Shared decision making, self management support and care planning.

Changing relationships in public services

A Train the Trainers Programme for NHS South West

Supported by
Session 1
Welcome, introductions, group working
Welcome

• Workshop facilitator introductions
• Practicalities
  – Fire alarms
  – Toilets
  – Food and drink
  – Anything we forgot?
Why are we here?

• **Purpose**: aims and learning objectives
  – Knowledge, skills and confidence in teaching others the principles and practice of shared decision making
  – Knowledge, skills and confidence in facilitation and coaching skills

• **Principles**
  – Adult learning
  – All teach, all learn
    • Connected, evolving conversations *preference* to
    • Disconnected, dissolving conversations
    • Parking lot for questions/challenges that could halt progress
Introductions

• Your name
• Your organisation and your role
• What expertise/experience/qualities you bring to this workshop
Reflective exercise (next slide). Firstly, ground-rules for working in groups

- Brief introductions
- Elect facilitator
- The aim is to learn from each other
- One person speak at a time. Propose boundary (‘no more than a minute’)
- Offer a point of view rather than impose a point of view
- Reflect (‘what I think you are saying is..’).
- Then use link and learn to move the conversation onwards (‘and I’d like to add that....’)
- Don’t be afraid to challenge. Consider prefacing challenges with ‘I have an alternative view’ or ‘I have a challenge’. Use reflections and link and learn (‘however’ is preferable to ‘but’)


Why are we here?

• Do we need to change relationships in public services?
• Why?
• Feedback
Our time together

January 25th morning

• **Session 1.** Welcome, introductions, timetable, introduction to group work and practice. 11.00-11.30

• **Session 2.** Shared decision making *overview and case for change*. 11.30-12.00

• **Session 3.** Long term conditions- *the challenge and the case for change*. 12.00-12.30

• **Session 4.** Shared decisions about treatments- *the challenge and the case for change*. 12.30-13.00

• 13.00-14.00 lunch
January 25th afternoon

- **Session 5.** Conversations about the case for change. 14.00- 14.30
- **Session 6.** Self management support and care planning *overview.* 14.30-15.00
- **Session 7.** Reflect, contextualise. 15.00-15.30
- 15.30-16.00 Tea
- **Session 8.** Workforce and systems. 16.00-17.00
- **Session 9.** Care planning and self management support *skills rehearsal Part 1.* 17.00-18.30
Our time together

January 26th all day

• Agreeing our agenda for the day 09.00-10.00
• Care planning, self care support skills
• Care planning, self care support skills and coaching rehearsal
• Shared decision making skills
• Shared decision making skills and coaching rehearsal
• Facilitating large groups
• Managing conflict
• Your action plan
Team and practice level training
Step 1. Getting on the agenda

• Stakeholder map
• Elevator pitch to give you a foot in the door. Do not forget that you are supported by NHS South and the national and regional LTC and Right Care QIPP teams
• Who could you train?
  – Community matrons, re-ablement teams
  – Specialist nurses in LTCs
  – Interface services
  – Primary care teams
  – Secondary care teams
Step 2. Presenting a case for change

• A half hour presentation and exercise for a team, a practice or a board at level 1 or 2 activation.
• Aim of the session is that the training programme becomes *more important* for them.
  – Session 2 is a good overview of SDM, care planning and self management support
  – Session 3 focuses on LTCs
  – Session 4 focuses on shared decisions about treatments
Step 3. Delivering the programme

- Community matrons, re-ablement teams, LTC nurses (care planning and SMS)
  - 2 sessions of 2 hours minimum
  - 3 sessions of 2 hours preferable
  - Use section 6 for first hour (could consider using section 3 instead)
  - Use section 7 for next hour
  - Then sections 8, 9 and 10
  - Ensure team nominates a lead to implement system changes
  - Ensure team develops a leader and action plan to sustain changes in long term
Step 3. Delivering the programme

- **Primary care teams (care planning, SMS and brief introduction to SDM and treatments)**
  - 6 hours best. 9 hours doable but needs small team (ie extra training for LTC nurses)
  - Sessions as above
  - Ensure team nominates a lead to make system changes
  - Ensure team nominates a lead and an action plan to sustain change in the long term
Step 3. Delivering the programme

- **Interface services, secondary care teams (SDM re treatments)**
  - 3 hours single session
  - Session 4 then session 11
  - Ensure team nominates a lead to make system changes
  - Ensure team nominates a lead and an action plan to sustain change in the long term
Session 2
Shared decision making
An overview and the case for change

A 10 minute presentation, a 15 minute group exercise then a further 5 minute presentation
‘No decision about me, without me’
Shared decision making is a process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action.
supportive system

Activated, engaged patients

☑ Working in partnership
☑ Sharing decisions
☑ Planning care

Optimal functional and clinical outcomes

Prepared, proactive, trained teams
When is it relevant?

• Shared decision-making is appropriate in any situation when there is more than one reasonable course of action
• In this case, the decision is said to be ‘preference sensitive’
• Most (nearly all) health and healthcare decisions are ‘preference sensitive’
What does it represent?

A significant shift in the relationship between clinicians and patients, citizens and public services
Commissioning for patient need

A system that captures the wishes of individual patients can be aggregated up and used to inform a new commissioning strategy based on patient need.

A commissioning strategy to deliver care that people want—rather than care that clinicians feel they should have.

The care, treatment or support people *need* and no less. The care, support or treatment people *want* and no more.
What does it mean for clinicians?

A clinician who values the patient's role in managing their own health and healthcare.....

.....and who is *willing* and *able* to work in partnership with them to support them to make wise decisions.....

...about how to manage their health and healthcare

An attitude

Knowledge, skills and confidence
Clinical teams need motivational tools and skills.

Decisions

- About lifestyle
- About medication adherence
- About accessing services
- About possible planned interventions

Clinical teams need decision support tools and skills.
Reflective exercise
Your attitude to shared decision making
Each table is assigned a statement (see next slide)

• On a scale of 0-10, to what extent do you *as an individual* agree with the statement?

• Arrange yourselves on an imaginary line across the back of the room
  – 0/10 agreement on left of room
  – 10/10 agreement on right of room
  – Other numbers on a spectrum between

• Then go back to your tables to discuss

• Then feedback

Workbook page 9
Statements

Table 1
Shared clinical decision making between patients and healthcare professionals is a meeting of equals and experts.

Table 2
Healthcare professionals are responsible for supporting patients to make decisions that patients feel are best for them, even if the professional disagrees.

Table 3
Healthcare professionals should routinely encourage patients to access independent information, and come prepared with their own questions and ideas.

Table 4
The healthcare professional should routinely tailor information to individual patient needs and allow them sufficient time to consider their options.
Feedback
The challenge we face
When asked in polls........

• 85% of clinicians believe they share decisions about treatment with patients

• 50% of patients believe this is the case
Proportion of inpatients who wanted more involvement in treatment decisions (Care Quality Commission 2010)
And diabetes......

had at least one check up in the last 12 months

discussed ideas about the best way to manage their diabetes

agreed a plan to manage their condition over the next 12 months

discussed their goals in caring for their diabetes

Challenging the gap

.......................... from healthcare professionals

We do it already!

My patients don’t want it

I don’t have the time!

Will it work?

What if they don’t do what I think they should do?
So what is the problem? Is it:

**Why should we do this?** (importance)

or

**How can we do this?** (confidence)
Why should we do this?

- **Ethical imperative** (patients want to be involved more than they are)
- **Legal imperative** (medicolegal requirement to discuss options, risks, consequences prior to any intervention)
- **Evidence base** supports (see resource pack)
- **Appropriate allocation of resources** (patients get ‘the care they need and no less, the care they want and no more’)

The active involvement of patients is key to all of the priorities.

Candace Imison
June 2011
Pause, breathe, reflect
Session 3
Long Term Conditions: An overview, the challenge and the case for change

A powerful case for change- 10 minute presentation
Then a 20 minute exercise; barriers to change
The Challenge – Long term Conditions (LTCs)

- **15.4 million people** in UK live with at least one LTC
- **69% NHS budget**
- 50% General Practitioner consultations, 65% of out-patient appointments and 70% of inpatient bed days
- Aging population and rising numbers
- At current rate of growth, expenditure on LTCs would **increase by 94% by 2022** (with minimal real potential increase in NHS budget)
- Our healthcare system is not currently configured to cope with the increased demand

No change is not an option
CCGs need to work with Acute Care Trusts to develop integrated approaches. A key issue is the sharing of incentives to promote high quality care.

Strategic partnerships between local authorities, community and voluntary organisations

The Expert Patient Programme
Telehealth, telecare

Software to support care planning, risk stratification, and monitoring quality

Multidisciplinary team in primary care coordinating care
Risk stratification

Evidence based guidelines incorporated in IT systems
Service user facing decision support at every ‘decision point’ in clearly delineated care pathways
Activated, engaged patients

Supported system

- Working in partnership
- Sharing decisions
- Planning care

Optimal functional and clinical outcomes

Prepared, proactive, trained teams
The overall marker of success

- **Activated** patients

- **Working in partnership** with prepared and trained clinical teams in scheduled appointments in a supportive system

- **To proactively manage health** and to anticipate and plan for times of need (care planning and anticipatory care planning)
Activation (measured by using the ‘Patient Activation Measure’ – the PAM)

Knowledge, skills and confidence to manage one’s own health and healthcare

See Hibbard J, Collins A Health Expectations 2011 and resource pack
Levels of activation

Level 1
- Build Knowledge Base, Self-Awareness & Initial Confidence
  - Understand condition and/or disease prevention basics and their role
  - Become aware of own behaviors and symptoms
  - Pursue small steps to build confidence

Level 2
- Increase in Knowledge, Initial Skills Development
  - Close any knowledge gaps
  - Clearly understand the role they must play
  - Focus on clinically meaningful behavior change through small steps
  - Most behaviors will not yet achieve guideline level

Level 3
- Skills Development, Gains in Knowledge
  - Strive for behavior development consistent with guidelines
  - Be self-aware and good at monitoring one's health and responding to changes
  - Lifestyle behaviors come into stronger focus

Level 4
- Maintaining Behaviors & Techniques to Prevent Remission
  - Achieve guideline behaviors
  - Maintain behaviors and learn to anticipate difficult situations
  - Develop bounce back strategies
  - Focus on closing gaps around nutrition, activity, and coping with emotions

ACTIVATION PREDICTS OUTCOMES
Support for activation: care planning and self care support.

• Our aim should be to support people with long term conditions to develop the knowledge, skills and confidence to manage their own health and healthcare (to become activated).

• In other words, to support people with long term conditions on their journey of activation

• Compared with people at low levels of activation, people at high levels of activation tend to enjoy a higher quality of life, have better clinical outcomes and make more informed decisions about accessing medical services.
LTC QIPP workstream

20% reduction in unscheduled admissions

People with LTCs confident and supported to manage own health at home

Know population and stratify for risk of admission

Co-ordinate care and case manage high risk patients

Systematically and reliably implement self management support

Outcome
Proxy outcome
Primary drivers
Reflective exercise
How important is it to you that we support people to manage *their own* health and healthcare?
What led you to say the number you said?
How confident are you that you/your service/the NHS support(s) people to manage *their own* health and healthcare?

0-not at all confident

10-extremely confident
What led you to say the number you said?

What challenges and barriers do we face?
Barriers and tensions

Managing time

Managing yourself

Managing the relationship

Managing risk

Adapted from Howie J BJGP 1996
Self management of warfarin and INR.
Cochrane review Heneghan et al April 2010

1. Clinician management of warfarin and INR
2. Self monitoring of INR and clinician advice re: warfarin dose
3. Self management of INR and warfarin

Compared to groups 1 and 2, group 3 have
• same risk of bleeding
• 50% fewer thrombotic episodes
• 36% lower mortality
There are significant challenges to address...

And we will address them over the coming sessions together.
Session 4
Shared decisions about treatments: An overview, the challenge and the case for change

A 20 minute presentation, then a 10 minute exercise
Shared decisions about treatments

Proportion of inpatients who wanted more involvement in treatment decisions (Care Quality Commission 2010)
J Allison Glover, 1938

Practice variation: Glover’s discovery and the ethical imperative

- 10-fold variation in tonsillectomy
- 8-fold risk of death with surgical treatment

- “… tendency for the operation to be performed for no particular reason and no particular result.”
- “…sad to reflect that many of the anesthetic deaths… were due to unnecessary operations.”

Slide courtesy of Dr Al Mulley, Foundation for Informed Medical Decision Making and the Dartmouth Center for Health Care Delivery Science
Practice variation: its re-discovery by Wennberg

- 17-fold variation in tonsillectomy
- 6-fold variation in hysterectomy
- 4-fold variation in prostatectomy

“The need for assessing outcome of common medical practices”

“Professional uncertainty and the problem of supplier-induced demand”

John E. Wennberg, 1973
Why should we do it?

- Ethical imperative
- Commissioning for need and challenging/balancing ‘supplier capture of the market’
- Information overload
- Financial imperative; unwarranted variation
Variation in UK

Awareness is the first important step in identifying and addressing unwarranted variation; if the existence of variation is unknown, the debate about whether it is unwarranted cannot take place.
Musculoskeletal programme - variation in knee replacement activity

Primary Knee Replacement - AgeSexNeeds standardised cost per 1000 population for PCTs
Satisfaction after knee replacement

- 82% satisfied
- 11% unsure
- 7.0% not satisfied

PROMs vary according to satisfaction score
Shared decision making about treatments:

Patients who don’t have decision support:

• Are 59 times more likely to change their mind
• Are 23 times more likely to delay their decision
• Are five times more likely to regret their decision
• Blame their practitioner for bad outcomes 19% more often
Shared decision making about treatments:

- Reduces unwarranted variation due to practitioner preferences
- Improves satisfaction
- Reduces wish to proceed to invasive treatments
- Reduces negligence claims
What is shared decision making?

Decision aid + Decision support = Shared decision making
Decision aid and coaching in gynaecology

**Treatment costs ($) over 2 years**

- Usual care: $2751
- Decision aid: $2026
- Decision aid + coaching: $1566
Decision Aids reduce rates of discretionary surgery

RR=0.76 (0.6, 0.9)

O’Connor et al., Cochrane Library, 2009
What are our challenges?
They are significant

- Clinicians have been selected out by the system to become rational decision makers
- EBM, NICE guidelines represent a paradigm that does not take account of patient preferences
- Training
- Measures currently being developed (activation, decision quality)
When might it **not** be appropriate to share decisions about medical/surgical treatments?

- Table top discussions
- Feedback
Session 5
Influencing others
Stakeholder mapping

• Spend 10 minutes on your own or in a pair thinking about who you want to influence to take this agenda forward.

• Draw a mind-map of those people, where they work, how influential they are and how close you are to them
Stakeholder mapping

The local hospital

Dr Smith
Medical Director

Mrs Jones
Hospital Manager

Me
Influencing conversations

• Think of having conversations with the people on your mind map

• **Q1 What are the constituents of persuasive conversations?**

• **Q2 What are the constituents of non-persuasive conversations**

• Table top discussion

• Feedback
Persuasive conversations

• ‘Elevator conversations’
• 30 second ‘pitch’ that persuades someone to want to know more
• What are your 30 second pitches for our work (assume you are now an expert at delivering the programme)
• Work as teams of 3- practice!

Workbook page 16
Session 6
Care planning and self management support
Overview, context, challenges

20 minute presentation
20 minute reflective exercise
Self care is usual care

- Life with a long term condition: the person’s perspective
- Interactions with the service: planned or unplanned

The person living their life with a LTC (Long Term Condition)
Self care is usual care

Hours with professional / NHS = 3 in a year

Self care = 8757 in a year

The person living their life with a LIC
About lifestyle

About medication adherence

About accessing services

About possible planned interventions

Decisions
So it should be the job of the service to ensure that...

...People are supported to make informed and personally relevant decisions about managing their own health and healthcare.

Am I going to stick to that exercise regime?

Should I take that pill today?

Do I really want that heart operation?
What is self care?

- 5 minute discussion on tables
- Feedback

Workbook page 18
The 3 domains of self care

- My condition (Biological)
- The way I feel (Psychological)
- What I do (Social / Behavioural)
People who optimally self care are:

• Optimistic,
• Determined,
• Contextually informed (health information that ‘makes sense to me’),
• Confident,
• Problem solvers, decision makers....
• ....Who inhabit rich social networks

All of these are amenable to change – often with simple interventions
In other words, they have high levels of activation

**Level 1**
Starting to take a role
Patients do not yet grasp that they must play an active role in their own health. They are disposed to being passive recipients of care.

**Level 2**
Building knowledge and confidence
Patients lack the basic health-related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

**Level 3**
Taking action
Patients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

**Level 4**
Maintaining behaviors
Patients have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Increasing Level of Activation
Self care and self care support

• **Self care** is what people who live with long term conditions do to manage their own health

• **Self care support** is what their friends, carers, relatives, health, social and 3rd sector does to support them to self care (or not..)
What is Self Care Support?

“Self care support is what health services do in order to aid and encourage people living with long term-conditions to make daily decisions that improve health-related behaviours and clinical outcomes. It can be viewed in two ways: as a portfolio of techniques and tools; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership”

Tom Bodenheimerer CHF 2005
What is care planning?

• A scheduled appointment or series of appointments with a person with a long term condition
• That supports them to decide how they want to proactively manage their health and healthcare
• And what they want from health or social services in order to do this
SDM, Self care support and care planning

Scheduled follow up appointments, providing motivational support

Shared decision making
Decision aids

Scheduled care planning appointments, providing proactive support

Scheduled care pathway, providing specific interventions

the person living their life with a LIC

episodic consultations
Do we do this? Diabetes

- had at least one check up in the last 12 months
- discussed ideas about the best way to manage their diabetes
- agreed a plan to manage their condition over the next 12 months
- discussed their goals in caring for their diabetes

Reflective exercise

• Exploring your philosophy – What do you think?
• Work in groups of two or three
• On a scale of 0-10, how much do you agree with the following statements?
Statements

• The person with a long term condition is in charge of their own life and managing their condition(s)

• The person with a long term condition is the main decision-maker in terms of how they live with and manage their condition(s)

• The person with a long term condition is more likely to act upon the decisions they make themselves rather than those made for them by a professional

• The person with a long term condition and the health care professional are equals and experts
Session 7
Take stock

Workbook page 21
This is an important first session for any team to consider- before you teach them skills They need to figure out:
Who to train
How to change the system to make sure that it supports enabling conversations
You could do an ‘importance/confidence exercise here- to see if a practice is really up for this. Slides 42-48 talk you through this.

One of the challenges that always comes up is how to manage time. Explain that all of this course is about managing time effectively. The next exercise may help.
In groups of 3 (there may be 1 group of 2)

- 2 people have 2 conversations
- Role play the 2 roles
- 1 person observe
Your conversations

• Are between a doctor and a patient
• The patient is Mrs Smith.
• She is 56 years old
• She has diabetes and heart problems
• She is depressed and morbidly obese
• She comes to her doctor after her 6 month review has shown her blood sugars are high
Conversation 1. The clinician’s agenda

• The doctor wants Mrs Smith to lose weight
• She is unprepared for the consultation
• She doesn’t know why she is seeing the doctor
• Have a 5 minute conversation......
Conversation 2. Mrs Smith’s agenda

- The doctor wants to support Mrs Smith to manage her own health
- She is prepared for the consultation; she has had an ‘agenda sheet’ (next slide)
- She knows why she is seeing the doctor; she was told her blood results before she saw the nurse even. She knows what the results mean and the things she can do to manage the results better

Workbook page 24
Here are some things you can choose to talk about at your next appointment. If you have other concerns, write them in the grey boxes.

- Blood glucose monitoring
- Taking medications
- Skin care
- Your understanding of your condition
- Diet
- Losing Weight
- Daily foot care
- Depression
- Smoking
Now have a second conversation.....
Feedback
Prepared patients have productive conversations
System interventions that can support patients to prepare

- Patient held record
- Patient access to record
- Results sharing before appointment
- Agenda setting sheets
- Access to high quality information
- Self management programmes that teach assertiveness
- Peer support groups
- ‘Buddy system’
Note for when you work out ‘in the field’

• At this point, we would coach practice teams to think through what changes they might want to think about

• We’d encourage them to:
  – Elect someone to take responsibility for the change
  – Select one change
  – Try it out on just a few patients (5-10) and get their feedback
  – Meet again to plan the next change
Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Understanding the problem. Knowing what you’re trying to do - clear and desirable aims and objectives

Measuring processes and outcomes

What have others done?

What hunches do we have? What can we learn as we go along?

Act  Plan

Study  Do

Session 9
Care planning and self care support
Skills workshop
Part 1
What does (reasonably) good look like?

A 15 Minute vignette
Overview

- Invite a story
- Negotiate agenda - patient agenda first
- Invite patient to set goals
- Plan follow up on goals
The Three Enablers

– Agenda setting
  • Agreeing a joint agenda
  • Exploring ambivalence, decisional balance

– Goal setting & action planning
  • Small and achievable goals
  • Builds confidence and momentum

– Goal follow-up
  • Proactive – instigated by the system
  • Soon – mutually agreed and ideally within 14 days
  • Encouragement and reinforcement
Negotiated agenda setting

Supporting patients to become active partners
Negotiated agenda setting

Skills

• ‘What do you want us to talk about today?’
• ‘What do you want to make sure we talk about today?’
• ‘What should we focus on today?’
• ‘What are your priorities for today?’
• ‘What one thing should we talk about today that would help you feel we used the time well?’

The language of partnership, focus and priority
Negotiated agenda setting

Skills

• Compile the list by *reflecting*:
  – ‘OK- let’s talk about your diet’

• Then enquire about other priorities:
  – ‘Is there anything else/is there something else/what else shall we talk about?’

• Add to list as necessary

• Enquire again (‘*anything else….’’)

• One last question if patient shows no desire to add to list
  – ‘are you sure?’
Lots of priorities

• ‘To do each of your concerns justice, why don’t we focus on the most important for you today—and then make sure we meet again soon?’
Clinicians Agenda

• ‘I wonder if we could/should also talk about......’
• If yes: ‘Good- let’s do that’
• If no: ‘OK- perhaps we can talk about that next time’
Practice..

• In groups of 3
• 1 person observe
• Other 2 have 2x 2-3 minute conversations
• Person 1 is clinician, person 2 Mrs Smith
• Practice **agenda setting** with the agenda sheets.
• Then observer offer coaching support- see next slide
Observer act as coach - coaching tips

What did you do well?

What would you do more of next time?

What would you do less of next time?

What would you stop doing next time?

Then- if necessary:’ Could I add in a few thoughts?’ (ask before advise). Use same grid
Day 2
Welcome
What’s your agenda?
Our agenda is:

• Care planning, self care support skills
• Care planning, self care support skills and coaching rehearsal
• Shared decision making skills
• Shared decision making skills and coaching rehearsal
• Facilitating large groups
• Managing conflict
• Planning your work
• Your action plan
Session 10
Care planning and self care support
Skills workshop
Part 2
Building trust

- On tables
- What can clinicians do to build trust in clinical conversations?
- Why would clinicians want to build trust?
Feedback
Building trust

• Unconditional positive regard (Carl Rogers)
  – Supportive
  – Enquiring
  – Curious
  – Appreciative
  – Non-judgmental
Building trust

• **Open ended questions- invite a story**
  – ‘tell me about’

• **Affirmations, normalisation**
  – ‘You have done so well to try’ (affirming *change talk*)
  – ‘of course’, ‘naturally’, ‘why would you not..’, ‘many people in your position tell me similar things’

• **Reflections**
  – ‘You have told me that...’, ‘What I think you are saying is’, ‘What I heard was..’

• **Summaries- A package of reflections and agenda items**
  – ‘You told me how challenging it is to become more active and lose weight and we have agreed that we are going to talk about becoming more active in our conversation today’
Practice- thin slice learning this time

• Practice means:
  – Role play- could choose to be a ‘patient’; could choose to role play a simple everyday change- more exercise, smoking etc
  – Working with people with long term conditions
  – Working with actors

• The principles are the same

• The coach is in control
Coaching thin slice learning

1. Introductions etc
2. Ask trainee what skill
3. Ask trainee confidence level out of 10
4. Ask trainee to tell role player the clinical scenario (or provide). Remind not too hard!
5. Check with role player they are happy
6. Ask trainee to tell role player what point in consultation they want to start
7. Set rules; trainee or coach can time out at any time
8. Coach time out when trainee struggles—or has missed vital skill
9. Use role player as primary resource—and the rest of the participants
10. Feedback using coaching grid at end
11. Practice till confident then cement with one more session
12. Re-evaluate confidence
Short role play/coaching to demonstrate
Practice, practice, practice in 3 large groups/subgroups of 3
Activation- again

• We should be tailoring our interventions to the level of activation...
<table>
<thead>
<tr>
<th>Stage</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning</td>
<td>Importance scaling</td>
</tr>
<tr>
<td>Level 1</td>
<td>Explore ambivalence</td>
</tr>
<tr>
<td>Finding a way</td>
<td>Supported small achievable goal setting to increase confidence</td>
</tr>
<tr>
<td>Level 2</td>
<td></td>
</tr>
<tr>
<td>Travelling</td>
<td>Sign posting information, education &amp; specialist services</td>
</tr>
<tr>
<td>Level 3</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td></td>
</tr>
<tr>
<td>Staying on track</td>
<td>Support to increase problem solving skills</td>
</tr>
<tr>
<td>Level 4</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
</tr>
</tbody>
</table>
How do I know their activation level?

• Listen for ‘change talk’- phrases such as ‘I tried to…’, I thought about..’. Acknowledge and affirm.
• Think of using the following phrases:
  • ‘What has been working well for you?’
  • ‘What have you been doing that is contributing to your health?’
  • ‘What do you know about living with...?’
  • ‘What ideas do you have?’
  • ‘What are your thoughts about what you can do?’
Importance and ambivalence

• We only invest in change if it is of fundamental importance to us
• Change can be tough going- it needs to be rewarding
• **Rewards** can either be:
  – **Intrinsic** (ie this change is intrinsically rewarding for me- I am going to stick with it)
  – **Extrinsic** (ie even though I know this change is the right thing for me, it’s going to be tough at first- I need to reward myself)
Exploring importance

• Drawing from the priorities on the agenda sheet
  – ‘Which is your priority for us to talk about today?’
  – ‘Which shall we focus on today?’
  – ‘Do you mind if I ask you a few questions about that?’
‘On a scale of 0-10, how important is it for you to change your smoking habit right now?’
‘6 out of 10’

• What led you to say 6?
• What led you to say 6 and not 5?
• What led you to say 6 and not 7?
And, if 7 or more..

- That’s pretty important..
- Shall we think of ways of going about that?
If 4 or less

• ‘It seems that (the change) isn’t a priority for you right now’- pause, use body language to invite comment
• ‘Is there anything else we should focus on?’
• Or- if high medical priority (smoking for instance):
  – ‘could/shall we talk about that next time?’
  – Or:’ let’s talk about that next time’
5 and 6: ambivalence

• Is normal!

• Empathy
  – ‘It’s natural to feel the way you do’

• Double sided reflection
  – ‘On the one hand you are telling me you want to lose weight...on the other hand (naturally) you like your food!’

• Invite story
  – ‘What’s good about carrying on eating the way you do?’
Then:

<table>
<thead>
<tr>
<th>Good things about staying the same</th>
<th>Not so good things about staying the same</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Good things about changing</th>
<th>Not so good things about changing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Practice, practice, practice in 3 large groups/subgroups of 3
Goal setting and action planning

• A goal is something to work towards
• An action plan is a way of getting there
Goal-setting and action planning
What does reasonably good look like?

A 10 minute vignette
Key skills

• Define the goal
  – ‘I want to become more active’

• Support problem solving if goal is nebulous
  – ‘So, you want to become more active- what could you do/ what comes to mind?’
  – ‘What else?’
  – ‘What else?’
  – ‘Which are you going to focus on?’
• Clarify objective
  – ‘You’ve told me you are going to walk more
• Support assembly of first weeks action plan’
  – ‘When will you start?’
  – ‘How many times will you walk in the first week?’
  – ‘Where will you go?’
  – ‘Picture yourself doing the walk- what could stop you doing it?’
  – ‘What else?’
  – ‘How will you manage that obstacle?’
  – ‘What else comes to mind?’
  – ‘What else?’
On a scale of 0-10, how confident are you that you will achieve the first weeks plan?
‘6 out of 10’

- ‘What led you to say 6?’
- ‘What led you to say 6 and not 5?’
- ‘What led you to say 6 and not 7?’
6 or less

- Low confidence - predicts low chance of success
- What could you say?
7 or more

• High confidence- predicts high chance of success
• What could you say?
Goal follow up

- Ideally within 2 weeks
- Phone, email, personal
- Using your knowledge, what are the skills you would use for follow up?
- Feedback
Practice, practice, practice in 3 large groups/subgroups of 3
Training the workforce
Shared decision making about treatments and care planning/self care support..

Are complementary skillsets

Who do you need to train in your workforce, and where do you start?

The next few slides are designed to support CCG level conversations
1. Shared decision making about treatments

2. Care planning and self care support

- Who should be trained?
- Who will you start with?
- Why?
- Do you give different staff groups different degrees of training?
- Table top discussions
- Feedback
Specialist contexts

Care plans important: the noun

Generalist contexts i.e. primary care

Care planning important : the verb

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What’s your role? Where do you work? In the real world?

**Specialist contexts**

- **Specialists - long term review: uncommon conditions, children**

**Specialist nurses**
- E.g. respiratory, neurological

**Discharge planning**

**Cancer Specialist nurses working with survivors**

**District nurses**

**Community matrons**

**Primary care teams carrying out proactive and systematic care of populations with LTCs**

**Generalist contexts i.e. primary care**

- **Case management**
- **‘Unique Care’**

**Care plans important: the noun**

**Care planning important: the verb**

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Some general tips

• Deliver training in pairs to start with
• Ensure you have looked through the slides the night before!
• Cabaret style tables
• 8 minimum, 20 absolute maximum to start
• Use lots of exercises and formats; mix people around, separate ‘cliques’
• Groups of 3 works well
• Group feedback only after a conversation (the deafening silence)
• However, don’t be afraid to invite feedback (‘what do you think?’)
• Safety- ask for volunteer
• Valuing all contributions equally
• Be the change
Start on a high

• Brief introductions- who they are, what their jobs are
• ‘What has put a smile on your face this week?’
• Celebrate success- ‘What are you already doing well?’
• Articulate your role- ‘This is a programme designed to support you to build on your already impressive levels of skills’
• All teach all learn
Keep energy high

- Move people around
- Get them talking
- Slides as prompts
- Capture important contributions on flipcharts and feedback
- Aim is to harness the *power of the group*
Finish with an action plan

• What are you going to practice?
• How important?
• What led you to say that?
• How confident?
Facilitating large groups and managing conflict

• Key skills for managing conflict
  – Car park
  – Reflect ‘what I think you are saying is....pause’
  – Roll with resistance ‘that’s a good challenge’
  – Use the group ‘what do others think?’
  – Attempt to align ‘My reflection is that what you are saying is pretty similar to...’
  – However if not aligned, clarify your own position without suggesting you are in conflict ‘I have a different point of view’
Facilitating large groups and managing conflict

• If persistent
  – You are the facilitator and you are responsible for everybody’s learning
  – Clarify boundary, offer a way out and seek permission. ‘I am uncertain that this conversation is helping the rest of the group. I propose we talk this through at break-time. Is that ok?’
How confident are you to use the skills that you are going to teach?

• Which 1 skill do you need to improve?
• How are you going to do that?
Your action plan

- Who are you going to train?
- How are you going to arrange the training?
- What further support do you need from the SHA?
- How are you going to support each other?
- What else?
- What else?

Workbook page 46
Session 11
Shared decision making about treatments
Is different to shared decision making about behaviour change.
Clinical teams need motivational tools and skills

Clinical teams need decision support tools and skills

Decisions

- About lifestyle
- About medication adherence
- About accessing services
- About possible planned interventions
What makes a good decision?

• Think of an important decision in your life—buying a house/car etc
• Write down things you thought about when making the decision
• List specific features of the decision making process that were important to you
• Then have a table top discussion
• Then feedback
Shared decision making

Decision aid + Decision coaching = Shared decision making
Decision support tools

• **Patient decision aids**
  – Available on internet
  – Patients can use them in their own time
  – Can take 2 hours to use
  – *See:*  [http://decisionaid.ohri.ca/](http://decisionaid.ohri.ca/)

• **Option grids**
  – Less freely available
  – Much more useable
  – Can be used in clinic
  – *See:*  [www.optiongrid.co.uk](http://www.optiongrid.co.uk)
Option grids

• Spend 5 minutes looking at an option grid
• What are your initial thoughts?
• Feedback
3 key stages

Choice talk

Option talk

Decision talk
2 key enablers

Provide decision aid/option grid

Support deliberation
Deliberation

Prior preference → Informed preference

Choice talk  Option talk  Decision talk

Decision support
Glossary

• **Deliberation**
  – Process whereby patients make a decision informed by their own preferences- ‘what matters to them’

• **Choice talk**
  – Patients informed that more than 1 reasonable option exists
  – Preferably given options prior to consultation
Glossary

• **Option talk**
  – Patients informed about different options; benefits, risks and possible consequences
  – Patients invited to explore ‘what matters to them’

• **Prior and informed preferences**
  – Prior preferences based on existing knowledge and expectations
  – Informed preferences based on knowledge of all options and possible benefits and harms
1. **Establish** diagnosis or explanation

2. **Step back.** Check there is agreement on nature of the problem.
   
   ‘we agree that there is a problem with arthritis in your knee....pause’

3. **Choice exists.** Be explicit- many patients expect to be told what to do.
   
   ‘There are a number of things we can discuss’
   ‘I’d like to share some information with you about your options- is that OK?’
1. **Choice talk**

4. **Justify choice** and clarify partnership/support
   ‘We need to think about what’s important for you’
   ‘I am here to help you think this through’

5. **Check reaction.** Patient engagement may be evident- however if not:
   ‘Before we think this through in more detail, I just want to check that you are comfortable with us thinking this through together’

6. **Defer closure and emphasise partnership.** Some patients want you to decide; however this will lead to a decision that is not informed by ‘what matters to them’
   ‘I really want us to come to a decision that’s right for you. To help us do that, why don’t we look at a little more information. Is that OK?’
Practice.

- In groups of 3
- 2 conversations between clinician and patient
- 1 coach. Check for 5 steps (step 2 onwards)
- Scenario to practice is on next slide
Clinical scenario

- Mrs Jones is 68
- She is overweight and complaining of knee pain
- An Xray confirms arthritis
- You have just told her she has arthritis
- The options she faces include getting more active, losing weight, taking analgesics or seeing a surgeon with a view to an injection or possible surgery

Workbook page 42
2. Option talk. Introduce option grid

• **Step 1.** *Here is an option grid*
  – Tell them that this is a summary of the reasonable options

• **Step 2.** *Please take a look at it*
  – Check they are happy to read it for themselves

• **Step 3.** *Highlight the bits that matter most to you*
  – Supports them to guide the conversation

Workbook page 43
2. Option talk.

• **Step 4.** ‘*Do you have any questions?’*
  – Focusses conversation on what matters for them

• **Step 5.** ‘*It’s yours to keep*’
  – Reinforces that the information is theirs
  – Remind them to look for other sources of information
3. Preference talk, decision talk

**Step 6.** ‘In terms of what you know about your options, what’s most important for you?’
- An open question which invites patients to express their preferences; they may be most interested in risk, predictability, outcome, recovery etc etc

**Step 7.** ‘To come to a decision that’s right for you, what else do you need to know?’
- Ask if patients have knowledge gaps as a result of expressing their preferences
3. Decision talk

- **Step 8.** ‘Are we ready to make a decision about what’s right for you’
  - An open question that invites reflection
  - May be followed by ‘what else do you need to know’
  - Or: ‘it’s natural to feel uncertain. Take your time.’

- **Step 9.** Patient articulates decision. Affirm decision, reinforce partnership.
  - ‘We agree that we’ll go ahead and.....’
4. Confidence talk

• **Step 10.** Check for confidence

  ‘*On a scale of 0-10, how confident are you that this is the right decision for you?*’
Practice, practice, practice.

• In groups of 3
• 2 conversations between clinician and patient
• 1 coach.
• Use option grids supplied
The care, treatment or support you *need* and no less
The care, support or treatment you *want* and no more
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