REDEFINING CONSULTATIONS:
CHANGING RELATIONSHIPS AT THE HEART OF HEALTH
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Registered as a charity in Scotland number SCO42833.

Registered office:
1 Plough Place, London, EC4A 1DE

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ACKNOWLEDGEMENTS

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And for their leadership of and support to the People Powered Health programme, thanks to:

• Halima Khan, Ajay Khandelwal, Francesca Cignola and Tina Strack at Nesta

• Matthew Horne, John Craig and Leonie Shanks at Innovation Unit

• Professor Paul Corrigan
# REDEFINING CONSULTATIONS:
CHANGING RELATIONSHIPS AT THE HEART OF HEALTH

## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>About the series</td>
</tr>
<tr>
<td>5</td>
<td>Foreword</td>
</tr>
<tr>
<td>6</td>
<td>Why redefining consultations is central to People Powered Health</td>
</tr>
<tr>
<td>8</td>
<td>Changing the conversation</td>
</tr>
<tr>
<td></td>
<td>Care planning and pathway planning</td>
</tr>
<tr>
<td></td>
<td>What's needed for successful care planning?</td>
</tr>
<tr>
<td></td>
<td>Mapping Patient Pathways in Newcastle</td>
</tr>
<tr>
<td></td>
<td>Focus on Year of Care</td>
</tr>
<tr>
<td></td>
<td>Focus on People Powered Health in Leeds: care planning in practice</td>
</tr>
<tr>
<td></td>
<td>Referrals and social prescribing in People Powered Health</td>
</tr>
<tr>
<td></td>
<td>Focus on People Powered Health in Stockport: wellbeing pathway planners</td>
</tr>
<tr>
<td>16</td>
<td>Changing the format</td>
</tr>
<tr>
<td></td>
<td>Group consultations</td>
</tr>
<tr>
<td></td>
<td>Benefits of group consultations</td>
</tr>
<tr>
<td></td>
<td>How to do it: lessons from group consultation practice</td>
</tr>
<tr>
<td></td>
<td>Focus on SUN Croydon: group consultations in acute mental health</td>
</tr>
<tr>
<td></td>
<td>The benefits of SUN</td>
</tr>
<tr>
<td></td>
<td>What does a SUN group look like in practice?</td>
</tr>
<tr>
<td></td>
<td>Focus on People Powered Health in Calderdale: group consultations in a pain clinic</td>
</tr>
<tr>
<td>24</td>
<td>Changing roles and relationships</td>
</tr>
<tr>
<td></td>
<td>Focus on People Powered Health in Newcastle: patients and health trainers working in partnership</td>
</tr>
<tr>
<td>26</td>
<td>Changing culture</td>
</tr>
<tr>
<td>27</td>
<td>Conclusion</td>
</tr>
<tr>
<td>28</td>
<td>Endnotes</td>
</tr>
</tbody>
</table>
About the series

Redefining Consultations: changing the relationships at the heart of health is the third in a series of six publications that draw on the experience of teams who took part in People Powered Health, a project led by Nesta and Innovation Unit from 2010-2012.

The series includes:

- **People Powered Health**, health for people, by people and with people, foreword by the King’s Fund
- **The Business Case for People Powered Health**: building the business case, foreword by the NHS Confederation
- **By us, For us**: the power of co-design and co-delivery, foreword by National Voices
- **More than Medicine**: new services for People Powered Health, foreword by Macmillan
- **Networks that Work**: partnerships for integrated care services, foreword by ACEVO
- **People Helping People**: peer support that changes lives, foreword by MIND
- **People Powered Commissioning**: embedding innovation in practice, foreword by NAPC
- **Redefining Consultations**: changing relationships at the heart of health, foreword by the Royal College of GP’s

Acknowledgements

We’d like to take this opportunity to acknowledge the ideas, hard work and insights of all the patients, service users carers, practitioners and commissioners who have been part of the People Powered Health programme. Special thanks go to the teams in the six localities:

- Calderdale
- Earl’s Court
- Lambeth
- Leeds
- Newcastle
- Stockport

You can find out more about their work and about People Powered Health at [www.nesta.org.uk](http://www.nesta.org.uk).
Foreword

There is strong evidence to support the development of new relationship between patients and professionals in the consulting room. Patients tell us that they want us to do more to support their own self-care. And we know that patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of care.

This is especially true for the growing number of patients living with one or more long term conditions. People with long-term conditions account for more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days as well as 70% of the total health and social care spend in England.

However, shared decision making is not yet the norm and many people want more information and involvement in decisions about treatment care or support than they currently experience. Embedding this shift into systems, processes and workforce attitudes, skills and behaviours is a considerable challenge.

In response, the GP consultation of the future will need to be much more adaptable. For patients with comorbidities or complex health needs, longer consultations are needed to allow for the needs of the patients to be adequately discussed and for enhanced communication to occur with the patient, their carers and different healthcare providers. A structured care planning approach will be essential to support patients to understand and manage the impact of long-term conditions and to ensure the provision of a personalised and co-ordinated package of care. Models of care such as group consultations, social prescribing, and peer to peer support will also become increasingly important.

The RCGP has been at the forefront of work to roll out such approaches more widely across general practice and we welcome this report as an important contribution to the debate, showing what can be done when professionals in their communities are empowered to work with people with long term conditions to implement new ways of delivering care.

The key is to make more effective the dialogue between the patient and GP that is so vital to the care we provide every day and changing the doctor-patient relationship into a doctor-patient partnership. Doing so will not only improve the quality of life for patients with long term conditions, but will also give them more control, better health and better well-being.

Nigel Mathers is Vice Chair and Care Planning Lead, Royal College of General Practitioners
Why redefining consultations is central to the People Powered Health approach

Consultations sit at the heart of health care. They are the first point of contact and the archetypical interaction with the health service for most patients and, at their best, consultations underpin, support and guide a patient’s journey through the system.

In the People Powered Health approach, consultations take place through collaboration – a meeting between equal partners with a common purpose. One partner brings professional expertise, clinical excellence, support and navigation. The other brings their own skills and knowledge about their life, lifestyle and social situation; their willpower, energy, motivation and strengths; and their goals, values and aspirations.

The relationship between doctors and patients is at the heart of our health system. If we want a different health system, we need a different type of relationship.1

The Health Foundation, When Doctors and Patients Talk: Making Sense of the Consultation

There are a number of models for how consultations currently take place, depending on the context – GP, pre-operative, nurse practitioner, out-patient and specialist. In their orthodox form consultations have in common some basic ‘rules of engagement’, a defined set of interactions in which the professional diagnoses the problem, plans the treatment and prescribes the solution. Not only do patients lack control in these interactions, but unlike the medical staff, they are often not clear even what the rules are. As the Health Foundation puts it, for patients it often feels as if doctors have a ‘map’ that the patient cannot see.2

It is not just patients who find this frustrating – for clinicians too the rules of the game often prevent them from building productive relationships with those in their care, many of whom have complex health problems with complex causes, that cannot be easily understood within the confines of the consultation. The clinical model traditionally used for situations ranging from triage in casualty to diagnosing a winter cold is inadequate for dealing with the increasing challenge of social-medical long-term conditions which requires partnership not just prescription.

Some services, providers and projects are changing the game, moving towards new models of interactions between patients, service users and the health service that focus on outcomes, not outputs. They are creating purposeful, structured conversations that drive towards patient-driven goals of wellbeing – not diagnosis-driven aims of ‘cure’. However, the majority of consultations in the NHS still follow the traditional model, with new ideas, formats and practice yet to go to scale.
A partnership approach to consultations is being demonstrated in a wide range of settings from acute mental health to musculoskeletal support groups to health trainers working in pulmonary rehabilitation. All rely on a core set of new interventions:

• **Changing the conversation** to focus on patients’ goals and outcomes, through care planning across an entire pathway and a system of referral and social prescription that incorporates non-medical provision.

• **Changing the format** to provide flexible, alternative structures according to what is most useful to the patient, not most convenient to the institution.

• **Changing relationships** to value patient experience and new professional and non-professional roles as sources of expertise.

The culture change required for collaborative working can be difficult for patients as well as practitioners. Both have become accustomed to the current relationship dynamic, even if they are frustrated by it. Those who have persevered are demonstrating progress towards more equal, more productive and more human-centred care.
Changing the conversation

Consultations are the basic building blocks of interactions between patients and clinicians. They carry enormous potential as a space to jointly assess needs and problems, develop and design a plan for care and treatment, and together review progress and evaluate success.

There’s been a cultural and professional change in attitude, mindset and behavior, when I did my training as a clinician some years ago, it was very much the professional or the clinician who knew best, knew most – led the conversation. Now the person, patient, service user knows best and often they lead that relationship and that conversation.”

Paul Morrin,
Director of Integration, Adult Health and Social Care
Leeds Community Healthcare Trust

The role of the healthcare professional is to facilitate, not dictate, this process – supporting the patient as part of a team identifying goals and navigating the routes to get there together.

In the People Powered Health approach, care planning (sometimes called pathway planning) is a key concept. It generally takes a broader approach than many current applications of care planning, encompassing any service that may help with a patient’s overall wellbeing. Care planning across the whole pathway of care that a patient experiences is a process in which a patient, with help, identifies and compiles their health and wellbeing goals; sets achievable targets for progress towards these; and puts in place the support and resources to get there.

In the People Powered Health programme, the concept has grown up in the Stockport team to describe both a pathway to recovery (rather than a plan for treatment) and a more inclusive route to that recovery likely to take in a wider range of services that include but go beyond clinical interventions. This could range from peer support, to advocacy or assistance with housing, to exercise classes, to volunteering opportunities. Those working alongside the patient may be clinicians or one of a wider range of roles, including peers, health trainers, volunteers or advisors, opening up the consultation definition to give equal space to non-clinical interactions.

At the commissioning level in Stockport, pathway planning is used to collate individuals’ needs to plan community services. At the consultation level they sit at the heart of practitioner-patient relationships, engaging patients in their condition and care. The process can (and
often does) result in a written physical plan, but it is the action of collaborative working that is most important. The range of conversations between patients and practitioners that take place under the umbrella of consultation are often fragmented, point-in-time encounters with the patient being relied upon to join up the narrative in-between.

Whether called care planning or pathway planning, the aim is the same – to give patients control over their care, its direction and goals, the knowledge of what to do in moments of crisis, the confidence to take charge of their own health where they are able and a structure of support for when they are not.

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**Focus on Year of Care**

Year of Care describes the on-going care a person with a long-term condition should expect to receive during the course of a year, including support for self-management, which is costed and commissioned.

Year of Care puts people with long-term conditions in the driving seat by making routine consultations with clinicians collaborative through care planning and then ensures that the local services that people need to support their care plan are identified and made available through commissioning.

Although Year of Care was always envisioned as a solution for a range of long-term conditions, including for people with comorbidity, it was piloted with people who have diabetes. Diabetes affects nearly 5 per cent of the population, uses nearly 10 per cent of NHS resources and contributes to 10 per cent of premature deaths. So the need was real and urgent and the lessons and new skills learned can be readily transferred to other conditions.

Implementing Year of Care involved extensive training and collaborative working in three pilot areas and a further 12 health communities. This led to important learning for commissioners including:

- A new commissioning model for long-term conditions - introducing care planning and better self-management at the centre of care for people with long-term conditions. This encouraged service redesign, new approaches to commissioning and whole system change, leading to better integration of services.
- A practical guide to commissioning and delivery of non-traditional services to support self-management through the third sector including the barriers and solutions.

The evaluation found benefits including changed behaviours in self-management by people with diabetes and higher productivity, improved knowledge and skills and greater job satisfaction amongst clinicians. The evaluation also found that implementation requires extensive changes to culture and systems locally.

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“We talk about people’s hope and dreams and then give them the means to get there.”

Collin McCabe, Personalisation and Prevention Service Manager, Stockport Mind.

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Redefining Consultations: changing relationships at the heart of health | 9
What’s needed for successful care planning?

There are essential elements that need to be in place for care planning to work successfully:

• **An atmosphere of trust:** including an engaged, informed patient and a practitioner committed to partnership working.4

• **Institutional processes that support this relationship:** including collaboration across services; multi-disciplinary teams and time for practitioners working together to discuss patients’ care; more flexible allocation of time; the extension of roles and consultation skills training; and ensuring a useful flow of information around the system.

• **A referrals system** that is robust: clinicians knowledgeable and willing to refer patients to more than medical provision supported by a flexible, agile commissioning process that is responsive to community needs.5

Mapping Patient Pathways in Newcastle

Newcastle’s development of new patient pathways for those with long-term conditions aims to reduce its rate of non-elective admissions by 11 per cent and reduce the use of emergency and primary care services.

The team has developed a full map of patients’ progress through available pathways, including all services they might encounter – both what is visible to patients on the journey and the back-office provision and commissioning activity that makes these happen.

The maps have been used to raise questions, concerns and stimulate understanding and debate of local needs and gaps in provision. They have also been used as the basis for individual scenarios – plotting real individuals with particular lifestyles and characteristics to test whether new pathways would meet their needs, and looking at designing/commissioning new services if not.

“Care Planning is about making more effective the dialogue between the patient and GP that is so vital to the care we provide every day and changing the doctor-patient relationship into a doctor-patient partnership.”

Dr Clare Gerada, RCGP Chair of Council
Care planning enables the patient or service user to:

**Set the agenda of the consultation** around what they would like to achieve. This might be clarity around what their goals are; compiling a list of questions; or constructing a fully formed plan.

**Set their own goals**, including medical, social, emotional and lifestyle goals. While the clinical goal for a COPD patient might be to reduce the number of attacks, the goal for the patient might be to be able to go swimming with their family - the route to which is gradually increasing their level of activity.

**Develop their own care plan** to map out how these goals will be met, any barriers to progression and discuss where, how often and from whom they would like care and support to be provided.

**Review their own progress** according to their own metrics of success. Have any further barriers been identified? Are they ready for the next step? Are these still the right goals?

**Make shared decisions** with practitioners as equal partners and in a context of mutual trust.

For more on personalised pathways see *By Us, For Us.*
Focus on People Powered Health in Leeds: care planning in practice

The Leeds Transformation Programme is a city-wide agreement to work together towards a new model for health and social care. It has implemented the Long-term Conditions Implementation Programme, often known as the ‘Sir John Oldham’ model of system change.

The model has three steps: risk stratification; integrated teams; and systematic self-management. A core part of the project is therefore focused on systemising self-management across the city, working jointly with service users, carers and the voluntary sector to co-design, co-deliver and embed a network of systematic self-management support across health and social care, the voluntary sector and local communities.

The process rests on patients and carers being supported through a care planning process to identify and achieve their own goals, including education programmes for patients and professionals in shared working. The emphasis is on professionals to facilitate rather than deliver care planning, helping patients through evidence-based appraisal of the options available to them.

Care Planning is expected to reduce reliance on acute health services, reducing the number of GP visits, length of hospital stays and long-term social care placements, thereby bringing significant financial benefits. It will also improve the health and quality of life of patients by helping them to be more independent, expanding their peer networks and supporting them to be more active in their communities.

“Our culture and approach is one that recognises the patient or service user as an asset; they bring valuable skills to the relationship with the professional. It’s about fostering a new dynamic within the system in which the person, the patient or service user, is seen as an equal within that relationship with the professional, and the professional works alongside the individual patient in the delivery of the plan of care.”

Paul Morrin, Director of Integration, Adult Health and Social Care Leeds Community Healthcare Trust

Learn more

Care planning requires a fundamental shift in the content and context of consultations. Effective training can be an important part of making care planning a part of everyday practice.

To find out about care planning training, visit NHS diabetes here.
Referrals and social prescribing in People Powered Health

People Powered Health consultations are both a method of care in themselves and a means of constructing pathways for recovery, care and wellbeing. This includes referrals to services providing more than medicine in health, social and community care, and prescriptions to non-medical interventions such as exercise and activity, diet and nutrition, arts-based therapies, peer support, coaching and mentoring, and employment and welfare support.

The key to accessing these services is a system of robust, flexible and timely referral. A system commitment to social prescribing and referral to non-typical support gives clinicians a mandate to refer patients to suitable, less expensive, community, voluntary and self-directed support. For the referrals system to support People Powered Health, the following must be in place:

**A range of alternative provision options to which GPs are entitled and encouraged to refer.** Commissioning bodies should be engaging with providers of non-clinical provision, community groups and patient organisations. They should be proactively commissioning provision so that it is available and known to GPs, in addition to reactively shaping provision according to patients’ needs.

**Referrals should be part of a structured care planning process,** with patient preferences playing a much more important role. Integrating referrals with a care planning process gives clinicians an explicit mandate to refer as they and the patient think appropriate.

**A more collaborative relationship** between commissioners, practitioners, patients, secondary and primary care providers and non-typical provision. Building stronger relationships between all parts of the system results in GPs who are knowledgeable about the alternative provision on offer; consultants being more informed about the patients they are seeing; and the system better able to anticipate need.

**The ability for patients to self-refer** through more open-access services and better awareness of available local options.

**A platform/system that enables this process and makes it as straightforward as possible.** This includes systems within practices, such as algorithms on practice IT systems to automatically flag up suitable patients and even ‘auto-enrolment’ or ‘auto-referral’ for patients, carers and service users who match particular criteria.

For more on social prescribing see More Than Medicine
For more on joined-up commissioning processes see Networks That Work

What’s next?

Adapting mainstream mechanisms to encourage referrals that support People Powered Health could be one way of scaling this work in the future. For example, Local Enhanced Service payments could be used to pay GPs for social prescribing.
A collaborative approach to commissioning and a strong consortium of providers underpin the new Prevention and Personalisation Service run by Stockport Mind alongside All Together Positive, a user-led social enterprise.

The service enables users of mental health services to co-create care pathways, supported by a Wellbeing Pathway Planner and access to a wide range of services from a variety of networked providers including peer groups, volunteering, debt and housing advice and clinical support.

There are three steps to the pathway planning process, which happen on a timeframe that works best for each individual.

- **Initial emotional support**, talking through why the service user is there and how they feel about themselves and their life in general, both including and going further than their mental health.
- **Identifying aspirations** for how the individual would like their lives to look in a week, a month or a year’s time.
- **Identifying barriers** that are keeping the individual in secondary care (e.g. medications, social isolation) and preventing the individual from moving towards those goals, then working to remove, manage or overcome them.

“**It’s about recovery as a person, not recovery from a disorder. You can have a disorder and still recover as a person.**”

**Nick Dixon,**
Joint Commissioning Manager (Mental Health),
Stockport Council

What’s new?

**What’s new about Stockport’s wellbeing pathway planners?**

- **Focusing on aspirations** – service users’ pathways are determined by their aspirations rather than their mental health diagnoses.
- **Measuring what matters to users** – progress is measured against each individual’s own goals and using a holistic health and wellbeing to measure outcomes such as the strength of their social networks.
- **Building for scale** – by rolling out pathway planners slowly, embedding them in GP practices across the city and building service databases, Stockport is designing a service which can operate at scale.
Progress is measured against an individual's own goals, supported by outcome frameworks that look at headway made towards goals in categories such as volunteering, employment, finances and wellbeing. Individuals' mental and emotional health is also measured through WEMWBS, the Warwick-Edinburgh Mental Well-Being Scale. Service users are asked to complete this as early as possible in the process to have an accurate baseline and again around three months later. The tool includes questions such as 'how often do you feel loved?', and talking these through can be a valuable emotional process in itself.

The service aims to help two categories of people: those who are at risk of worsening in their condition and going into secondary care (the Prevention Pathway), and those who are in secondary care and could be supported by primary care and community services instead (the Recovery Pathway).

The Prevention and Personalisation Service works closely with For Local Advice and Guidance (FLAG), an independent service that puts people in need of practical or emotional help and guidance in touch with local organisations best able to provide it – from counselling to legal advice to the community gym. The service has also started to embed Wellbeing Planners directly in GP surgeries, to build up the trust of GPs in the new pathway and provide direct referral access.

Since the launch of the service in 2012 there has been a significant decrease in the number of people referred to the mental health secondary care Single Point of Access. GPs have also reported a decrease in repeat appointments with service users who had previously accessed the GP on a regular basis but for whom there was no clear place to refer. In the first two months of the service one GP referred 36 frequent attenders with complex and mental distress who were unsuitable for secondary care. The new pathways are ultimately expected to reduce referrals and re-presentation to secondary care by at least 60 per cent, and increase discharge rates into primary care by 25 per cent.

For more on Stockport’s approach see Networks That Work and By Us, For Us.

Collin McCabe, Personalisation and Prevention Service Manager, Stockport Mind

“One service user talks about feeling like ‘a pea in a tin of peas’ – squashed in with everyone else who’s feeling unwell. But just by talking about it feels like someone’s taken the lid off and shown him that there is something beyond this tin of peas, this service land, and he can actually get there. What we’re doing is helping put a plan in place and identify what’s needed.”
Changing the format

It is possible to completely transform the traditional model of consultations by altering the context in which they occur, creating new spaces and settings in which interactions between patients/users and practitioners can happen.

The format of consultations is restricted only by current norms of practice. In reality, they can take any form. In People Powered Health we have come across examples of consultations held in groups of more than one patient; with more than one clinician; over email or Skype; or with more flexible lengths of appointment according to a patient’s needs.

Such arrangements are proving to be both:

- **Efficient**: in Calderdale the consultant can treat 15 patients in the time she would normally take to see nine; and

- **Effective**: a systematic review of shared appointments for long-term conditions in 2012 showed that group consultations improved intermediate clinical outcomes for type 2 diabetes.

Group consultations

Group consultations embody the People Powered Health principle of shared working and putting human interactions and relationships before institutions and processes.

They create a context for open discussion and collaborative problem-solving in which a sense of shared enquiry is built through learning from peers in a more relaxed environment that is ‘owned’ by patients. Patients set the agenda for the meeting by sharing their challenges, which they then go on to tackle together, with the support of a professional who is always present. Patients can teach and learn from one another with as much or as little interaction as they feel comfortable. And patients’ progress and quality of care can be benchmarked against that of others.

Not everything can be dealt with in the whole group. The practitioner also protects time to meet with people one to one after the session. Often patients will be happy to discuss practical challenges but prefer a confidential conversation around medication for example. But these meetings are quick and are often reduced in number as people decide to try new tactics learned from others in the group.
Benefits of group consultations

New consultation formats can’t happen without breaking out of the restriction of ten minutes per patient, one patient at a time, often with a gap of a number of months between appointments. Longer consultation formats on a much more regular basis inevitably take up larger chunks of time for clinicians per session. But group consultations are efficient in clinicians’ time overall – groups in Calderdale, for example, number up to 15 patients at a time and involve one or two clinicians.

In addition, evidence from Calderdale and research from the Health Foundation suggest that the current model of one-on-one consultations can be ineffective – and therefore highly inefficient. Patients fail to take in much of the information that is given to them due to the lack of time for reflection during the consultation and the pressured environment in which it takes place.

Croydon’s Service User Network has shown that a mixture of formal and informal support means people are better able to manage their crises, helping them to avoid harmful situations and reducing admittances to A&E. An audit looking at the impact of SUN on hospital bed day use after six months of membership showed a total decrease from 330 days to 162 days, with A&E attendance reduced by 30 per cent.

What’s next?

In order to scale group consultations, healthcare professionals need to be trained to be not just deliverers of one-to-one interactions, but facilitators of groups.

A skilled facilitator will ensure that no one person dominates the group, that people are able to learn from each other and that the balance of content is suitable for a clinical interaction. These are skills that need to be taught during initial training or revalidation.
How to do it: lessons from group consultation practice

• Don’t rush the planning and preparation for introducing the new format. It can be a huge culture change both for practitioners and patients, all of whom should be involved in the new design and in setting the ground-rules for the consultations themselves.

• Choose carefully who would be best to run the consultations – a GP, physiotherapist, nurse, pharmacist, midwife, specialist – and make these decisions according to what would most benefit the patients, not who will be most likely to be available.

• Helping patients prepare for the session beforehand is important to familiarise them with the format and give them a chance to ask questions about what will happen and who will be there. As part of Calderdale’s Self-Management Programme patients are given a taster of what a group session will be like before they sign up to the course, so they can arrive prepared and comfortable with what will be expected of them.

• Utilise existing navigator, health trainer and buddy/befriender roles to engage patients in the groups and link them in with patients’ overall health journeys and care plans. The consultations must occur in a wider context of patient support, not as a discrete activity to which the wider group of practitioners who interact with the patient has no connection.

• Think about what the ideal outcomes of the consultation, or series of consultations, will be. These may change on a session-by-session basis according to what patients find most helpful, but there should be an overall aim in mind – e.g. patient education, building networks, teaching practical skills, building care plans.
Focus on

SUN Croydon: group consultations in acute mental health

The Service User Network (SUN) project in Croydon is a mental health service designed and co-run by its members. It provides extra support outside mainstream services to people who have a diagnosis of personality disorder or long-standing emotional and behavioural problems.

The project was established in response to a South London and Maudsley NHS Foundation Trust survey, which identified around 4,000 people diagnosed with personality disorder who did not have access to a service meeting their needs. It was formed in consultation with existing service users, with the continual development of the service shaped through forums and conversations. SUN runs four group sessions a week, focusing on emotional and practical support.

The project accepts anyone without requiring referral or diagnosis, with the aim of making it accessible as quickly and easily as possible and removing the feelings of users of having services imposed upon them. Service users come for an initial welcome session and can then become members, but are not required to attend a minimum number of groups. Members have a wide range of mental health issues including interpersonal relationship difficulties, managing mood, feelings of self-harm and social isolation. The project has 75 members, with an average group size of ten – groups are capped at 15 to ensure that there is enough time for everyone to be heard.

Underpinning SUN’s approach to empowerment and engagement is a principle of therapeutic community. Rather than being either user-led or professional-led, SUN builds on an ethos of ‘creative partnership’ that emphasises working together through crises. The core support resource lies in the group members’ experiences, with the group itself acting as the therapeutic agent.

“I believe the fact that you’re not made to go to the groups and can refer yourself is a really clever point. If I felt I was being coerced into going to every group I would probably not go. You can go every day, you can go once a week or once a month. You can not go for three months, and then if you’re feeling a little bit dodgy you can go back for a couple of weeks just to fill up your tank again.”

Nicole, SUN member
Each group contains at least one professional facilitator experienced in multiple aspects of mental health, whose role is to create and maintain a dynamic that enables and empowers service users to support one another. There are no one-to-one sessions available, ensuring a level of openness and trust that permeates all interactions. Because of this openness and unpredictable mix of who might present on any given day, managing risk is crucial. This is mitigated through the structure of the model, with groups following set protocols for time and structure. The protocol serves to support and provide a sense of continuity and safety to members.

In their second group visit, members construct a Crisis & Support Plan (CASP), which is individual but developed jointly and continually reviewed by the group. The CASP identifies key challenges for that member and safe, helpful and practical steps to coping. It constitutes both a risk assessment and identifies thoughts and behaviours for modification.

At points of crisis, members are able to follow a clear and familiar procedure as set out in their CASP, and will be able to access another member of SUN in person or on the phone. This support also prevents traditional trigger points and times of stress from becoming crises, reducing the need for acute services and A&E visits.

What sets SUN apart from peer-support groups is its emphasis on a creative partnership between mental health service users and professionals, something that many of its members have not experienced before.

“Getting to learn to trust people because of my issues was a big barrier for me but SUN slowly eked it out of me. In a very kind and caring way, not in an inquisitive and nosey way. It made it easier and easier to talk.”

Nicole, SUN member

Claire, SUN member

“Part of the model and one of the reasons the groups are so structured is that we internalise that sense of being able to cope, having somewhere to put things and bring things and work things through... For me the shape of the group has given me a shape inside to be able to work things through, to be creative in my thinking, to see that there are possibilities and most of all to know that there is hope.”

For more information on the SUN project, see ‘The SUN Project: Open Access Community-Based Support Groups for People with Personality Disorder’.16
The benefits of SUN

The benefits of the SUN approach are evident both quantitatively and qualitatively:

- A 50 per cent reduction of in-patient psychiatric bed use by six months of membership, sustained over two years\(^7\) and a reduction in acute emergency services.
- No completed suicides by members in the three years since the project began, despite being a very high-risk population.
- More empowerment of patients after six months of membership and an 88 per cent retention rate over 12 months.

What does a SUN group look like in practice?

<table>
<thead>
<tr>
<th>Introduction and Feedback</th>
<th>45mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Name round and check in</td>
<td></td>
</tr>
<tr>
<td>• Feedback from last group read from group book</td>
<td></td>
</tr>
<tr>
<td>• Feedback from staff team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Break</th>
<th>15mins</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Main part</th>
<th>50mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depends on day (CASP/Welcome, Practical or Support)</td>
<td></td>
</tr>
<tr>
<td>• Topic varies each week</td>
<td></td>
</tr>
<tr>
<td>• Wishes of members</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Break</th>
<th>10mins</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reflection and planning</th>
<th>30mins</th>
</tr>
</thead>
</table>

Aim to allocate as:
- review of activity in group, if necessary plans for evening (20mins)
- group book (10mins)

Nicole, SUN member

“I’m not alone anymore. I spent 15 years thinking I was the only person with my problem… Before I joined SUN I was feeling very low, very alone, isolated, uncared for. Not thought about. Just given my weekly prescription of tablets and told to go back home… It’s life changing, because you can see ‘oh there are possibilities for me, I can come out of the backwater, I can do this, I can do that – there is reason for me being here’.”
As part of People Powered Health, Calderdale is piloting group consultations to help improve service delivery pathways for patients with musculoskeletal pain.

The new consultation model has three core purposes:

• Supporting patients in self-management.
• Creating more equal partnerships between professionals and patients.
• Ensuring that the skills and capabilities of service users play an instrumental role in service improvement and delivery.

In the initial piloting of the project it was found that patients often asked questions that they had previously been given information about in their individual consultations, showing the benefit of revisiting topics in a more relaxed and less pressured environment.

As part of the Health Foundation’s Co-creating Health programme, Calderdale provided clinicians with skills for supporting self-management. Although this part of the programme was successful, the evaluation identified a need to stimulate patient activation in different forms. This was important because according to the Health Foundation, informed, active patients are one half of the partnership approach that underpins effective healthcare. The Calderdale group consultation work started in response to an issue of delays in follow-ups, which caused patients to lose motivation.

The team felt that the cohort could benefit from group interaction, and specifically chose patients who were sceptical about self-management to replicate what it would look like in day-to-day practice, alongside an anaesthesiologist, pain consultant, physical therapist and expert patient.

Dimple Vyas, Consultant Anaesthetist

“We set an agenda for people to go round the room asking one after another what was the most important thing they could talk about. It happened that by the time they’d got to the end of the group most of the agenda had formed itself... The bond that formed in the group through agenda setting was significant and helpful.”
“The way we set out group consultations – we wanted to stick to the principles for People Powered Health co-design. We used patient focus groups and process mapping of what happens to get a better understanding and to get their ideas and input – would they see this as beneficial, what would add value – and then look at what would work practically.”

Dimple Vyas, Consultant Anaesthetist

Consultations are led by an advanced practitioner and physiotherapist. Instead of having the normal follow-up clinic for patients who have recently had a spinal injection, patients were invited to come to a group consultation together for two and half hours. The new model provides a supportive space for patients to motivate and help one another and to rebalance the consultation dynamic by putting the patients in control of the agenda, with the clinician in a facilitation role.

The focus of the consultations is on looking at what issues patients face, both collectively and individually, and setting goals and agendas for future group and individual appointments with clinicians. Follow-up group sessions happen two weeks after the initial session, to give patients time to reflect on what they’ve learned and to make progress towards their goals.

Learn more

Different models of group consultations have been used in a variety of settings in the USA:

- Centering healthcare
- Veteran affairs – shared medical appointments for diabetes
- Clinical microsystem - shared medical appointments
Changing roles and relationships

Patients’ expertise in their own care, particularly for those with long-term conditions, is becoming more valued by the health service. But the expertise of non-clinical professionals, volunteers and peers in roles such as navigators and health trainers is also central.

These new roles - navigators, health trainers, pathway planners, wellbeing coaches, community matrons and advisors - open up the possibility of new types of care and new contexts for delivery. The roles use a range of experience, viewpoints, contexts and methods of care alongside doctors, nurses and consultants. In the People Powered Health approach these wider roles are seen as core, not supplementary, to the effective provision of care.

At its heart, the People Powered Health approach is about the relationships between the people in the system - patients/service users, carers and practitioners. It’s about constructing tools, services and processes that can support these to become partnerships towards shared goals of health and wellbeing.

Using non-clinical professionals, volunteers and peers in roles that complement clinical care is a valuable way of supporting patients. These roles can, for example, support people to make important lifestyle changes that improve symptoms.
Focus on People Powered Health in Newcastle: patients and health trainers working in partnership

“I can walk 100 yards without stopping, it might not sound like much but at one point I couldn’t walk 1 yard without stopping.”

Albert has COPD. He used to be a property inspector but stopped being able to walk up stairs as his condition worsened. He began having panic attacks; didn’t want to eat; had a feeling of suffocating – he simply couldn’t get enough air in his lungs. He developed a fear of going outside his house, where the cold air would make him panic and start to sweat. Two weeks after he left his job he collapsed and was taken to hospital.

Albert stayed in intensive care for four weeks, then spent another four weeks housebound. His weight went from 10 stone to 6 stone.

His son contacted the British Heart Foundation, who said that the best way forward was to get some exercise. He contacted Albert’s local gym, at the Lemington Centre, who said that they were running pulmonary rehab classes.

Albert’s first meeting was with Dee and Wendy, who are both health trainers. They spent a long time together talking through what he wanted to get out of the classes – what were his aims? They assessed him every month from then on.

Having now been a member of the gym for two and a half years, Albert has achieved one of his main goals: he can play with his grandchildren. Meeting other people at the gym with similar difficulties took away the stigma of his condition and improved his confidence. He can go to the toilet and have a bath by himself. He’s got his dignity back, and his panic attacks have stopped.

For more on the role of health trainers in Newcastle see More Than Medicine.

Albert Baker, Member of Lemington Community Gym, Newcastle

“The role of the health trainers in the centre itself is one of motivation and inspiration. They are asking you how you are feeling, how you are moving, how you are doing. You want to be your best... I think more doctors should be pointing people here to these centres, it gives people motivation, exercise, it gets them out of the house, they meet people. The doctor should have been a bigger role in referring people to places like this.”
Changing culture

Changing consultations requires a change in professional ethos and in patient expectations. Professionals need to recognise that patients have significant strengths as well as biomedical needs. Patients need to be prepared to become equal partners in managing their care.

A collaborative approach to consultations challenges professionals’ perceptions of their own role in their patients’ care. This includes the realisation that they are part of a productive partnership, and not necessarily the expert in every dimension of the arrangement. Practitioners need to feel confident in their own identity and ability to work in this way.

In Stockport, the Prevention and Personalisation Service is building trust with GPs by acknowledging their concerns and tackling them head-on. The Wellbeing Pathway Planner embedded in one surgery is a qualified psychiatric nurse - reassuring GPs that the service will identify clinical needs and deal with risks appropriately.

“For the GP to hand over the support of one of their patients to us takes a lot.”

Collin McCabe, Prevention and Personalisation Service Manager, Stockport Mind

SUN undertakes some of this work by running workshops and presentations to increase the skills of professionals in new ways of working in mental health settings. The Year of Care developed care planning training also supports clinicians to interact with patients as partners.

“What we mean by mental health encapsulates the idea that it’s a very broad concept. We all have a mind, and therefore we all have mental health and, potentially, mental health difficulties ... It’s not simply about a professional and someone with mental health difficulties - them and us - but rather a group of people in a room talking about shared experiences with each being able to contribute their solution ... If people can feel confident moving away from a traditional medical psychiatric model and towards partnership, they can realise the creative endpoints that we see in SUN.”

Dr Barry Jones, Lead Clinician, SUN Croydon
Endnotes


2. Ibid.


15. Ibid.


By Us For Us:
The Power of Co-Design and Co-Delivery

People Helping People: Peer Support That Changes Lives

Redefining Consultations: Changing Relationships at the Heart of Health

People Powered Health: Health for People, By People and With People

The Business Case for People Powered Health

More Than Medicine: New Services for People Powered Health

Networks that Work: Partnerships for Integrated Care and Services

People Powered Commissioning: Embedding Innovation in Practice

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