Shine 2012 final report

Project title

Recovery Coaching in an acute inpatient setting

Organisation name
Hampshire Hospitals NHS Foundation Trust

December 2013

The Health Foundation
Tel 020 7257 8000
www.health.org.uk

Part 1. Abstract

Project title: Recovery coaching in an acute inpatient setting

Lead organisation: Hampshire Hospitals NHS Foundation Trust

Partner organisation: The Performance Coach & Winchester University

Lead Clinician: Beverley Harden

Abstract
Please describe your project as a narrative account (up to 800 words) that reflects the experience of

Background:

The problem:

Our patient, carer and staff feedback clearly tells us that service users and carers are frequently, disempowered by acute care provision, environments and attitudes. This debilitates individuals mentally and physically, reducing their independent functioning, which for elderly or vulnerable service users may mean requiring prolonged rehabilitation and care or being unfit to return home. The impact of this is very significant for our patients and their families and all components of acute, community and social care capacity.

We have changed service models to reduce this however; fundamentally, we have not changed our 'way of being' with patients or the language we use in acute care. We believe this to be a simple but powerful omission. Thus, unintentionally, we have maintained a strong professionally led environment of 'tell' rather than 'coach'. We need to change the game.

Intended improvement:

Our theory is that by changing the nature of the therapeutic interactions and the language used between clinician and patient, we will liberate the patient from being passive recipients of care and to become partners with ourselves in the care relationship (as opposed to being care givers and care receivers) by raising awareness and increasing the patients perceived responsibility in their participation in their recovery.

Stepping out of the traditional/conventional language used in patient care will create a common and consistent approach across the professions, but most significantly with those spending the most 1:1 time with patients on acute wards.

Recovery Coaching' will give staff the framework and the dialogue to achieve this, but most importantly will help them to personally adopt a different perspective on the care relationship and the benefit of participating as a coach. We spend a lot of time training staff in clinical skills, and no

time in how to deliver the message or how to promote partnership and encourage patients to participate fully in their recovery at all levels (rehabilitation, learning new medicines, self management and discharge planning).

Description of our innovation:

We developed the concept of 'recovery coaching' to support acute inpatient elderly care rehabilitation. We designed a training intervention, supported in practice, to achieve 'coaching conversations' between our staff and our patients and their families. The objective being to promote a sense of partnership in the interaction , particularly with our support staff, who have most time with patients undertaking basic activities of daily living (e.g. washing, toileting patients), maturing their interactions from a highly task orientated approach to a coaching approach.

This innovative intervention supported through the Shine project allowed us to challenge the fundamental basis of *"I do it for you*" to *"I will do it with you*", allowing the patient to become an integral partner in their health care.

Methods:

The study was a pre/post intervention design to evaluate the impact of the Recovery Coaching training on patient and staff outcomes. Ethical approval was granted by The West Midlands (Solihull) NRES Committee.

Patients who met our inclusion criteria for the study were invited to consent to be part of the project. Then the following data was collected for all participants:

- Basic demographics – Gender, age, marital status, place of residence, care needs pre-admission & at discharge
- Hospital Anxiety and Depression Scale (HADs) – to enable correlation with mood on admission
- Barthel - Activities of Daily living scale – a measure of care needs on admission and discharge
- Elderly Mobility Scale (EMS) – scale for assessment of mobility taking into consideration, balance, locomotion and key position changes.
- The Modified Falls Self-efficacy Scale(MFES) - to present the patients feelings of self efficacy on discharge from the ward
- Date of discharge, date patient fit for discharge i.e. when social care section 5 is completed (to off-set delays awaiting discharge arrangements.)

A sub group of staff were interviewed to allow evaluation of the training and how it felt to use the Recovery Coaching approach.

Statistical analysis was performed by Winchester University to allow for robust and academic rigour in the analysis of the intervention that would be difficult to quantify in its impact due to its nature.

What has been achieved?

What went well?

The appointment of a research practitioner rather than a project manager was a great success; her input enabled the process to run relatively smoothly. Staff became increasingly engaged in the project due to her active involvement on the ward that promoted the buy-in and the enthusiasm of the team.

The Recovery Coaching training sessions proved invaluable not only in teaching skills to promote a coaching on the ward, but also as a marvellous team building exercise. The sessions were run with a mixture of staff members in each group. (See Table 1). During these sessions each staff member was provided with a much clearer insight to how each staff group worked daily in their care roles and this insight transferred back out onto the ward after the training and still continues to this day.

The support of Springfield Consultancy was also extremely appreciated in supporting the set up of the project and talking through the issues that arose during the course of the project.

What have been the challenges and how have these been overcome?

Ethics:

Our academic partners had to seek ethical approval from their University for their part in the study and a pre-requisite was that the NHS had given ethical approval. Ethical approval was granted on its first attempt, however the trust research department advised that a substantial amendment had to be raised due to changes in the wording in the patient information sheets and data transport to our academic partners. It was not until this was received in late June that data collection could start.

Staff Issues:

- Recruitment of a research practitioner delayed the project start by 6 weeks.
- Ward sister leaving and a new one being appointed.
- Staffing shortfalls across all professions.

The delays encountered by the ethics re-submission and the appointment of the research practioner along with the staffing shortfalls were overcome by changes made to the dates of the Recovery Coaching training which was adeptly supported by our training consultants 'The Performance Coach'. Our research practitioner worked closely with the ward sister in her transition to the ward and the projects running on the ward. We had anticipated that issues would arise within the running of the project and built in contingency plans to allow us the time to deal with them as they arose.

Data collection:

Undertaking research on an acute elderly care ward and trying to collect information for the study was sometimes difficult due to the medical fitness of the patients and/or their capacity to be able to consent to take part. D&V outbreaks occurred twice during data collection temporarily halting the

project. The research practitioner and ward staff worked hard to overcome these obstacles by staying in daily contact

The self efficacy measure utilised had limited reliability in assessing the self-efficacy in this type of cohort of patients as many participants felt that some of the questions did not reflect their normal situations. This was accounted for in the data analysis. In future these questions could be changed to better reflect the patient situation for this part of the investigation.

Part 2. Quality impact: outcomes

Nature of setting and innovation:

This study was undertaken on a 28 bed acute elderly care rehabilitation ward at an acute hospital in the South of England.

Course of intervention:

Recovery Coaching training was provided by an external coaching organisation (*The Performance Coach*) to all ward staff over a one month period half way through data collection. Each staff member attended a two day workshop in which they were presented with the recovery coaching concept and shown how to utilise and practice its techniques within their patient contacts on the ward. Mop-up sessions were later provided for those staff unable to attend the original workshops or new to the ward. Towards the end of the project a select group of staff members undertook "Super Coach" training in the coaching concepts to be able to sustain the learning on the ward. Staff numbers and their roles are presented in table 1.

Table 1: Recovery Coaching training - staff numbers

Staff Group	Numbers
Ward doctors	4
Ward Sisters	2
Staff Nurses	10
HCAs	15
Therapists	6
Ancillary Staff	6
Super Coaches	5

Primary and secondary data and its impact on quality:

Source of data and how easy it was to access:

Patients admitted to the ward were assessed by the medical team to confirm that they were medically fit and had the mental capacity to participate in the study. They were then approached by the research practitioner, given information about the project and then signed consent if they agreed to participate. If they requested information about the project was also supplied to their family/carers. Of the five questionnaires used to collect data, only two, the demographic information and the self efficacy (MFES), needed to be collected by the research practitioner in person. Three questionnaires formed part of the patient's normal care routine on the ward (HADs, Barthel, EMS). Therefore copies of these could be taken for analysis from the patient record. (See Appendix 2 for copies of all questionnaires).

Staff members willingly participated in interviews with a member of the University team to discuss their experience of the recovery coaching training and its implementation on the ward.

Changes made demonstrated by the data:

In total sufficient data was gathered from 46 participants. 22 in the pre-intervention stage and 24 in the post intervention stage. Although due to these relatively small numbers no statistically significant changes could be found there was some evidence of change in the post recovery coaching group in their Barthel (ADL) scores and their self efficacy scores. (See table 2)

Table 2: Barthel and Self Efficacy Scores for both groups Admission & discharge (Means & SD)

Group	Barthel Score Admission Mean (SD)	Barthel Score Discharge Mean (SD)		Self Efficacy Score Discharge Mean (SD)
Pre- Intervention Group	50.5 (20.76)	63.0 (18.87)		77.1 (28.35)
Post – Intervention Group	45.2 (19.39)	63.7 (23.12)		84.0 (32.09)

The mean scores indicate that there was a slightly higher increase in the patients independence in terms of their Barthel(ADL) scores in the post intervention group, and that they reported higher feelings of self efficacy on discharge.

Changes to place of residence and care needs between admission and discharge were also examined by group. (See table 3)

Table 3: Residence on discharge and care required

Group	Discharge home with same level of care as on admission	Discharge home with additional care packages	Discharge to Residential Care
Pre- Intervention Group (n=22)	9 (40.9%)	7 (31.8%)	6 (27.3%)
Post Intervention Group (n=25)	15 (60%)	8 (32.0%)	2 (8.0%)

The findings suggest that the intervention is supporting an overall improvement in functional ability and independence on discharge. This could have a significant impact for an aging population. In order to afford care costs in the future the maintence of independence will be key in managing care costs, in terms of

- Length of stay
- Care Homes
- Care Packages

Along, with the capacity to prevent delays to discharge and allowing people to return on discharge to their own homes.

The staff reported coaching conversations with patients/relatives feel more purposeful, and they feel skilled to have the multifaceted conversations in a constructive way and the value tools to frame these conversations.

''*This approach feels very caring and dignified, we are working with individual concerns, that gives patients time and support to develop a plan'*

"'earlier conversations with families and involving them more in talking things through, has been a game changer"

"'we used to present patients with the solutions now we work together to help them to find their own solutions, this way they own them"

Description of Confidence:

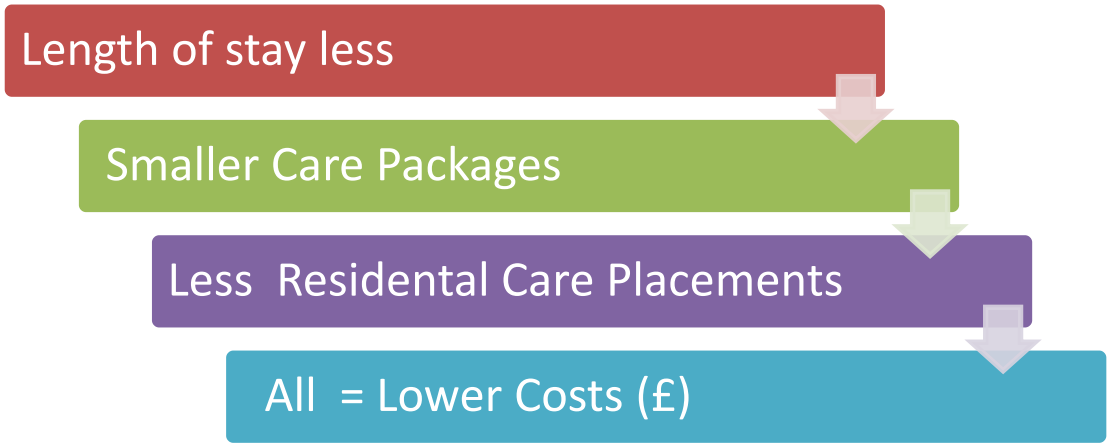
The data was in line with our original targets; and having Winchester University undertake our data analysis has provided us with the strong and thorough academic overview we sought. The approach we undertook has been a tremendous success and has benefitted the ward greatly.

Adjustments made to the outcome measures from our original application:

Though our original intention was to compare both the patients Hospital and Anxiety (HADs) scores and the self-efficacy scores (MFES) on admission and discharge, this was not undertaken because of limited time. In future this would need to be factored into the project timeline.

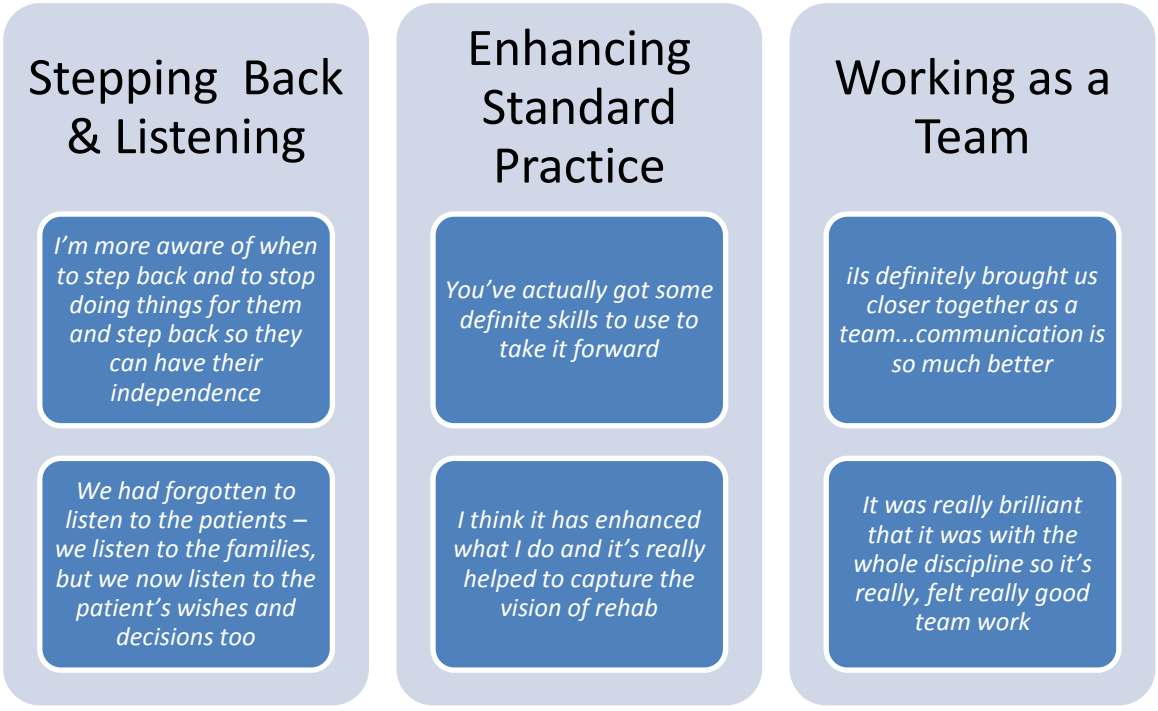
Our assessment of the effect of the project on the quality of the service and the experience of patients:

Interesting preliminary data, though on a small scale, indicates trends towards changes in quality. In particular, the Barthel and self- efficacy scores demonstrate that the post training participants in this study scored higher on these scales at discharge compared to those participants' scores prior to the Recovery Coaching training. Service improvement data also indicates changes in the following:



With an aging population, Interventions such as this will be essential for affordable long and short term costs in the NHS and social services.

One of the most tremendous successes of the project has been the impact of the intervention on the ward staff themselves and this has been clearly demonstrated by their reflections on the training, what it means to them and how they provide the care for their patients.



Part 3. Cost impact

This section is intended explain the measures of cost you used and to detail outcomes (up to 500 words). You should address the following points

- Please summarise your key cost measures and explain how your understanding of the financial impact has moved on since the beginning of your project.
- Describe how you have estimated the cost of existing services / pathways / packages of care. Are there any issues or limitations that need to be taken into account?
- How have you calculated the cost of the Shine intervention? Are there any issues or limitations that need to be taken into account?
- How have you accounted for the implementation costs (e.g. staff time for training and change management activity)?
- How have you demonstrated a cash-releasing saving from your Shine project? Has a benefit been realised and who has benefited financially?

Summary of key cost measures and our understanding of how the financial impact has moved on since the beginning of the project:

This project sought to gather robust evidence for proof of concept of Recovery Coaching as opposed to evaluating the financial impact, particularly cash releasing savings. The reason for this is that it was very unlikely that we would have been able to measure the financial impact of Recovery Coaching in the limited time available with adequate reliability. Moreover, calculation of true financial impact is challenging across a system. For example, cost saving in one area may result in increased cost in another.

However, we did anticipate that there may be data and information from the project that suggests cost savings could be achieved, not just within the secondary care context but potentially in primary care as well. In this respect, there are indications that the self-efficacy gains derived by patients from Recovery Coaching could possibly reduce the level of input post-discharge and that it could prevent discharges to residential care.

A key cost measure in the hospital setting is length of stay. We have not been able to draw any conclusions, given the limited scope and timeframe of the project, which would suggest Recovery Coaching, affects length of stay. However, we can make some preliminary predictions. (See Table 4)

We have demonstrated the credibility and validity of the Recovery Coaching approach and will be keen to continue our study over a lengthier period of time as this would allow us to measure the cost impact of the intervention.

How we calculated the cost of the Shine intervention and any issues or limitations that need to be taken into account

How we accounted for the implementation costs:

We were able to manage the set-up and implementation costs of Recovery Coaching, particularly the training, within the Shine budget, which was in line with our original budget forecasting. We also built into the training the additional costs of Super Coaches to ensure self sufficiency after the projects end.

This split into:

- Development and training
- Project management
- Evaluation

How we perceive the cash-releasing saving from the Shine project. How it the benefit has been realised and who has benefited from it financially:

The study showed that on average each patient left hospital 17 hours earlier in the post intervention group (0.7 days). This equates to the following:

Table 4: Preliminary Predications of Cost Reduction of Length of Stay

	Cost reduction
26 patients leaving 17 hours earlier @ cost of £175 per bed a day	Reduces Length of stay costs by £124 124 x 26 = £3224 over 3 months of intervention = £12,896 over a year

Although not cash releasing, this has the benefit of improving inpatient flow, thereby reducing fines from Accident & Emergency and Ambulance waiting times. More importantly this will also improve patient care and safety. The study also highlights the potential to reduce care package and residential care costs, although these figures are only understood longitudinally and this was outside the scope of this study.

Setup and implementation costs formed part of the Shine project. We intend to continue to spread Recovery Coaching at Hampshire Hospitals NHS Foundation Trust, initially in older peoples care. Our Super Coaches will deliver this training and we anticipate backfill costs for the training to be approximately £5000 per ward. However, project management and the roll out of the programme will be required at additional costs.

.

Part 4: Learning from your project

This section is intended to summarise your achievements and the main changes observed in the quality of care **(**up to 850 words). Please address the following:

- Did you achieve all of what you hoped to achieve at the start of the project? If so what helped you do so?
    - For example was it the contribution of a particular individual or group of people that made the difference? Why was this important?
    - How did you get staff buy-in to carry out this innovation? Were there any approaches more successful than others? Why do you think that was the case?
    - What have you learnt about how to collect financial information?
    - Was it an aspect of organisational culture, technology or policy (national or local) that helped you?
- Please tell us about the challenges and the things that didn't work out quite as planned
    - If you didn't achieve what you hoped for, what were the reasons for that?
    - Were there any aspects of organisational culture, technology or policy (national or local) that acted as a barrier?
    - Did staff change or leave? What impact did that have?
    - What did you do to try to overcome the challenges? How successful were these efforts?
    - Were your original ambitions realistic given available resources and timescales?
- What would you do differently next time when implementing an improvement project?

Did we achieve all that we hoped to achieve at the start of the project? If so what helped us to do so.

The original project scope was scaled down after consultation with Springfield Consultancy.

The challenges and things that did not work out quite as planned:

Our original ambitions were realised in the most part though the numbers we had originally hoped to recruit to the study of 40 in each stage were not achieved, due mostly to time constraints on the behalf of the research practitioner and the delays in starting the project. The project was also further delayed by ethics submission and amendments.

The setting of an acute elderly care rehabilitation ward brings about its own set of challenges in terms of patient medical fitness and capacity. It was also unfortunate that at times patients could decline suddenly or become unwell due to another unforeseen medical problem arising. However the research practitioner worked closely with the medical teams to ensure appropriate patient selection.

The loss of the wards sister halfway through the first data collection period and the recruitment of a new ward manager. However, issues were quickly overcome and the settling in period was a lot quicker than it could have been due to the commitment of the new ward manager and the staff to accept and work with the changes.

We had intended to run the project on the ward from April to December with the Recovery Coaching Training to take place In July to avoid the winter months and summer holidays. However, due to the delays caused by having to pursue ethics approval we have had to delay the training. This pushed the training into the end of the summer holidays and thus we had to develop some contingency plans to support training whilst some staff were away. This required that we adapted the support that we commissioned from *The Performance Coach*. This was happily overcome due to the provider being very supportive and flexible in responding to our revised timeline for delivery of the training.

What would you do differently next time when implementing an improvement project?

The implementation and running of this improvement project has been an inspirational and educational learning curve for all involved. To conduct such a project involves good communication between all involved, along with the ability to be flexible at all times and to be supportive and respectful of each other's roles. To undertake a project of this size the importance of communication and teamwork in undertaking such an intervention cannot be underestimated as without this no intervention can come 'alive' and be achieved

We have learnt much about assessing financial benefits from interventions into patient care and this learning will stand us in good stead for future projects. In hindsight we have also learnt that factoring in enough time for data collection and paperwork is a key element to evaluating such an intervention and that to have a dedicated research practitioner with the skill set to undertake these tasks is a tremendous asset to such a project.

Part 5. Plans for sustainability and spread

This section is intended to communicate your plans for sustainability and spread (up to 500 words). You should include:

- How realistic will it be to sustain the benefits of the project beyond March 2014?
- How do you plan to spread this innovation beyond the Shine award sites? What additional resources (and from who) will you need to support this activity beyond the Shine funding period?
- Please detail any external interest/potential contacts that you have identified that you need to pursue and those that you have already engaged with?

This project has demonstrated that Recovery Coaching can offer positive benefits for both patients and staff. The results are adequately compelling for us now to spread this intervention more widely within our organisation. Our first area for spread will be older people care as we believe we will see a significant impact in this clinical setting. We are planning to implement this in late spring/early summer of 2014.

The teaching of Recovery Coaching techniques is now a part of the elderly care ward staff's skill set and will continue to be embedded into this ward's patient care culture. Five key staff have undertaken 'Super Coach' training in Recovery Coaching, enabling them to continue supporting the current staff in the use of these techniques in their daily patient care. It also means they are skilled now in the ability to teach new staff members as they come onto the ward. These Super Coaches are actively working on the ward by identifying patients for whom Recovery Coaching techniques will be beneficial and discussing at weekly team meetings how this is to be achieved.

The Research Practitioner has established in the staff room poster reminders of the techniques and ensured that handouts of the processes are available to all staff.

We are actively seeking additional funding to enable roll out at pace, project management and permit formal evaluation as we are building the evidence base. We have unsuccessfully bid for National Institute of Health Research funding; the reason given was that as a relatively new team we do not have a significant track record in research. Nevertheless, this continued service improvement work, underpinned by research evidence, will enable us to bid elsewhere for funding and possibly to the NIHR again at some future point.

The University of Winchester are funding a piece of work in collaboration with us to develop an assessment tool to understand health belief, self efficacy and activation of an inpatient stay – we would value working with the Health Foundation on aspects of this. Our work is also to be presented at Winchester University later this year as part of their Research and Engagement Week to highlight not only the intervention but the collaboration of ourselves and the academic team.

A poster on our project is to be presented at the International Forum on Quality and Safety in Healthcare in Paris in April 2014 and we are hoping to be able to further publish our project later in 2014 in the trade journals such as Frontline, Nursing Times, Rehabilitation Research, Policy & Education. (See Appendix 2.5 for earlier Frontline article).

A poster abstract has also been submitted for The Physiotherapy UK conference later this year. External expressions of interest in this project have come from the Health Foundation web site from all over England, most notably in stroke rehabilitation and a burns and plastics service. Locally a

number of GP practices have also expressed their interest in recovery coaching. The project will be presented to the Wessex Education Innovation group later this year by the research practitioner. The GP and medical education service at Southampton University Hospitals is also an area were a presentation of this work could be accommodated which could lead into more educational outlets.

It is hoped that additional funding can be secured to take this intervention from the acute elderly care setting and offer it to other teams within our trust and externally.

Appendix 2: Resources from the project

Please attach any leaflets, posters, presentations, media coverage, blogs etc you feel would be beneficial to share with others

- Appendix 2.1: University of Winchester Analysis Report (See Attachment)
- Appendix 2.2: Recovery Coaching Goal Setting
- Appendix 2.3 : Questionnaires used in project
    - 2.3.1 Hospital Anxiety & Depression Scale (HADs)
    - 2.3.2 Elderly Mobility Scale (EMS)
    - 2.3.3 Barthel Index
    - 2.3.4 Modified Falls Self Efficacy Scale (MFES)
- Appendix 2.4: Poster Presentation for International Forum on Quality and Safety in Health care – (Paris 2014)
- Appendix 2.5: Frontline Article Published by the Chartered Society of Physiotherapy- July 2013

Appendix 2.2

What is recovery coaching?

Recovery Coaching aims to:
Raise Awareness
And
Increase Responsibility
For Recovery

This involved the team reviewing goal setting

We highlighted five areas of discharge goals that the patients would be aiming to achieve before they left our ward. These were:

- Being able to dress and undress themselves or have a plan around it
- Being able to get into and out of bed or have a plan around it
- Being able to get into and out of a chair or have a plan around it
- Being able to get to the toilet or have a plan around it
- Being able to feed themselves or have a plan around it

It was with these aims and goals in mind that the staff undertook all their daily actions and approaches with the patients and based their coaching conversations around when working with them. Rather than solve problems for people the conversations discussed the issues, keeping responsibility with the patient and the family and raised their awareness to this responsibility in a respectful, caring and compassionate way.

"Instead of treating patients as passive recipients of care, they must be viewed as partners in the business of healing, players in the promotion of health, managers of healthcare resources, and experts on their own circumstances, needs, preferences and capabilities."
Coulter (2011)

Appendix 2.3 Questionnaires

2.3.1 Hospital Anxiety and Depression Scale (HADs)

Hospital Anxiety and Depression Scale

Scoring Sheet

		Yes Definitely	Yes Sometimes	No, not much	No, not at all
1	I wake early and then sleep badly for the rest of the night	3	2	1	0
2	I get very frightened or have panic feelings for apparently no reason	3	2	1	0
3	I feel miserable and sad	3	2	1	0
4	I feel anxious when I go out of the house on my own	3	2	1	0
5	I have lost interest in things	3	2	1	0
6	I get palpitations, or sensations of 'butterflies' in my stomach or chest	3	2	1	0
7	I have a good appetite	0	1	2	3
8	I feel scared or frightened	3	2	1	0
9	I feel like is not worth living	3	2	1	0
10	I still enjoy the things I used to	0	1	2	3
11	I am restless and can't keep still	3	2	1	0
12	I am more irritable than usual	3	2	1	0
13	I feel as if I have slowed down	3	2	1	0
14	Worrying thoughts constantly go through my mind	3	2	1	0

Anxiety 2, 4, 6, 8, 11, 12, 14

Depression 1, 3, 5, 7, 9, 10, 13

Scoring 3, 2, 1, 0 (for items 7 & 10 the scoring is reversed)

GRADING **0 – 7 = Non Case** **8 – 10 = Borderline case** **11 + = Case**

Appendix 2.3.2 Elderly Mobility Scale (EMS)

Rehabilitation Therapy Outcome Measure Elderly Mobility Scale

Patient details: attach addressograph

	Date:	**Date:**	**Date:**
Sitting to lying 2 – independent 1 – needs help of 1 person 0 – needs help of 2+ people			
Lying to sitting 2 – independent 1 – needs help of 1 person 0 – needs help of 2+ people			
Sitting to stand 3 – independent in under 3 seconds 2 – independent in over 3 seconds 1 – needs help of 1 person (verbal or physical) 0 – needs help of 2+ people			
Stand 3 – stands without support and able to reach 2 – stands without support/ needs support to reach 1 – stands but needs support 0 – stands only with physical support (i.e. help of one)			
Gait 3 – independent inc use of sticks 2 – independent with frame 1 – mobile with walking aid but erratic/ unsafe turning 0 – needs physical assistance to walk or constant supervision			
Timed walk (6 metres) 3 – under 15 seconds 2 – 16-30 seconds 1 – over 30 seconds 0 – unable to cover 6 metres			
Functional reach 4 – over 16 cm 2 – 8-16 cm 0 – under 8cm or unable			
Total			
Printed name			
Signature			

Appendix 2.3.3 Barthel Index

Patients Details		Patient's Weekly Barthel Index																
			Pre Adm	Day One														DC S5
Bowel	Incontinent (or needs to be given enemata)	0																
	Occasional accident (one/week)	1																
	Continent	2																
Bladder	incontinent or catheterised & unable to manage	0																
	Occasional accident (max once per 24 hours)	1																
	Continent (for over 7 days)	2																
Grooming	Needs help with personal care	0																
	Independent face/hair/teeth/shaving (if app)	1																
Toilet Use	Dependent	0																
	Needs some help, but can do something alone	1																
	Independent (on and off, dressing, wiping)	2																
Feeding	Unable	0																
	Needs help cutting, spreading butter etc	1																
	Independent (food provided in reach)	2																
Transfer	Unable – no sitting balance	0																
	Major help (one or two people, physical), can sit	1																
	Minor help (verbal or physical)	2																
	Independent	3																
Mobility	Immobile	0																
	Wheelchair independent including corners etc	1																
	Walks with help of 1 person (verbal or physical)	2																
	Independent (but may use any aid e.g. stick)	3																
Dressing	Dependent	0																
	Needs help, but can do about half unaided	1																
	Independent (including buttons, zips, laces etc)	2																
Stairs	Unable	0																
	Needs help (verbal, physical, carrying aid)	1																
	Independent, up and down	2																
Bathing	Dependent	0																
	Independent (or in shower)	1																
	Total																	

Appendix 2.3.4 Modified Falls Self Efficacy Scale (MFES)

Please tell me how confident you feel that **when you go home** you can do each of the following tasks.

The items on the scale are scored from 1 to 10, with 1 meaning "not confident/sure at all", 5 being "fairly confident/fairly sure," and 10 being "completely confident/completely sure."

Not confident at all				Fairly confident					Completely confident
0	2	3	4	5	6	7	8	9	10

1. You can get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10
2. You can prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10
3. You can take a bath or a shower	0	1	2	3	4	5	6	7	8	9	10
4. You can get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10
5. You can get in/out of bed	0	1	2	3	4	5	6	7	8	9	10
6. You can answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10
7. You can walk around the inside of your house	0	1	2	3	4	5	6	7	8	9	10
8. You can reach into cabinets or closet	0	1	2	3	4	5	6	7	8	9	10
9. You can do light housekeeping	0	1	2	3	4	5	6	7	8	9	10
10. You can do simple shopping	0	1	2	3	4	5	6	7	8	9	10
11. You can use public transport	0	1	2	3	4	5	6	7	8	9	10
12. You can crossing roads	0	1	2	3	4	5	6	7	8	9	10
13. You can do light gardening or hanging out the washing*	0	1	2	3	4	5	6	7	8	9	10
14. You can use front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10

*Rate most commonly performed of these activities.

Appendix 2.4: Poster Presentation for The International Forum on Quality and Safety in Health Care (Paris 2014)

LIBERATING THE VOICES OF ALL

Recovery coaching within an acute older persons ward

The Health Foundation
Inspiring Improvement

Authors:
Kibble SE., Gray D., Pratt-Sala M., Ross K., Johnson K., Packer J., Cross R., Harden B.

Clifton Ward, Hampshire Hospital's Foundation Trust, Winchester, Hampshire, UK

Context

Sally's story:

'Mum had a fall, she was admitted to hospital and in a week I saw my lovely mum go from the confident independent woman she was, to being scared to get out of her chair. She got weaker and less confident as the days progressed. Everyone was so busy, it was quicker to do things for her. Once better it took 2 weeks to get her walking and safe to go home with a carer twice a day. It seems we are making work for ourselves at her expense.'

This was a common story and considered unfixable without resources. Our objective was to change Sally's story.

Response

Root cause: it appeared that we paid little consistent attention to individual/family engagement in recovery and what we did, we did too late.

The innovation: to translate the concept of health coaching into 'recovery coaching'. This involves working alongside patients and their families to be clear about agreed goals to be achieved and enabling the patient to develop their own plans around how to achieve this, working in partnership, raising awareness and increasing responsibility to be active participants in the care relationship.

All staff on an acute elderly care rehabilitation ward undertook recovery coaching training and to investigate the effect of the intervention on patient care, a series of validated metrics were taken from consenting patients prior to the training taking place and after the training.
(See **Figure 1**, right)

Results

A number of validated questionnaires were analysed by the University of Winchester, These were the Hospital Depression& Anxiety Scale, The Barthel (ADL) scale, The Elderly Mobility scale and the Modified Falls Self Efficacy scale.

In total sufficient data was available from 46 participants. 22 in the pre-intervention stage and 24 in the post intervention stage. Although due to these small numbers no statistically significant changes could be found there was some evidence of change in the post recovery coaching group in their Barthel (ADL) scores and their self efficacy scores. (See **Figure 2.**)

The mean scores indicate that there was a slightly higher growth in the patients independence in terms of their Barthel(ADL) scores in the post intervention group, and that they reported higher feelings of self efficacy on discharge.

Changes to place of residence and care needs between admission and discharge were also examined by group. The findings are presented in **Figure 3.**

The findings suggest that the intervention is supporting an overall improvement in functional ability and independence on discharge, reducing pressure on care services.

The staff reported coaching conversations with patients/relatives feel more purposeful, they feel skilled to have the trickier conversations in a constructive way and value tools to frame these conversations.

Lessons Learnt

Changing the calibre of conversations had with patients and their relatives has the potential to be transformational in building active participation in recovery and improving clinical outcomes.

Building a common dialogue at ward level appears to reduce professional silos and liberates staff to see the team focussed around the individual patient.

Figure 1.

Figure 2. Table 1

Group	Barthel Score Admission Mean (SD)	Barthel Score Discharge Mean (SD)	Self Efficacy Score Discharge Mean (SD)
Pre-Intervention Group	50.5 (20.76)	63.0 (18.87)	77.1 (28.35)
Post-Intervention Group	45.2 (19.39)	63.7 (23.12)	84.0 (32.09)

Figure 3. Table 2

Group	Discharge home with same level of care as on admission	Discharge home with additional care packages	Discharge to Residential Care
Pre-Intervention Group (n=22)	9 (40.9%)	7 (31.8%)	6 (27.3%)
Recovery Coaching Group (n=25)	15 (60%)	8 (32.0%)	2 (8.0%)

What the team said

"We are using the time we have with patients in a more constructive and useful way, not so much more as different"

"Earlier conversations with families and involving them more in talking things through, has been a game changer"

"Patients have often lost so much confidence, this is about recognising that and working back from there"

"This approach feels very caring and dignified, we are working with individual concerns, that gives patients time and support to develop a plan"

"We used to present patients with the solutions now we work together to help them to find their own solutions, this way they own them"

"Our healthcare assistants are transformed, they are engaging more with the team to develop and achieve the goals, what is striking is the increase in team working across the professions as we all share the approach, it puts the patient central to the team"

Hampshire Hospitals NHS
NHS Foundation Trust

THE UNIVERSITY OF WINCHESTER

Acknowledgments
Dr. Andrew MacDowell, The Performance Coach.
Dr. Merce Pratt-Sala, Dr. Debra Gray, Dr. Kirsty Ross, Psychology Dept., University of Winchester.

Further information: beverley.harden@hhft.nhs.uk

Appendix 2.5: Frontline Article Published by the Chartered Society of Physiotherapy- July 2013

The Chartered Society of Physiotherapy

Rehabilitation - You can't treat someone until you've walked a mile in their shoes

Physios are encouraging all staff on a ward to take part in a research study in which they step into patients' shoes. Chris Mahony reports

Physios in Winchester, Hampshire, are spreading the message about empowering hospital patients and the benefits of 'recovery coaching'.

Encouraging patients to be self-confident, to set themselves ambitious but achievable goals and to be as active as possible throughout their recovery underpins the physiotherapy ethos.

However, physios are only with their in-hospital patients for a relatively small part of the week.

From August, patients on a 28-bed rehabilitation ward at Winchester Hospital will benefit from the therapy ethos round the clock through the piloting of a 'recovery coaching' scheme devised by senior rehab physio Kay Johnson and her occupational therapist (OT) counterpart.

The pilot will run in tandem with a service improvement project based around the recovery coaching.

Ms Johnson says: 'Coaching has been used in mental health but not in acute rehab settings.'

In a research project that starts over the summer, ward staff will be trained in recovery coaching – thinking and acting in ways that improve patients' independence and confidence, helping them prepare for discharge (preferably to their own home) and a return to routine daily life. All ward staff from healthcare assistants to doctors will complete the training over a two-week period.

They will all be expected to use the recovery coaching model in their work between August and Christmas before its impact is evaluated (see 'The pilot in detail').

From admission, the patients – and where appropriate their carers and relatives – will be encouraged to do things that will speed up their recovery and bring discharge closer.

Patients are partners

Beverley Harden, Hampshire Hospitals NHS Foundation Trust's associate director of workforce and education and a physio by background, explains: 'This is teaching the language of rehab to others. "We wanted 24-hour rehab provided by a multidisciplinary team in a ward context. In reality, this means patients doing things for themselves when they can.

We say to the patients from the moment they arrive that we are going to work with them but recovery is their responsibility as well. So much of this is communication – coaching patients, carers and staff to improve the independence of patients. We will be talking to carers and relatives, encouraging them to take the patient for a walk or to the café for a cup of tea when they visit rather than sitting by the bed for three hours.'

In her research proposal, Ms Harden said the project will 'change the quality of the conversations' between staff and patients and ensure the patients are partners in their own care – rather than passive recipients.

Walking in patients' shoes

She suggests recovery coaching requires staff to 'walk in the shoes of the patient' and to 'work with rather than do [things] for the patient'.

For Ms Harden coaching to improve independence and recovery will be an important tool in meeting the demographic pressures of an ageing population and more people with multiple long-term conditions and complex needs.

'Improving independence during a hospital stay should be a priority as our population ages but it is not happening enough in the acute sector. That means too many older people in particular are transferred to care homes costing around £1,000 a week or are unable to leave hospital or come back as emergency admissions. This pilot will tell us if by changing the language and approach on the ward we can promote independence and recovery and improve the patient experience."

'Coaching has been used in areas such as mental health and long-term conditions in the community but this is taking it upstream into the daily care of patients in hospital.'

Ms Johnson says the idea came out of a brainstorming session she had with her OT counterpart, Jane Packer.

'I work very closely with the senior OT and we recognise the overlap of therapy. We wanted to get everyone using a rehab approach "24/7" even when therapists are not here.

There is no point us doing rehab if the rest of the multidisciplinary team, whose training differs, do not have the same approach.'

Their idea was greeted enthusiastically by Ms Harden who has a health coaching background. She guided it through the research approval process, securing Health Foundation funding to work with the University of Winchester which will evaluate the project and outcomes by next March.

Clifton rehabilitation ward was chosen because there is already an emphasis on rehab – many of its patients have come from other parts of the trust having made a partial recovery. She says: 'Patients come here to be more active and with such an emphasis already on rehab the pilot results are probably going to be less dramatic than on another ward. However, if we make a difference here then we can really claim we will make a difference on medical wards and other parts of the hospital.'

Doing more with less

Brimming with enthusiasm in an office on Clifton Ward, Ms Johnson adds: 'Rehab should not start on the rehab ward – it should start on admission to hospital. We are celebrating what we do well and trying to get a consistency of approach across the multidisciplinary team.'

Ms Johnson admits that the challenge to the NHS to do more with less was a factor in developing the project – she expects that the evaluation will show recovery coaching produces shorter hospital stays for the trust while improving job satisfaction amongst its workforce.

Both Ms Johnson and Ms Harden reject suggestions the timing of a project aimed at getting patients to do more for themselves sits ill with the Francis report on Mid Staffordshire and its focus on neglect and apparent indifference from healthcare staff on the wards.

Ms Harden's research proposal does note as a risk the need 'to ensure that training reinforces that coaching is undertaken in a way that keeps care and compassion at the heart of the dialogue'. The research proposal calms any nerves by noting that coaching theory 'very much supports care and the training will emphasise and reinforce this'.

Ms Johnson says: 'We are not taking care out of healthcare – we are empowering the patient. We are establishing goals with them and this fits in with the government's quality agenda.'

Ms Harden goes further, seeing recovery coaching as the embodiment of the patient empowerment and compassion Francis called for: 'This is perfect for Francis because it is about empowerment and making care both compassionate and patient-centred.

'Recovery coaching keeps the responsibility for recovery with the patient and raises their awareness of this but within a supportive, caring and compassionate ward environment.'

The aim is to make every conversation and every action count in terms of encouraging

recovery and independence. For therapists of both the physio and OT variety, much of the recovery coaching training will reinforce their professional training and their current working style. Ms Harden acknowledges, however, that for other professions, trained to focus primarily on how they can care for someone better, some degree of change in thinking will be required.

CSP professional adviser Clare Claridge welcomes the project on several fronts: 'This is a really good example of physiotherapists driving change – they've looked at a problem and considered how altering a very established way of running a ward could improve the quality of care and clinical outcomes.

'It is really interesting that this is based on how allied health professionals approach care as enablers and with patient-centred goals.

This is about recognising the different approach we bring to a ward or service – the emphasis we put on enabling and empowering patients – and using education to establish a 24-hour rehab environment through a team approach.'

It will be an exciting time for physios on the ward, as Ms Harden notes: 'Physios will see more of the good work they do being perpetuated by other professions and by families and carers.' *fl*

The pilot in detail

The University of Winchester study will test the hypothesis that a coaching approach to be used by all staff will result in older patients on a rehab ward retaining higher levels of independent function and self-efficacy. They should be able to return home sooner while feeling more confident. The pilot will run for nine months – including pre-intervention and post-intervention data collection.

A baseline dataset will be collected through daily living scores (using the elderly mobility scale and Barthell Index) on admission and discharge.

Self-efficacy scores will also be recorded. This information is already collected on the ward and will cover around 60 patients at both pre-intervention and post-intervention stage.

Around 15 patients and carers will be interviewed by university researchers on admission.

Length of stay and care needs on discharge will be important elements of the evaluation.

Qualitative data will be collected after several months of coaching activity through semi-structured interviews with patients and nursing staff.

Patient interviews will focus on the patient's experience of coaching and how it has been implemented. This will include exploring their understanding of the key phrases, concepts and ideas of recovery coaching. Nurses will be asked about their experiences of the training,

the implementation of recovery coaching and what they see as the benefits or limitations of the approach.

Article Information

Author(s) Chris Mahony

Issue date:17 July 2013

Volume number: 19

Issue number:13