frances Early, Centre for Self-Management Support, Cambridge**

Dr Early has been the evaluation lead on a few of the co-creating health programmes Petrea Fagan and her team have rolled out. She was brought on to design and correlate evaluation on outcomes for the programmes. Dr Early also reiterates that rigorous evaluation is imperative as measuring outcomes insures that programmes are recognized for their worth, modified and embedded in and are the catalysts for sustainable change. She believes that any programme, with our robust evaluation measures, no matter how effective they might be, are not sustainable in view of the finite health resources that faces the NHS.

**Dr Frances Early, ,** Research & Evaluation Lead **Centre for Self Management Support, Cambridge**

**TPC Leadership Group**

TPC Leadership Group have been working in the health sector since 2001, delivering a wide range of innovative programmes with public and private health organisations, supporting them to nurture cultures that deliver high-quality, continuously improving behavioural change and health care.
TPC Health has experience of working in partnership with healthcare organisations to understand their culture and put together programmes to enhance leadership and organisational development capability.
Their health coaching programmes aim to support organisations to create sustainable solutions thereby enabling leaders at all levels to take charge of their own learning and development agenda in support of better patient outcomes.
Health Coaching has been rolled out by TPC in the past four years primarily by Dr Andrew McDowell and Dr Penny Newman.
So far 4000 clinicians in 75 agencies have been trained across acute, Allied Health Professionals, nurses and community.

TPC has a 2-day workshop to train health professionals, a 4-day workshop to train health coaches or a 10-12-day workshop to train the trainer. Initially they go in and have a half day introductory session to assess need, get buy-in and establish where the focus/need might be in that organisation. Coaching has been rolled out in mainly in long term condition areas, end of life and primary. Coaching in terms of shared decision making has been rolled out across AHP and other clinicians at various sites.

TPC Health Coaching were at the forefront of the East of England, Leeds NHS Trust and the Symphony Project in West Somerset Health Coaching initiatives (All discussed in this report)

Penny is also a fellow with UCL Partners who work in partnership to co-create, test and implement health solutions, which embeds improvements in the everyday health working systems and collaborate with patient groups, commissioners, primary care, community care, the third sector, government and industry. Penny works closely with Amanda Begley, Director of Innovation and Implementation on the health coaching initiative to ensure that the programme of work around health coaching are responsive to the needs and experiences of patients receiving care and ensuring that by actively seeking to understand the patient perspective that measurement of patient experience informs improvement.

Primarily the focus is to activate the clinicians. Dr Penny Newman is passionate about health coaching and believes that it is imperative to activate clinicians and champions across an organisation, as they in turn spread the word and the momentum grows. Her experience over the last five years has led her to firmly

believe if we wait around for service changes or patient education then we are losing an opportunity to move health coaching forward. It is important that service models, contracting models and evaluation are focused on but she maintains that if we waited for this to happen prior to rolling out health coach training, then the impetus would be lost. She believes changing to a health coaching culture comes from having those champions who believe in the ethos of 'patient-centred care and health coaching leading the charge is the way to gather impetus and create innovative change.

Dr Penny Newman & Dr Andrew McDowell, founders of Health Coaching, TPC Leadership Group

## HEALTH FOUNDATION

The Health Foundation were at the forefront of funding person-centred care initiatives over the last 7 years. These were around self-management support and shared decision-making. Programmes such as Co-Creating Health, Making the Magic and Shared Decision-Making were funded and rolled out over sites based in the community and within NHS teams around the UK.

Their website has a number of articles summarizing some of these programmes. Co-Creating Health was a large scale directed programme they ran to test whether it was possible to embed self-management support into routine clinical practice. They worked with 8 sites in phase 1 and 7 sites in phase 2. Both phases were evaluated:

Co-Creating Health – Evaluation of First Phase –

- The self-management support programme for patients improved the activation and quality of life of people with long-term conditions.
- Adopting self-management approaches requires long-term behaviour change, and the interventions to achieve these also need to be long-term.
- Self-management support must be normalised into existing ways of working within health economies.
- Techniques to support self-management, including agenda-setting and goal-setting, were well received and implemented following training.
- Co-delivery is an important way of changing patients' and clinicians' perceptions of their roles.

Co-Creating Health – Evaluation of Phase 2 –
A range of factors were identified which influenced the 'embedding' and sustainability of co-productive activity. These are outlined below and can be summarised as:

- shared understanding of the nature and value of co-productive activity
- recognition of the benefits of co-producing self-management support
- a supportive infrastructure
- capacity and resources.

Through analysis and narrative, the evaluation highlights:

- the benefits of training teams rather than individuals
- the importance of support from senior leadership within the clinical community
- the added value of integrating with concurrent initiatives
- the value of providing support for both patients and clinicians after their initial self-management training as they seek to embed new habits.

In 2014 they published an evidence review looking at the most common measures used to measure person-centred care and made available a spreadsheet of measures to help people thinking about measurement for different approaches, including self-management support.

Lessons learnt according to Suzanne – you need to 'measure what matters' and consider how do we go about getting real value out of our outcome measures


Suzanne Wood, Programme Lead
Person Centred Care

**Whittington Hospital, London –**
Lead for Self-Management Support and Behavioural Change – Claire Davidson
The Whittington Hospital is part of Whittington Health which provides general hospital and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield and Camden. The organisation was established in April 2011 following the merger of The Whittington Hospital NHS Trust with NHS Islington and NHS Haringey community health services. We have an income of £281m and more than 4,000 staff delivering care across North London in The Whittington Hospital and from 30 locations in Islington and Haringey. As one organisation providing both hospital and community services, we are known as an "integrated care organisation"

Whittington Hospital was one of the initial sites where Co-creating Health was piloted and rolled out in 2009. One of their areas – Islington already had a self-management strategy in place.
The first phase was rolling out the self-management support programme in the diabetes area from 2009 -2011. In the second phase in 2012 they rolled it out to respiratory and muscular-skeletal (MSK) where they had Stanford patient Self-Management programmes in place and primary.

The team are now working with fifth year medical students doing a version of the Advanced Practitioner Training partnered together with UCL.
Whittington has just received additional funding to roll-out training to the asthma service for one year.

600 staff have been trained and 7 cohort trainings are run each year.

Diabetes Self- Management Programme
The Self-management Programme for Patients (SMP) aims to help participants strengthen their health-related behaviours. It does this by developing health literacy, building appreciation of peer support, developing collaborative decision-making skills and building knowledge of self-management techniques as well as participants' skills and confidence to use these techniques.

The programme breaks new ground in a variety of ways. It was developed specifically for a UK context and is co-delivered by a clinician and a patient, creating a powerful model of partnership and collaboration for participants.

It aims to help participants build knowledge and skills for their own long-term conditions, alongside developing generic self-management skills such as problem-solving and action planning, which are particularly important for people with multiple long-term conditions.

The learning to manage your diabetes – is a free self-management course for people with Type 2 diabetes. The programme provides the opportunity for people living with Type 2 diabetes to understand more about their condition and to develop the knowledge, confidence and skills to help them manage their diabetes more effectively

Initial training in co-creating health – Advanced Development Programme (ADP) was rolled out to the Health Professionals in the diabetes service including Senior Clinicians
Included in these trainings were consumers/lay people with diabetes
At the same time a Diabetes Self-Management Programme (DSMP) that was initially developed from the Health Foundation Self-Management Programme, was rolled out.
A train the trainer programme was also developed - Included in these trainings were consumers/lay people with diabetes that were trained as co-facilitators.
The DSPP was for Patients with Type 2 Diabetes and who had had a diagnosis for three months. The DSPP is a 7 week programme where participants come together for group session once a week for three hours. Topics include 'what is diabetes, food, medication, complications, foot care, monitoring, and unanswered questions. Each session is facilitated by a health professional

together with a trained consumer facilitator. Each session includes a coaching sessions in pairs or in small groups on an issue related to the day's topic. Main referrals come from General practice and the primary sector.

Strengths of the Programme
Quantitative data suggests that the strengths of the programme, are the lay involvement, the time the patients get to talk about diabetes, ethos in terms of feeling valued and listened to through the coaching approach, and the advantages of being linked into other services over the seven week period. Patients qualitative evaluation points to what made a real difference was someone noticing them and 'caring' and those who maintained their activation after the course were those who had a very connected GP or personal trainer or someone else who made them accountable and cared in the primary sector.
An audit on the 2016/17 medical files have just been completed and the qualitative preliminary results show that one year post the DSMP that patients have had a 0.9% average reduction in HBA1C. This research is due to be released and published within the next six months.
The APD training was rolled out to the respiratory and MSK Co-creating health professionals in the second phase, as they already had the Stanford patient Self-Management programmes in place, so in these areas it was more of a Clinician behavioural change.

In terms of the strengths of the overall programme having a dedicated Self-Management Support and Behavioural Change Team with a Lead, an Administrator, a Coordinator and a part-time trainer – a dedicated team to lead the way, coordinate trainings, train the trainers, set up dedicated programmes etc. has been hugely valuable in embedding in the programme.

Having two dedicated consultants – one in the diabetes area and the other in the respiratory area as champions has also ensured that the message of co-creating health has spread.


Claire Davidson – Lead for Self-Management Support and Behavioural Change, Whittington Hospital, London

Key lessons learned

It is imperative to get the key medical specialists involved and invested in the approach from the outset as they provide a huge force in terms of getting others in the service on board.

Having the service leadership buy-in is also valuable, and having those key people on the initial steering group, in order to get the message to the right people and across the organisation.

Working in the areas where the energy is, to grow the concept has been another key theme and Claire and her team are now looking to embed it into quality improvement initiatives with the Organisation and Development Team across the organisation

And lastly, having a whole systems approach in terms of having the coaching ethos as part of the Managers and Team Leaders and structures that support it. Co-creating health and Advanced Development Programme is very much now part of the Board's ethos and embedded in their Sustain and Transformation Plans (STPs).

Challenges

In the diabetes programme the challenge has been about raising awareness across a large geographical area and getting referrals from the primary sector. There are still also ongoing challenges in getting health professionals to move from the 'expert/telling' model to the 'coaching/asking' model as patients want answers.

Evaluation
Initially clinicians were evaluated pre and post workshop training but it appeared that was not providing so much value as some health professionals subjectively related themselves high in certain areas feeling they were already strongly operating in a person-centered way. The Whittington team reviewed this as it appeared that during the training several clinicians were very activated in terms of feeling they had learned some valuable behavioural change skills. Now the evaluation form is administered at the end of training and then sent to participants 3-6 months post training.
The qualitative results have demonstrated four main themes: -

- Health professionals are more willing to listen to their patient
- Rate that they feel they have become more person-centred
- Have more ability and skills in their toolbox to assess a patient's readiness to change and support them in this.
- These clinicians also rate that they have an increased sense of job satisfaction.

**Leeds NHS Health Coaching Initiative**
In Leeds there are 57,000 Health & Care Staff across the Mental Health Trust (Community), Hospital Trust, Community Trust and Leeds Council servicing a population of approx. 900,000.
The Leeds movement to shift the biomedical model of health professionals being "expert and the fixer" and the patient as being "novice and passive" to one of parity begun in 2014 when the Yorkshire and Humber Leadership Academy brought the idea of health coaching to a small group of health and local authority workers in Leeds.
In 2014 they funded a train the trainer programme and trained 15 local clinicians. Since late 2014, Leeds has trained over 400 staff in health coaching and introduced the idea to a wide range of health and care staff including nurses, doctors and allied health staff working across organisations and sectors. These staff are using the health coaching skills with children, adults and families accessing health and care services in Leeds. Evaluation focusing on staff having different conversations with service users in Leeds is under way and due for completion in late 2017.

Health coaching initially was implemented in services where people wanted to work with behavior change models. The philosophy is 'work with' not 'do to'. Pockets of individuals were trained across the Leeds Healthcare Community by Dr Andrew McDowell and the TPC Group. Train the Trainer (6 day training was also rolled out)
A steering group was formed with champions from across the 4 trusts which also included key organizational and development people. This group have led

the health coaching initiative and have been pivotal in championing it, obtaining ongoing funding and rolling out the training. In June 2016, a Health Coaching Innovation Lead, Jonathan Lace was employed to bring the strands of the initiative together. So far around 600 health professionals have been trained in the TPC Health Coaching Model.

A pre evaluation based on TPC Coaching principles is administered prior to the Health Coach Training and a post training workshop questionnaire is sent out to participants two months after the coaching training. Leeds Beckett University has been employed to evaluate these results and are due to release a report in the next two months.

Health Coaching has now moved to more of an approach around having those productive "better conversations" across the organization.

Funding for the Innovation Lead ceases in March 2018, so funding bids to keep the initiative going are being furnished now.

Lessons Learned

In some areas the coach approach is working really well – the Healthy Living Service, in terms of lifestyle changes with people with long-term conditions have seen noticeable increase in outcomes around patients losing weight, reducing alcohol intake and ceasing smoking. The health coach training saw the Smoking Cessation Pathway change their pathway and working with the patient on 'what was important to them' and 'what their goals were'. This has resulted in a much higher smoking cessation rate and had the spin-off effect of increasing staff satisfaction & happiness.

In other areas it has not worked so well, particularly in areas where the managers and team leaders have not either been trained in health coaching or have not embraced the concept and are more directive in their management style.

Perhaps one of the more critical insights or lessons learned from setting up the Health Coaching programme, has been that it is essential to have clarity around what outcomes you want from the project from the start, and what tangible evidence you require which will inform evaluation methods.
Getting rigorous evaluation methods sorted from the outset is also vitally important.

While the Leeds Trust have access to 7000+ Patient Activation Measure (PAM) licenses, and use of PAM has been encouraged by health practitioners engaged in health coaching, evaluation of patient activation has not occurred. This is directly related to the work load pressure that health practitioners are under in terms of volumes and demand in terms of patient numbers.

Supervision sessions were initiated to provide support to the health coaches, but attendance became very poor and these have been subsequently scrapped. This again, appears to be systematic of the high volume of direct patient contact and huge demands on the healthcare systems and staff being pressured for time.

Another key learning was that there are pockets of health coaching happening right across the health and care staff in Leeds in the strength based social work, the 'making every contact count' initiative and the 'Year of Care' initiative that has been rolled out to 75% of the practice nurses in the GP Practices across Leeds.

Thus, intensive health coaching is not right for everyone and different layers are needed to sustain culture change and address what is important at all levels. Having the two day Health Coaching Workshop available for those working with complex long term conditions, and the 'Making every contact count' for all contacts with patients at the lower end of the strata is important. However, Jonathan Lace and his team have identified a gap in the middle for those everyday coaching conversations and 'Making every contact count' – they are looking at developing a one day training course to address this gap.

The Organisational & Development Team (of whom their lead is a member of the health coaching steering group) have introduced in their division a 'Manager as Coach' programme, one-to-one coaching, team coaching and health coaching addressing all levels of finding out what is important to his staff as well as the patients they serve.

**Summary and Conclusions**

The programmes and NHS sites visited highlighted the innovativeness and the successful outcomes of person-centred care approaches. The behavioural change of health professionals and effective patient outcomes that were evident from the self-management programmes in the Whittington Diabetes programme and in the Penny Brohn Life & Wellbeing programme highlighted the positive effect

on health and wellbeing that these patient centred care programmes had made. The Symphony Programme in a Primary setting not only showed average length of stay had reduced at the local secondary care facility, it also highlighted that patients felt more listened too, valued and that they were now more active participants in their own healthcare. Correspondingly, qualitatively the General Practitioners reported feeling that the health coaching model had enabled their workload to be shared across the multi-disciplinary team, and as a result appointments had decreased, work life balance had improved and they had a greater level of work satisfaction**.**

However, it is noted that it may have been easy to achieve these outcomes in a dedicated programme/facility such as for Penny Brohn – a specialised cancer support centre - rather than having multiple demands like primary care and NHS Trust sites.

While there are some strong thoughts that changing to a cocreating health/ health coaching culture, comes from the momentum that those champions in the healthcare organisation, who believe in the ethos of 'patient-centred care' and health coaching, will bring in leading the charge. However, from the site visits the author does not believe that this alone leads to ongoing sustainability. Indeed, from his research Phillips (2015) maintains that to be successful in implementing the co-creating health framework, requires willing champions, a health system that supports this behavioural change and build in evaluation and audit to show outcomes is imperative.

The Health Foundations rigorous research of Phase One & Two of Co-creating Health supports this premise and in particular the importance of support from senior leadership within the clinical community to ensure the 'embedding in' and ongoing sustainability.

The NHS Hospital sites that the author visited where there was a 'popcorn' approach to rolling out training across the organisation, appeared to be now, 3-5 years down the track, struggling to find ongoing funding and support for the initiatives. Where programmes had support at a management level and organisational processes and structures were put into place to support the initiative the programmes appeared to be more embedded and sustainable and behavioural change in staff and patient, more evident. The recently released Person Centred Care Framework (2017) findings supports this premise, in that it is not enough to teach health coaching and key enablers, without organisational structures and rigorous evaluation that support this.

This was evidenced by the Leeds Coaching Model and the ABMU Co-creating Health model and to some extent the struggles that West Suffolk were having in trying to embed health coaching organisation wide.

From the sites visited on this Fellowship, it is clear that to be successful in making a sustainable behavioural and model of practice change in healthcare, it is critical to have a three pronged approach to successfully embed in the culture change. Whether it be co-creating health, health coaching or relationship centred practice, it is therefore essential to have staff training enablers, patient self-management education/programmes and structures that support the change including service delivery processes and evaluation. All three components need to exist in order to embed in patient centred care behaviour change and ensure ongoing sustainability.

Reporting Back

I have reported back to the Relationship Centred Practice Steering Group who has members of Consumer and Clinical Council and the Director of Quality Programmes from Hawkes Bay District Health Board (HBDHB) sitting on it.

I also have presented back the findings to the Health Professions Allied Health Forum at HBDHB.

A full evaluation of the Relationship Centred Practice Workshop materials has been undertaken and parts of the workshop revamped to address patient's motivation and accountability. The new workshops were rolled out to 50 people in November and more workshops are being rolled out in March and May. The qualitative evaluation from these workshops have had very positive evaluations to date.

The key findings from the Winston Churchill Fellowship were presented at the Central Region Allied Health Directors Meeting in Wellington in November 2017.

An abstract to present Relationship Practice and the Winston Churchill Fellowship findings at the 2018 Allied Health National Conference in May at Te Papa in Wellington is currently in progress.

I have also been in discussions with Dr Nicola Kaye at the Person Centred Research Team at the Auckland University of Technology to ascertain if they will partner in a rigorous evaluation of Relationship Centred Practice outcomes – one of the keys to successfully embedding Relationship Centred Practice and one of the main findings of the Fellowship in the UK, in terms of ongoing sustainability.

**References**

Ask Three Questions Campaign (2010) www.cardiffandvaleuhb.nhs.uk
Alcorn, K. and Brome,K., (2014) Occupational performance Coaching for Chronic Conditions: a Review of the Literature. NZ Journal of Occupational Therapy 61(2):49-56
Berkman ,N. Sheridan, S. Donahue, K. Halpern , D. Viera, A. Crotty, K. Holland , A. Brasure , M. Lohr, K. Harden, E. Tant, E. Wallace, I & Viswanathan, M. (2011) Health literacy interventions and outcomes: an updated systematic review. Evid Rep Technol Assess (Full Rep)(199): 1-941.
Core Skills and Education Framework (2017) Health Education, England
Coulter A, Collins A. (2011) Making shared decision-making a reality. No decision about me, without me. London: King's Fund,
Elywn, G. Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012) Shared Decision Making: A Model for Clinical Practice. Gen Intern Med: 27(10): 1361–1367
Gottlieb, K., Sylvester, I. and Eby, D. (2008) Transforming Your Practice: What Matters Most (Nuka Model)
Health Education England, Skills for Health and Skiills for Care, 2017
Health Innovation Network, (2014)What is Perspn Centred Care and Why is it Important ? South London
The Health Foundation Phase Two Evaluation Report, (2014) Helping measure Person Centred Care, London
Hibbard, J. & Gilbert , H. (2014) http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health
Joliffe, R., Seers, H., Jackson,, S., Caro, E., Weeks, L., Polley, M. (2014) The Responsiveness, Content Validity, and Convergent Validity of the measure Your Self Concerns and Wellbeing Patient Reported Outcome Measure. Integrative Cancer Therpaies 1-9
Kings Fund (2012) Patient and family Centred Care.
Macdonald ,G. Kayes, N,.Bright F (2013) Barriers and facilitators to engagement in rehabilitation for people with stroke: a review of the literature.NZ Journal of Physiotherapy 41(3):112-121
Ministry of Health (2016) Community Engagement with People with Disabilities. NZ Government
Ministry of Health (2016) NZ Health Strategy. NZ Government
Ministry of Health (2016) Self-management Support for People with Long-term Conditions. NZ Government
Ministry of Health (2012) Rauemi Atawhai: A guide to developing health education resources in New Zealand
Ministry of Health (2015) A framework for Health Literacy
NZ Guidelines Group (2012) Effective healthcare behaviour change in long -term Conditions: A review of New Zealand and international evidence. Ministry of Health
Phillips, A. (2015) Engaging Clinicians in Cocreating Health (unpublished doctoral thesis, University of South Wales)
Pitama, S., Huri, t. & Lacey, C. (2014) Improving Maori Health through clinical assessment: Waikare o te Waka o Meihana NZMU 127(1393) 107119
Seers, H. gale, N, Paterson, C., Cooke, H., Tuffrey V., & Polley, M. (2008) Individualised and complex experiences of integrative cancer support care: combining qualitatative and

quantaitative data. Support Care Cancer, 10-1007
The Health Foundation (2014) Person Centred Care Made Simple.
Taipukenga Limited, 2016 The Meihana Model 'Hui – Engagement & interventions with whānau Māori (Families)' as adaptedby Te Nahu ,L. from Pitama, S (et al) to incorporate the HBDHBs values
Walter, M. (2014) How can we motivate patients to change? . Kai Tiaki: Nursing NZ 19(11):

## Glossary

MyCaW (Measure yourself Concerns and Wellbeing) which is a validated, person-centred outcome measure, designed specifically for the evaluation of cancer support services.

PAM - The Patient Activation Measure is an internationally-used and validated patient questionnaire, which measures the level of activation. This is the skills, knowledge and confidence that a person has to manage their own health.

Relationship Centred Practice – A New Zealand model of patient centred care which includes shared decision making, health coaching and patient activation.

Shared decision making (SDM) - is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Patient Reported Experience Measures (PREMs)
Patient Reported Outcome Measures (PROMs)

## APPENDIX ONE
## PROGRAMME

**Confirmed Itinerary**

**Week of 9 October – London/Bristol/Wales**

9 October – 9.30am Meet up with Dr Penny Newman (Better Conversations) and Dr Andrew McDowell TPS Health Coaching in London

9 October – 1.30pm Amanda Begley - NHS Acclerator - UCL Partners in London

Travel to Bristol

10 & 11 Oct October Bristol (1 day)
Helen Seers - Penny Brohn Cancer Care – Realising the Value
(a programme commissioned by the NHS England to take forward a commitment and develop a range of tools and recommendations to embed person centred care for the wider health care system.) Getting a greater understanding of the 'Realising the Value' Programme

13 October Port Talbot, Wales David Hughes - Clinical Lead - Co-creating Health, Podiatry & Othhotic Services

14 & 15 October South Somerset - Deborah Neal - Vanguard Project, Yeovil, South Somerset

**Week of 16 October - Cambridge, Leeds & Suffolk**

16 October - Petrea Fagan- Physio and Trainer - Centre for Self Management Support - Shadowing Petra as she is a Senior Lecturer and Facilitator of the Co-Creating Health Framework both in Cambridge and in Wales

17 October - Leeds

Jonathan Lace
Leeds Community Trust
Health Coaching Innovation Lead
Leeds and York Partnership Foundation Trust
Twenty One Fifty, Thorpe Park, Leeds

18 October & 19 October - West Suffolk Hospital -
Nina Frimley &Trudy Dunn - Clinical Specialist Physiotherapists /Health Coaching Trainers

**Week of 23 October - Cambridge**

23 & 24 October Dr Penny Newman
Dr Penny Newman
Medical Director/ Health Coaching Lead
NHS Innovation Accelerator Fellow
Norfolk Community Health & Care,
Norfolk

25 October Frances Early, PhD, Clinical Psych, Research & Evaluation Lead, in co-creating Health at Centre for Self Management Support. Looking at evaluation methods of co-creating health programme

26 & 27 Oct Petrea Fagan- Physio and Trainer - Centre for Self Management Support - Shadowing Petra as she is a Senior Lecturer and Facilitator of the Co-Creating Health Framework both in Cambridge and in Wales

**Week of 30 October - London**

30 Oct

The Whittington Hospital – NHS Trust – Self Care Programme
Diabetes

Claire Davidson – Lead – Person Centred Care Programme
The Whittington NHS Trust was a successful pilot site of the NHS in embedding self-management support through the three strands of the Co-creating Health programme, focusing on working with diabetes. I want to learn about the pitfalls, challenges and successes the team had in embedding this programme.

31 Oct – Suzanne Wood – The Health Foundation
I want to look at evaluation methods from a clinical and patient point of view of the co-creating health framework

1 Nov -Amanda Begley - NHS Accelerator - UCL Partners

2 Nov & 3 Nov Dr Andrew McDowell 01 Nov to 3 Nov TPS Health Coaching Director, TPC Leadership Group, London