



# Changing the Conversation with the Public

-From passive recipients to active owners of Health and Social Care

Travel to learn, return to inspire

**Michelle Tennyson**  
**Churchill Fellow 2018**

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# ABOUT THE AUTHOR



## Michelle Tennyson

### Assistant Director, Allied Health Professionals, Personal and Public Involvement & Patient Experience

I qualified as a Podiatrist from Durham School of Podiatric Medicine in 1994 and I have worked in a range of roles in England and Northern Ireland (NI) as a Podiatrist, a Podiatry Manager, an Allied Health Professional (AHP) Commissioner and now Assistant Director for AHP, Personal and Public Involvement (PPI) and Patient Experience (10,000 More Voices and Online User Feedback) in the Public Health Agency (PHA). I am passionate about Health and Social Care (HSC) in NI.

I am privileged and honoured to have been awarded a 2018 Churchill Fellowship to research how some of the leading HSC organisations in the world delivered a fundamental culture shift and whole system approach to the involvement of service users, carers and staff in decision making about their own health and HSC systems. The Fellowship provided the opportunity to undertake seven weeks of experiential study in Alaska, Arizona and Pennsylvania.

I applied for the Fellowship because I am committed to playing my role in this exciting period of HSC Transformation. 'Health and Wellbeing 2026 -Delivering Together' outlines that for too long HSC services have been planned and managed around structures and buildings and it makes a commitment to ensure the voice of the user is heard, and that service users and carers will play a key role in developing and implementing new services.

As the Assistant Director in the PHA with responsibility for implementing PPI policy I want to see HSC NI evolve from a position where decision making occurs with or without engaging with the service users, carers and staff to a position where decisions are coproduced and underpinned with strong enduring relationships. I want to see a shift in the historic professional power base and service users and carers emerging from being recipients of care to owners of their own care and HSC system.



# ACKNOWLEDGEMENTS

I would like to express my sincerest gratitude to the Winston Churchill Memorial Trust for providing me with this once in a lifetime opportunity. They believed I could make the difference I aspired to and trusted me not only to be an ambassador for the Trust itself but also to return from my travels to inspire.

I also want to thank my own organisation, the PHA, for providing the time to undertake the Fellowship and for funding formalised training programmes during the study period.

I must thank my PHA team who covered so well during my absence. I am constantly in awe of their commitment and enthusiasm for their work and for each other. I am so proud of what they achieve every single day. Special thanks to Martin Quinn, Linda Craig and David Todd for their specific help with this report.

I would like to thank everyone I met as part of this journey who shared their experiences, to those who welcomed me into their organisations and homes and to those who laughed and cried with me through this amazing experience. Some of those I met I am proud to call my friends. Some special thanks are outlined in Appendix 1.

On a personal note I could not have done any of this without the support from my husband Dean, the only one who really knows all (well almost all) of the stories behind my eyes and loves me anyway. He let me loose in the USA without complaint. I am truly thankful. Thanks also to my mummy and daddy, my amazing nephews and nieces and my wee sister Louise for always being there for me.

Finally, I must mention two of the most inspirational and impactful people on my career to date, Elizabeth Busby, 'BB', (RIP) and Nick Richards. BB taught me at a very young age to find the strength to do the right thing. She made me believe if I had passion and worked hard there was little I couldn't achieve. She also taught me the importance of a strong value base.

Nick Richards taught me to take risks and to 'stand in the gap' for my patients whatever the cost. The brother I never had.....



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# EXECUTIVE SUMMARY





In 2018 the Department of Health (DoH) built on the strong foundation of PPI with the launch of the Coproduction Guide for NI 'Connecting & Realising Value Through People'. Given DoH's position that Coproduction will only be successful if it is rooted in the culture of HSC the key question is - how does the NI HSC system move from pockets of Coproduction excellence to a position whereby Coproduction is in the bloodstream of every individual in every part of the system?

My learning & observations from the Churchill Fellowship on how key American health care systems have achieved this culture shift are presented in the form of Seven Enablers of Coproduction. Each enabler is outlined below with associated recommendations.

### ENABLER ONE - COMPELLING MOTIVATION FOR CHANGE - THE WHY?

1. Specific Clinical Lead and Service User/Carer Lead roles should be established to secure a Collective Leadership model for Involvement and Coproduction.
2. Involvement and Coproduction should be an integral component of undergraduate and postgraduate training programmes and form part of the commissioning agreements with DoH and provider organisations.
3. A robust local evidence base of the impact of Involvement and Coproduction on morale, service changes, safety, quality etc. is required to demonstrate the local impact of Involvement and Coproduction.

### ENABLER TWO - SIMPLICITY AND CLARITY

1. The language of Involvement-Coproduction should be simplified to make it more meaningful and user friendly, with a consistency of approach and shared understanding.
2. A system wide approach to the use of Plain English should be adopted.

### ENABLER THREE - A RELATIONSHIP BASED APPROACH

1. A relationship based approach to HSC should be adopted to strengthen relationships between individuals themselves (with a focus on self-care) relationships between colleagues and relationships with service users and carers.
2. Transformation of relationships should be given equal status to transformation of systems, structures and processes in any change process.
3. Work should be undertaken to ascertain the level of trust and confidence and health of relationships between service users, carers, the wider public and the HSC system in order to identify actions to strengthen.
4. Redefining the relationship between service users and carers and HSC system is necessary to effect the philosophical change from service users and carers as passive recipients of care to owners and coproducers of their own care and HSC system.



## ENABLER FOUR – UNDERSTANDING AND EMBRACING COPRODUCTION IN THERAPEUTIC AND STRATEGIC RELATIONSHIPS

1. Coproduction and Involvement approaches should focus on the two distinct types of HSC relationships i.e. Coproduction at the therapeutic level and at the strategic level.
2. Implementation of Coproduction approaches with clinical staff should be enhanced with the use of caring models such as Wondering, Following and Holding.



## ENABLER FIVE - BUILDING RELATIONAL CAPACITY

1. A HSC Induction model should be developed based on building relational capacity and embedding HSC values, PPI and Patient Experience Standards.
2. Building relational capacity should be integral to all staff training including undergraduate and post graduate training.
3. 'Improving the Patient and Client Experience' standards and 'Setting the standards' PPI standards should be reviewed.



## ENABLER SIX - EMBRACING VULNERABILITY IN LEADERSHIP – THE STORY BEHIND OUR EYES

1. Vulnerability in leadership should be recognised as a key leadership strength in HSC and be integrated into the approaches to secure the vision of the HSC Collective Leadership Strategy and HSC Coproduction Guide.
2. Senior leaders should model vulnerability in leadership behaviours.
3. There should be a commitment to addressing Diva subcultures.
4. Safe and respectful environments and a range of supports to encourage staff and service users and carers to be vulnerable should be created within HSC organisations.
5. Supportive, responsive, healing approaches to support staff and service users and carers should be established in organisations.



## ENABLER SEVEN - POSITIVE RELATIONSHIPS IMPACTING ON PLANNING AND STRATEGIC DECISION – MAKING

1. Organisations should pursue service user, carer and staff feedback in equal measure as a key component of Evidence Based Practice.
2. Organisations should be able to demonstrate how service user, carer and staff feedback impacts on Strategic Planning.
3. Processes should be developed for the sharing of service user, carer and staff experiences with training organisations.



**The application of the seven enablers and associated recommendations will support the delivery of DoH Coproduction guidance and push the boundaries of the role of the service user & carer, their relationship with HSC staff & the system. This will result in improved services & experiences for the population of NI. In turn this will impact positively on staff satisfaction.**

# BACKGROUND

In NI PPI is the active and effective involvement of services users, carers and the public in HSC services. Involvement can range from one-to-one interactions with service users and carers, in regard to their own health, through to more strategic engagements such as undertaking partnership working to codesign and coproduce services and influencing commissioning priorities and policy development.

The DoH introduced the terminology PPI to the HSC system through their 2007 Circular HSC (SQSD) 29/07 which set out the concepts and practice of Involvement. This was followed by the HSC (Reform) Act (NI) 2009 under which PPI is a legislative requirement. It is known as the Statutory Duty to Involve and Consult. Subsequently, a further circular on PPI was issued in 2012 HSC(SQSD) 03/2012 which clarified how PPI would be implemented and which organisations had responsibility for which element of policy implementation.

In 2018 the DoH built on the strong foundation of PPI with the launch of the Coproduction Guide for Northern Ireland 'Connecting and Realising Value Through People'. This practical guide supports the application of a Coproduction approach across the HSC system (DoH, 2018). The guide underpins the DoH's programme of work to transform HSC provision as envisaged in 'Health and Wellbeing 2026 - Delivering Together'.

Essentially 'Delivering Together' requires NI HSC to;

- Adopt a Coproduction approach in the development of new services and the transformation of existing services.
- Maximise the voices of service users and carers.
- Engage staff, particularly the staff who deliver HSC services.
- Build and strengthen partnerships with others who provide care and support such as other government bodies and community and voluntary sector colleagues. (DoH, 2017a)

Coproduction is regarded the pinnacle of Involvement. The New Economic Foundation (NEF) describes it as 'a relationship where HSC staff and service users, carers and the public share power to plan and deliver services together, recognising that all partners have

vital contributions to make in order to transform the HSC.' (NEF, 2013) Appendix 2 outlines DOH definition of Coproduction.

In service delivery, Coproduction is highly individualised to the unique needs of users (Bettencourt, Ostrom et al, 2002 cited in Realpe & Wallace, 2010). It depends on the development of a long-term relationship between the provider and the recipient where information and decisions are shared (Bovaird, 2007 cited in Realpe & Wallace, 2010).

Coproduction is not a one-off project or exercise; it must be rooted in the culture of the organisation and be part of everyday working practice, underpinning processes and decisions. DoH states, "Our goal in Northern Ireland is to support transformational change through a coproductive approach and promote the opportunity for all sections of the Northern Ireland community to partner with HSC staff in improving HSC outcomes" (DoH, 2018).

Coproduction challenges the assumption that service users are passive recipients of care and recognises their contribution in the successful delivery of a service (Cahn, 2000 cited in Realpe & Wallace, 2010). At the same time, it involves the empowerment of front-line staff in their everyday dealings with customers (Needham and Carr, 2009 cited in Realpe & Wallace, 2010).

**"We want a system that partners and organises health and wellbeing with people for people and by people"**

**- DoH**

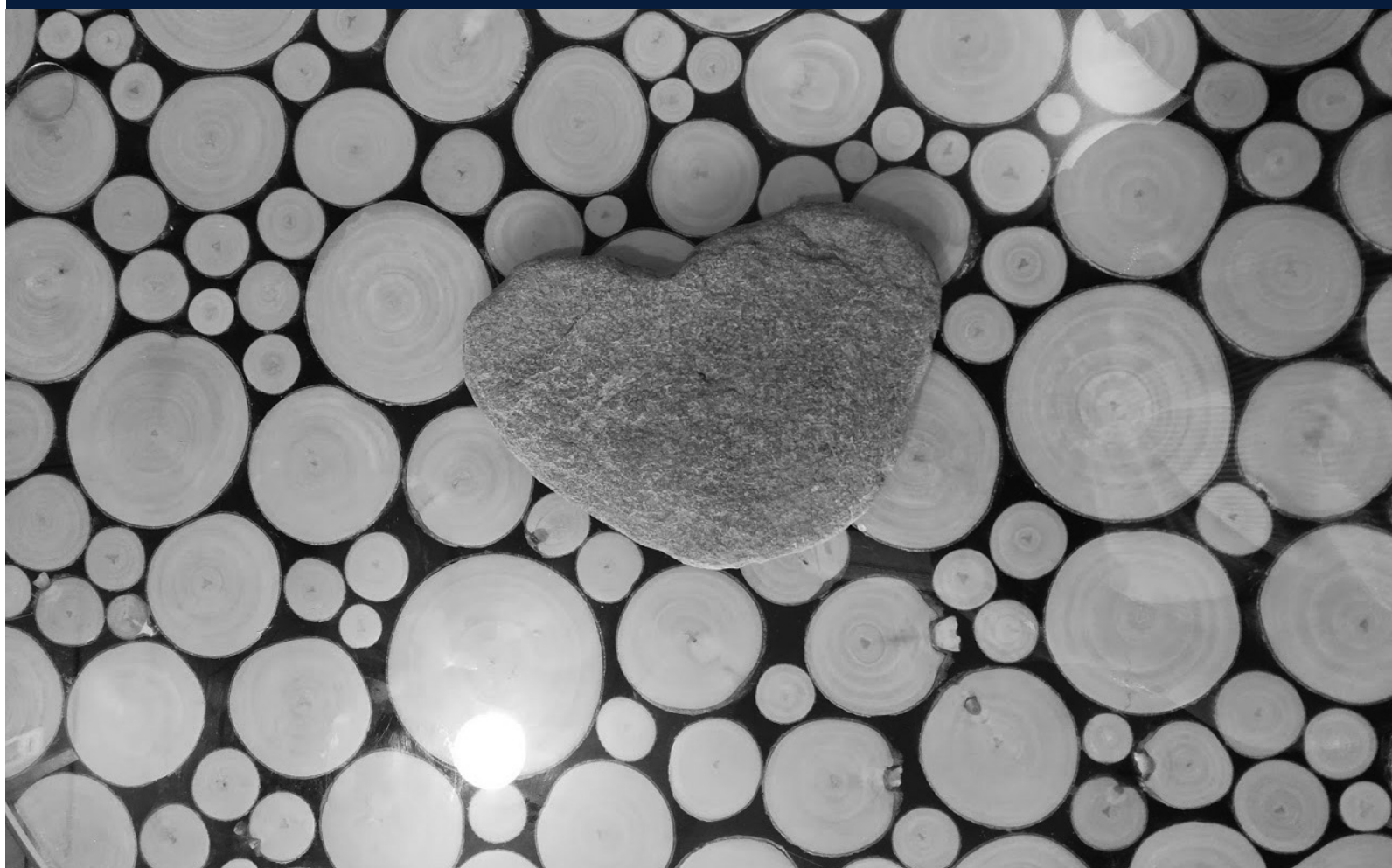
Involvement in HSC in NI is strengthened with legislation specific to PPI (2007), guidance on Coproduction (2018) and subsequent policies and guides. In 2016 research carried out by Queens University Belfast outlined that **“Although PPI in Northern Ireland still faces a number of challenges, this research has evidenced that there has been a great deal of work undertaken and a marked improvement, particularly in coordination, over the years since its first introduction as policy in 2007”** .

The research found that much of this progress in changing the culture and practice, towards a person centred service, was as a result of the leadership provided by the PHA. However “This research also has found that progress has been slower than anyone would have liked but nonetheless the picture is quite positive” (Duffy et al., 2017).

Tremendous work continues to be actively carried out by very committed HSC staff, service users and carers in NI on this agenda. It has created the foundation of meaningful Involvement, has built a critical mass of staff, service users and carers whose knowledge, experience and expertise in Involvement is bringing about tangible improvements in outcomes including quality, effectiveness, safety etc. Challenges however remain. These include:

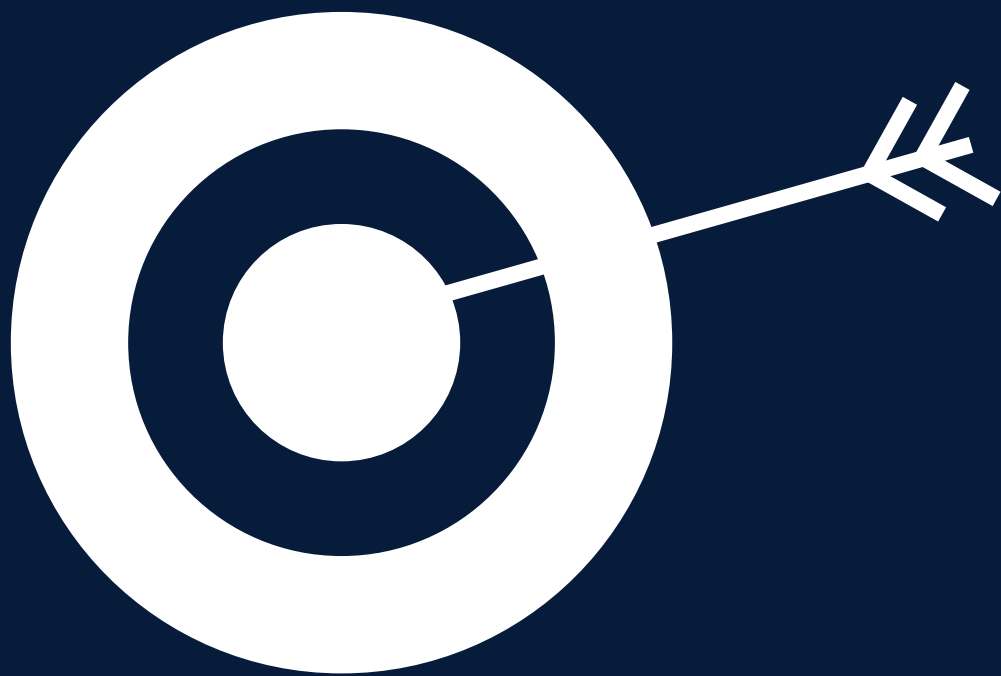
1. Strategic commitment to genuinely embed Involvement and Coproduction into culture and practice across HSC system.
2. Drive to integrate Involvement and Coproduction into training and development of all staff, clinical, managerial, admin and ancillary.
3. Effective resourcing, enabling staff to have the knowledge, skills and capacity to adopt and utilise the Coproduction approach.
4. Systemic support for and facilitation of service users and carers to partner with HSC systems as equals in the design, development and evaluation of services.
5. Understanding that developing partnership based health and social care requires ongoing investment of time.

Given DoH’s position that Coproduction will only be successful if it is rooted in the culture of HSC the key question is - how does the NI HSC system move from pockets of Coproduction excellence to a position whereby Coproduction is in the bloodstream of every individual in every part of the system?



# AIMS & OBJECTIVES

THE PURPOSE OF THIS REPORT



The initial objectives of this Fellowship were defined as follows;

- To explore the successes, failures and impact of introducing Coproduction approaches to Involvement in health and social care across a population.
- To examine the support given to the public to become involved in decision making processes.
- To examine the processes used to involve the most remote communities.
- To demonstrate practice based research and make recommendations for the direction of travel for Involvement and Coproduction in Northern Ireland.
- To identify partners in creating continuous dialogue and exchange on learning and involvement, at an international level.

The underpinning motivation for undertaking this work is the recognition that our HSC system in NI needs to progress in a timelier manner on widespread implementation of Involvement and to reach the goal of Coproduction. The expectation was to visit the organisations across the USA and find the answer. The one brilliant model, protocol, guide or method that would fully take Coproduction into the culture of HSC; however I found the answer to be much more complex.

The epitome of my learning was when I realised the ability to coproduce effectively is actually an outcome of strong effective relationships. These are the relationships between the HSC system and service users, carers and the public and also the relationships between colleagues within the HSC system and the individual staff have with themselves.

This changed my initial objectives to study Coproduction approaches and models and redefined the focus to a study of culture change to secure enhanced relationships.

The Fellowship objectives were therefore developed as follows;

- To examine how world leading organisations delivered radical whole system transformation through a fundamental culture shift and approach to building relationships as a means to secure the involvement of service users, carers and staff in decisions about HSC systems and their own health.
- To demonstrate practice based research and make recommendations for the direction of travel for Involvement and Coproduction in NI.
- To identify partners in creating a continuous dialogue and exchange on learning on Involvement, at an international level.

This report therefore sets out to share the learning and observations from the 'Changing the conversation with the Public - from passive recipients to active owners of Health and Social Care'.

**"Everyone has a story behind their eyes"**

**-Katherine Gottlieb**

# OVERVIEW OF THE FELLOWSHIP JOURNEY

**Belfast (Northern Ireland) - Anchorage (Alaska)  
- Utqiagvik (Alaska) - Belfast (Northern  
Ireland) - Phoenix (Arizona) - Philadelphia  
(Pennsylvania)**





The Fellowship focused on experiential learning in four areas of the USA primarily in organisations and systems that provide non-profit health care. The range of organisations offered a richness of experience relating to the populations they serve, their healthcare redesign achievements, their national and international recognition and their rich history.

I had the privilege of spending time and exploring the culture of Alaska Native & American Indian people and US Veterans through a number of facilitated visits in key organisations alongside studying, shared learning and resources. The key organisations were;

- Southcentral Foundation, Anchorage – recognised as one of the world’s leading examples of healthcare redesign and twice recipient of the Malcolm Baldrige National Quality Award.
- Department of Health and Social Services, Anchorage – responsible for healthcare policy for the protection and wellbeing of Alaskans.
- North Slope Borough (Health and Social Services), Utqiagvik – one of the most northern populations in the world. Primary focus to provide culturally safe care.
- Indian Health Service, Phoenix – Principle federal

healthcare provider and advocate for American Indian people.

- Creative Healthcare Management, Minneapolis – Creators of the Relationship Based Care Model.
- US Department of Veterans Affairs, Philadelphia - Veterans Health Administration is America’s largest integrated health care system.
- Pennsylvania Hospital, Philadelphia – Founded in 1751 it was the first hospital in the USA. Recognised nationally and internationally for excellence in healthcare and is consistently ranked amongst the top hospitals in the US.

Appendix 3 provides background information on each of the organisations. Appendix 4 references the many individuals who gave of their time to support the study.

A range of learning approaches were used to meet the objectives of the Fellowship including observation, dialogue, conference attendance and formal training as summarised in Table 1.

Organisation	Training/Conference	Venue	Dates
Southcentral Foundation	Pre Conference Core Concepts Training	Anchorage, Alaska	18 - 20 June 2019
Southcentral Foundation	8th Southcentral Foundations’ Nuka System of Care	Anchorage, Alaska	21 - 22 June 2019
Southcentral Foundation	Coaching and Mentoring Programme	Anchorage, Alaska	25 - 29 June 2019
Creative Heathcare Man-agement	Relationship Based Care Practicum	Phoenix, Arizona	18 - 22 Jan 2019
Indian Health Service	Reigniting the Spirit of Caring Training	Phoenix, Arizona	25 - 29 Jan 2019

Table 1 Conference and Formal Training



# THE FINDINGS




# SEVEN ENABLERS TO COPRODUCTION

DoH policy in Northern Ireland has already outlined the need for a culture shift to deliver the vision of a Coproduction approach. I present my learning and observations from the Fellowship on how other healthcare systems have achieved this culture shift in the form of 'Seven Enablers to Coproduction'.

The application of the seven enablers will support the delivery of the DoH Coproduction Guide and push the boundaries of the role of the service user and carer, their relationships with HSC staff and the HSC system. This will result in improved services and experiences for the population of NI. In turn this will impact positively upon staff satisfaction.

**"Health care is so straightforward."**  
*—no one ever*

We're doing something about it.

 **Banner** | **aetna**

 **CLEAR CHANNEL**

01596

# ENABLER ONE - COMPELLING MOTIVATION FOR CHANGE - THE WHY?

Coproduction requires a seismic culture shift and the HSC champions for Involvement and Coproduction, are required to be highly motivated by their belief that Coproduction makes a real difference. The challenge is how do we motivate, support and mobilise individuals who are not yet convinced of the value of the experiences of service users and carers and prefer to refer to hard evidence such as performance data and clinical research. How do we influence a system, (that is traditionally data and research driven), to embrace the views and experiences of service users, carers and staff as equally important to the decision making processes? How do we articulate compelling reasons for Coproduction?

I explored these questions with Southcentral Foundation (SCF) to ascertain how they influenced and motivated their system to change and they reflected on their learning and described the important 'Eureka Moment'. The 'Eureka Moment' came around the middle of the 1990s as they started to have conversations with the service users and carers and public about their own health care in preparation for assuming responsibility for the delivery of primary health care services from the federal government. At this time the culture was a traditional medical model where the role of the primary care clinician had largely become one of assessment, ordering of tests, making a diagnosis, referring on and prescribing medication. The process was described as transactional, whereby the primary care clinician was the prescriber of care and the service user/carer a passive recipient.

It was apparent that staff morale and service user satisfaction was very low and many service users and carers were deemed non-compliant as they did not 'take the advice' that was given by the primary care clinician. This also caused the primary care clinicians to be hugely frustrated that service users and carers weren't following their advice and direction

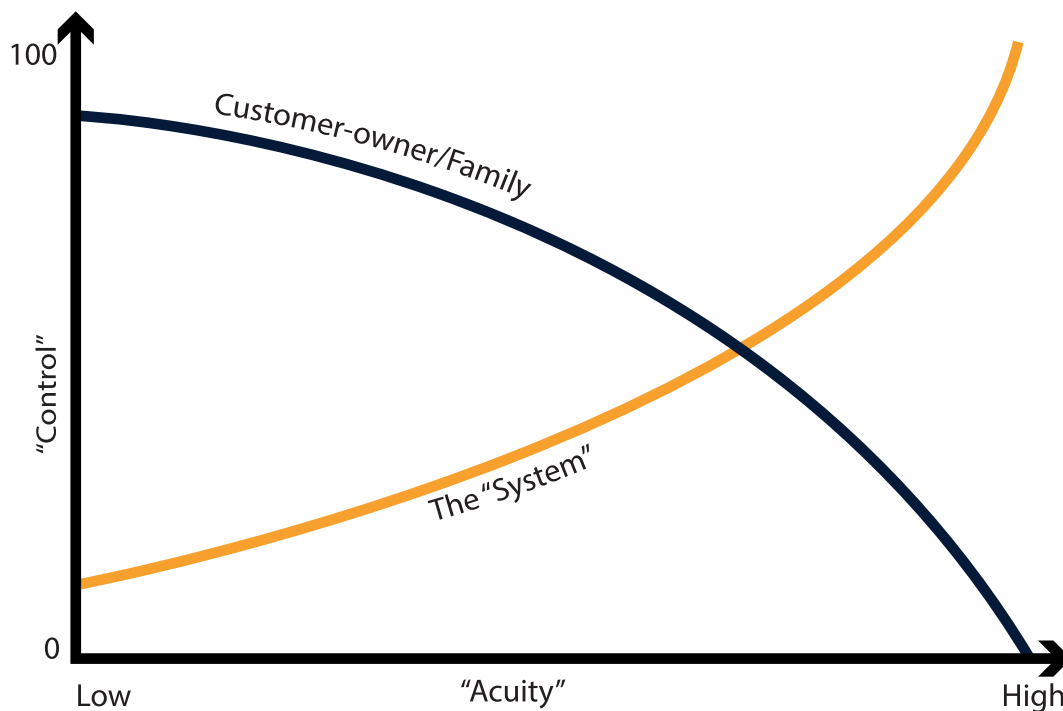
to improve their own health. It was evident that something significant had to change as the majority of the population that were incurring the greatest health spend were those with chronic diseases and those most often deemed non compliant.

The 'Eureka' moment came for Coproduction when primary care clinicians realised that their ability to 'control' or 'effect' behavioural change in their model at that time was unachievable. Whilst they talk about the 'Eureka' moment, in reality, it wasn't a sudden realisation, rather, the connection of good ideas, reflection and learning over a period of time.

Table 2 is presented by SCF to illustrate that health care professionals are only able to exert a high degree of control over patients with high acuity. For example when the service user is anaesthetised on an operating table it is possible for the clinician to control every aspect of the service user. Conversely when the service user has a chronic condition they and their families/ carers have low acuity needs and are in control, they decide what they will do and whether or not they will accept and apply healthcare advice. In this case they are neither dependent on the clinician nor under constant clinical scrutiny.

Source: Southcentral Foundation <https://www.slideshare.net/DrGrundy/southcentral-foundation-nuka>

# Control: Who really makes decisions



1. Control - Who makes the final decision influencing outcome?
2. Influences - family, friends, co-workers, religion, values, money
3. Real opportunity to influence health costs/outcomes - influence on the choices made - behavioural change
4. Current model - tests, diagnosis, treatment (meds or procedures)

**D**r Steve Tierney (SCF), Senior Medical Director of Quality Improvement expanded on this when he discussed the problems with continually applying productivity principles such as Six Sigma to improve adaptive systems i.e. healthcare is made up of human beings and human behaviours. He believes that Six Sigma type approaches work only in high acuity situations such as where the patient is intubated, ventilated and passive. Therefore to improve health outcomes that are dependent on human interactions and behavioural change it's necessary to move beyond the application of such productivity practices and to establish what motivates the behaviours and build trust to change them.

Doug Eby, Vice President of Medical Services (SCF), illustrates the concept in the following way. If the job is to throw a rock at a target, then if you practice enough, you can refine your technique and learn to hit the target every time. If the job is to persuade the bird to fly to the target, hurling it in the right direction is unlikely to help. You have to understand what motivates the bird and help it to fly to the target.

SCF primary care clinicians decided they needed to move beyond examining, ordering tests and prescribing medication and hurling the rock to the target. Their vision was to have a more meaningful impact on how their service users and carers lived their lives. They involved their service users and carers and the wider public in discussions about what they wanted from a new primary care system and agreed to be in the business of building trusting, long term relationships with service users, carers and wider public i.e. understanding what motivates the bird to fly to the target.

This relationship was to be a relationship where the service user and carer would be a partner rather than a passive recipient and the primary care clinician would become the provider of options. Care plans would be coproduced and the service user and carer voices would infiltrate decisions at all levels.

The creation of this compelling vision for change secured wide support across the healthcare system and led to a philosophical approach to relationship based whole system design. The system was shaped by the

following characteristics:-

- Outcome not income.
- Person not disease.
- Population not process.
- Service not practice.
- Providers of options.
- Provider and customer in shared responsibility.
- Direct input into healthcare redesign.
- Provider is partner not hero.

The wide support and the success of this paradigm shift was that SCF were able to strongly link the benefits of Coproduction and partnering with service users and carers to the changes desired by the clinicians and the public. There was something important to be gained by everyone if they embraced the change.

## RELEVANCE AND OPPORTUNITIES FOR NI

**F**rom my observations in the USA it is evident there needs to be a compelling reason to change from the traditional medical model of health care to a culture of Coproduction where service users and carers are partners with shared responsibility for their healthcare and HSC system. Coproduction must be more than a buzz word it must facilitate this new kind of relationship.

Deep exploration and commitment to the impetus for the Coproduction approach is required in order to motivate HSC staff, organisations and service users and carers to change behaviours and enter this Coproduction relationship. It is therefore important that we create our own NI 'Eureka moment!' to reach out to a much wider base of HSC staff and service users and carers as HSC PPI Leads are voicing concerns that those who are the existing champions for Coproduction are at saturation level and progress may be plateauing. PPI staff also highlight the challenges of being often viewed as the people who 'deliver the Involvement and Coproduction' rather than Involvement and Coproduction being owned by every single member of HSC staff. The impetus for Coproduction' must be owned by all HSC staff and also service users, carers and the wider NI population.

At a strategic level service users involved in Coproduction highlight they are feeling exhausted and worn out by the 'system' due to the level of demand and requests for their involvement. Challenges exist in attracting service users and carers to work with HSC staff to improve services.

The implementation of PPI policy in NI to date has been supported through the following mechanisms

1. The establishment of PPI Lead posts in the PHA and HSC organisations,
2. A regional PPI Forum,
3. A set of PPI standards which are monitored on an ongoing basis by the PHA
4. PPI training development programmes.

Whilst PPI Leads have made strong advancements in raising awareness of the need for and benefits of Involvement and Coproduction which have led to enhanced systems, processes and training, there remains a concern that the translation of Involvement and Coproduction into everyday clinical practice has not been so successful.

The opportunity exists now to drive Coproduction at the level of the individual relationship between the clinician and the service user/carer. Creating the 'Eureka!' moment and making the concept of Coproduction more meaningful for clinicians and service users and carers by relating it to their specific set of circumstances should increase the likelihood of success. A drive to secure small improvements at the front line should also increase the likelihood of success. Fitzgerald and McDermott (2017) found that initiatives at large scale led far from the front line have a high failure rate (Fitzgerald & McDermott, 2017).

To that end, strong clinical leadership in area of Involvement and Coproduction is necessary, mirroring a similar approach in other areas such as quality and safety and managed clinical networks.

Aligned to clinical leadership is the concept of service users and carers as leaders. This is briefly referred to in the HSC Collective Leadership Strategy Health and Wellbeing 2026: Delivering Together. In a collective leadership approach it is surmised that specific PPI leadership roles for service users and carers are required and should be established to work alongside PPI leaders and PPI clinical leaders.

An early intervention approach should also be taken to ensure that future clinical staff are invested in Involvement and Coproduction at undergraduate level irrespective of whether they see their future employment in HSC or the private practice. This approach is best supported through proactive engagement with Universities and other relevant training institutions. The training should extend much further than the definition and tools of Involvement and Coproduction. It should provide an opportunity to translate the theory of Involvement and Coproduction into the practicalities of how engaging service users and carers will positively impact upon the clinician and ultimately improve outcomes.

Finally, these approaches should be supported by building a strong local evidence base, illustrating how the Coproduction approach positively impacts upon the service user and carer outcomes. A regional approach to recording these outcomes could act as a motivator to Involvement and Coproduction, as clinicians are driven to deliver the best care possible to their service users and carers.

## RECOMMENDATIONS

1. Specific Clinical Lead and Service User/Carer Lead roles should be established to secure a Collective Leadership model for Involvement and Coproduction.
2. Involvement and Coproduction should be an integral component of undergraduate and postgraduate training programmes and form part of the commissioning agreements with DoH and provider organisations.
3. A robust local evidence base of the impact of Involvement and Coproduction on morale, service changes, safety, quality etc. is required to demonstrate the local impact of Involvement and Coproduction.

**"I've learnt that people will forget what you said, people will forget what you did but people will never forget how you made them feel"**

**- Maya Angelou**

# ENABLER TWO - SIMPLICITY AND CLARITY

Katherine Gottlieb, President and Chief Executive Officer (CEO), SCF firmly believes that organisational success and effective Coproduction starts with clarity of vision and unity amongst staff, the organisation and customer-owners (SCF terminology for service users). She highlights that all of the staff at SCF speak the same language from the Chief Executive to the administration officer to the service user and carer.

SCF staff reflected how this approach provides them with absolute clarity on what the organisation is setting out to achieve, the way of working and 'being' and the behaviours expected. They feel they can clearly articulate their specific contribution and feel valued as members of staff.

The service users and carers I met also identified clarity and simplicity of vision, mission and purpose as a particular strength. They stated that it helped with openness and transparency which they view as critical foundations for successful relationships. In

the time I spent with SCF I observed an organisation where everyone speaks the same language; everyone knows what they are working towards and how they are going about doing it. The simplicity and clarity also assists service users and carers to more readily partner with the organisation as they are clear about the joint aspiration which in turn facilitates a shared responsibility. This struck me when the service users and carers I spoke to were able to outline that the model of care was one where they had to also take responsibility for their own wellbeing and that SCF treatment models were largely built around the self-care and empowerment of the service user and carer.

Clarity is key to SCF success and they have been able to achieve it and harness support through not only coproducing it with service users, carers, staff and the wider public but also then translating and presenting it with a simple elegance. The vision and mission are aligned very closely with the strong and cherished Alaska Native and American Indian values and traditions. (figure 3)



Figure 3 The Vision and Mission statements of SCF



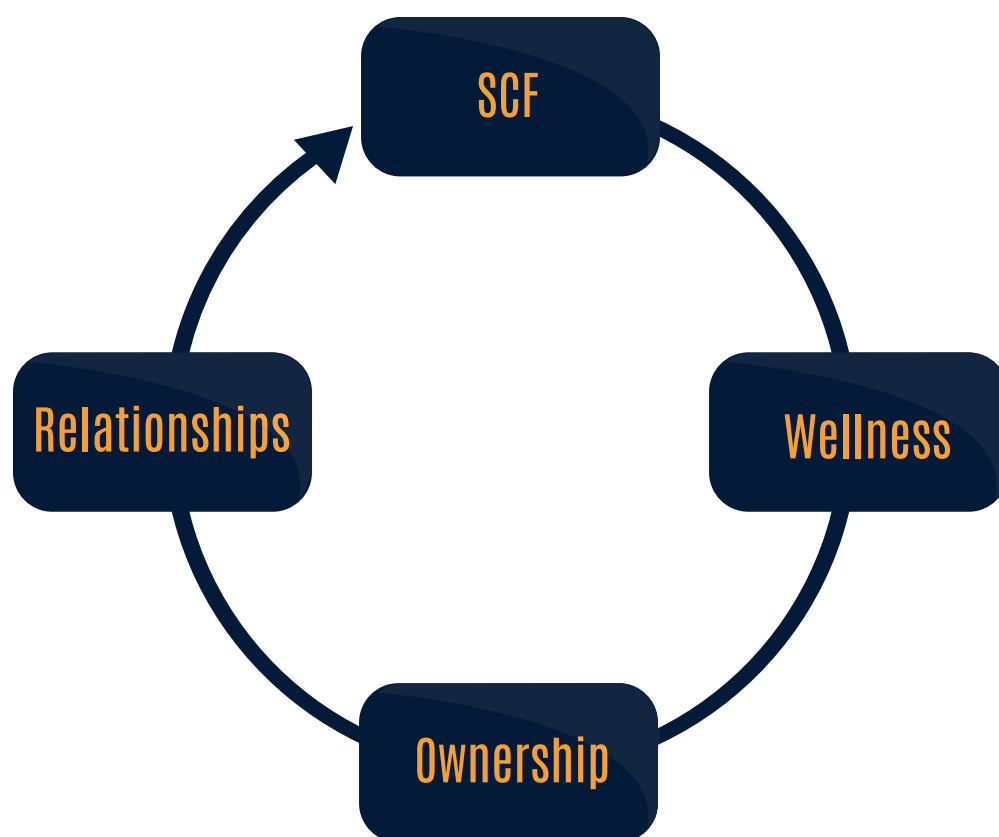
The Vision and Mission is underpinned by pledges on **S**hared Responsibility, **C**ommitment to Quality and **F**amily Wellness using the acronym of the organisation.

The Vision and Mission is operationalised through

1. Core Concepts – WELLNESS,
2. Leadership Principles – OWNERSHIP
3. Operational Principles RELATIONSHIPS.

This synergy is demonstrated in Figure 4

Figure 4 The relationship between the Vision and underlying principles of SCF



Each of the principles is expanded in Figures 5, 6 and 7. Each principle has been framed using powerful acronyms (WELLNESS-OWNERSHIP- RELATIONSHIPS) giving meaning and an easy way to remember each principle. This supports their daily application in practice.

Figure 5 Core Concepts for SCF Vision

## Core Concepts

**W**ork together in relationship to learn and grow  
**E**ncourage understanding  
**L**isten with an open mind  
**L**augh and enjoy humor throughout the day  
**N**otice the dignity and value of ourselves and others  
**E**ngage others with compassion  
**S**hare our stories and our hearts  
**S**trive to honor and respect ourselves and others

Figure 6 Leadership Principles for SCF Vision

## Leadership Principles

**O**perate from the strength of Alaska Native cultures and traditions of leadership  
**W**ill stand in the gap to align and achieve the mission and vision  
**N**urture an environment of trust that encourages buy-in, systematic growth and change  
**E**ncourage ownership of responsible, calculated risk taking  
**R**espect and grow the skills of future generations to drive initiatives and improvements  
**S**hare and listen to personal life stories in order to be transparent and accountable  
**H**edge people in by creating a safe environment where spiritual, ethical and personal beliefs are honored  
**I**mprove for the future by learning from the past, giving away credit and celebrating achievements  
**P**ractice and encourage self-improvement believing there is good in every person

Figure 7 Operational Principles for SCF Vision

## Operational Principles

**R**elationships between customer-owner, family and provider must be fostered and supported  
**E**mphasis on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)  
**L**ocations convenient for customer-owners with minimal stops to get all their needs addressed  
**A**ccess optimized and waiting times limited  
**T**ogether with the customer-owner as an active partner  
**I**ntentional whole-system design to maximize coordination and minimize duplication  
**O**utcome and process measures continuously evaluated and improved  
**N**ot complicated but simple and easy to use  
**S**ervices financially sustainable and viable  
**H**ub of the system is the family  
**I**nterests of customer-owners drive the system to determine what we do and how we do it  
**P**opulation-Based systems and services  
**S**ervices and systems build on the strengths of Alaska Native cultures

Through clarity and simplicity SCF achieved a positive dramatic impact. As part of a National Quality Award, Baldrige assessors interviewed hundreds of staff at SCF and concluded that all of the employees could recall the Vision, Goals and Principles but more importantly could describe exactly what each of them really meant. Staff demonstrated an enthusiasm for living them out every day within this organisation.

Appendix 5 contains a link to my blog on SCF Vision Mission etc.

Throughout my Fellowship journey I also observed the juxtaposition where some organisations (or parts of) lacked clarity and tended to have to 'go with the flow'. As a result staff felt reactive to the environment around them an example of this was complaint management. A lack of clarity for staff about how to deal with dissatisfied service users and carers and complainants resulted in a range of approaches being taken. The inconsistency created confusion and impacted on staff morale.

Such observations reinforce that the lack of purpose, loss of control and feelings of being overwhelmed that is often reported by staff can in part be attributed to lack of clarity within the organisation itself, within specific projects or individual workplans.

A lack of clear vision can result in complication of organisational language, systems and processes.

This concept also translates into the direct care of service users and carers when there is a lack of clarity about treatment goals. Often service users and carers have multifaceted components to their care requirements. When they are passive recipients and have not been involved as partners in the design of their overall plan they can feel at the mercy of 'the system' describing feelings of being lost, overwhelmed and alone.

## RELEVANCE AND OPPORTUNITIES FOR NI

My learning illustrated how important clarity of language and simple communication is in the move to a culture of Coproduction. In NI there are many terms currently in use to describe the involvement of service users and carers in individual care planning and strategic NI HSC decision making. For example Involvement, Coproduction, Codesign, Codevelopment, Involvement, Engagement, Partnership and Shared decision making.

It is my experience that these terms are now often used interchangeably, with the risk that the Coproduction vision becomes diluted through lack of understanding of the true concept and over complication of language. We must ensure that the language of Involvement and Coproduction is explicit and meaningful for our population. The time is right to simplify the language of Involvement and Coproduction in order to help us move together in the same direction.

Research commissioned by the PHA stated there is a need for simplicity and clarity when developing the PPI approach. Services user focus groups identified that the language of PPI and the terminology presented real problems for them. Lack of familiarity of the language was therefore felt to be something that could be detrimental to the effectiveness of PPI from a service user perspective. One service user stated 'At the moment PPI seems to be top secret. There are only a few knows where it is and understands it. It needs to be rolled out in a way that everybody knows it is there and understands it'. (Duffy et al., 2017).

Given Coproduction is built upon relationships of equals at all levels it raises the issue of the use of our language at every interaction. When it comes to writing about HSC issues or systems it can be easy to get distracted by complex jargon and overused terms with no commonly understood definitions. A number of NI HSC documents which are currently accessible to the public demonstrate some examples of language which may not be wholly accessible for the general public as illustrated on page 24.





**“Motivation comes from working with things we care about. It also comes from working with people we care about”**

**- Sheryl Sandberg (COO Facebook)**



# ENABLER THREE - A RELATIONSHIP BASED APPROACH

A consistent message during my Fellowship journey was the importance of relationships in achieving organisational excellence resulting in world class outcomes. Each of my hosts identified it was important to accept that effective Coproduction is quintessentially a product of the quality of relationships that exist within an organisation and key people and bodies around it. By focusing only on the tools and techniques for involving the public, an organisation would not deliver the vision for Coproduction. It requires strong, robust relationships that are built on Trust. Trust is the connector in the relationship.

Whilst HSC systems are known to be complex and adaptive systems in an ongoing state of change and demand, a constant factor is that the technical aspects of HSC are delivered in the context of human relationships. Essentially as human beings we rely on the strength of human relationships to thrive and survive. We are all born into the world vulnerable and weak and only grow as a result of physical and emotionally nurturing relationships.

With such complex elements HSC systems often place a greater emphasis on tasks, activity and clinical practice at the expense of relationships. Such a dynamic is also observed in how many HSC systems manage change processes where investment is focused on changes to processes and structures but less on enhancing relationships between the staff, service users/carers and the wider public.

The relationship based concept was explored deeper with the senior team for Creative Healthcare Management (CHCM) through discussion of their Relationship Based Care (RBC) model. The RBC model focuses on three key relationships that must be supported nurtured and supported to effect transformational care.

These are;

- Relationships with self.
- Relationships between colleagues.
- Relationships with service users/cares and the public.

## RELATIONSHIP WITH SELF

The first relationship is the relationship individuals have with themselves. This includes really knowing and understanding ourselves, enhancing our self-awareness, understanding our value base, understanding our beliefs and the reasons we believe what we believe and react in the way we react. It also encompasses the self-care approach. Self-care is the deliberate activities we do to take care of our physical emotional and spiritual wellbeing. Jayne Felgan, President Emeritus, CHCM, reinforces the mantra that **'self-care is not selfish care'**.

The RBC model highlights it's incredibly difficult to expect people to develop loving and caring relationships with others if they don't have that relationship with themselves. It was argued by both SCF and CHCM that staff who are struggling with inner personal conflicts will struggle to deliver optimum care to others. In summary self-care is caring for us in order that we can care for others.

## RELATIONSHIP WITH COLLEAGUES

The RBC model also highlights the vital importance of building healthy relationships with colleagues as such healthy relationships are more likely to improve the health care interactions particularly those that rely on effective communication and trust.

During the Fellowship journey I observed that trusting relationships with colleagues resulted in safer practices such as better handovers of clinical information and increased the likelihood of colleagues to challenge constructively when standards of care are lower. I also observed examples of poor team relationships and the differences in staff morale which impacted negatively upon service user and carer experience. From my observations it was evident that team work is the sum of all of its parts and when positive relationships exist morale improves and there's little that can't be accomplished together.

During my time with the Indian Health Service I undertook the 'Reigniting the Spirit of Caring' RBC training. During the programme fellow participants shared with me how the RBC approach facilitated the development of much stronger relationships with colleagues. They said they are much more aware now of what's happening around them in their work environment and they now wanted to support colleagues to deliver the best care possible.

They reflected upon improved self-awareness in the work environment and how to support colleagues to deliver the best care possible. Previously in these teams morale was low. They highlighted the positive impact of RBC such as a willingness to support colleagues, improved team spirit and sense of camaraderie.

## RELATIONSHIP WITH SERVICE USERS AND CARERS

At a strategic level when SCF and its population redefined the relationship with patients, they were termed customer-owners. It was felt that the term 'patient' represented a passive relationship where something is done onto the service user or carer. The term 'customer-owner' painted a picture of people using services and also having and accepting shared responsibility for their own healthcare choices and health care system. The terminology supported the paradigm shift SCF talks about where the clinician – customer-owner relationship is a partnership. The HSC practitioner is recognised as the provider of information and options as opposed to the prescriber of care. SCF clinicians describe their role now as one where they will walk beside the customer-owner to achieve behavioural change.

Approaches that enhance and elevate the importance of the one to one relationships with service users and carers shifts the emphasis from the provision of the clinical intervention to the creation of healthy therapeutic relationships and coproduced care plans.

Rosemarie Habeich, Director, Health and Social Services, North Slope described this as '**the practitioner meeting the service users and carers where they are at rather than where the practitioner is at**'. Such a partnership approach challenges the traditional hierarchical relationship with the practitioner at the top and places the power and behavioural change with the service user and carer.

**"You can't keep doing what you are doing if you want to engage with your population. It's not sufficient - it's not right - it's not ok. What would it be like to tear it apart and build it back up?"**

**- Steve Tierney, 8th Annual Nuka System of Care Conference**





## THE IMPACT OF RBC

Joanne Ruggiero, Chief Nursing Officer at Pennsylvania (Penn) hospital and her nursing colleagues from the 'Leaders at the Bedside Meeting' talked about the difference the implementation of the RBC approach made. They described RBC as the method to connect with people outside the disease process. Adopting the RBC model resulted in the following experiences;

- The creation of a safety net which helps staff to highlight 'good catches' or in other words the ability to identify near misses early.
- The catalyst for simplifying the language used in the clinical and strategic environment e.g. changing terminology of Serious Adverse Incident Meetings to Patient Safety Meetings.
- Improved reactions to issues. When an issue arises they stop and ask the question: Is this a systems issue or a person issue? This enhanced the no blame culture.
- Clinicians had permission to be less task orientated and more focused on caring practices e.g. the focus has shifted to what is important to the patient that day from the patient perspective agreeing their goals with the clinicians each day. Such goals (respecting confidentiality) are clearly visible on the patient's white board – an example of Coproduction in action.

My observations across the Fellowship Journey are that the impetus for most healthcare professionals is to care for people and to make a difference to their lives. Many staff talked about entering their professions as a vocation and a desire to provide public service through delivering effective care. The essence of care is defined when one human being connects with another. Relationships permeate every single part of the HSC system and therefore this enabler challenges organisations to focus on healthy relationships. This challenge highlights how improved relationships impact on staff to feel more motivated and energised at work and in turn positively impact service user and carer experience. For the teams I reflected with on a relationship based approach it was clear that with a focus on healthier relationships with self, colleagues and service users and carers improved productivity is a natural outcome.

What was clear in the organisations implementing the RBC model or relationship based approaches is that service users and carers and staff are respected equally. They are not only pursuing the health and wellness (physical, emotional and spiritual) of their service users, carers and the wider public but are also focused on pursuing the wellness of their staff.

## RELEVANCE AND OPPORTUNITIES FOR NI

During my Fellowship there was a clear focus on the relationship based approach and how it could support the vision set out in Health and Wellbeing 2020 – Delivering Together. Delivering Together (DoH, 2017). This strategy commits to partnership with service users, families, staff and politicians through the Coproduction approach and therefore the implementation of Coproduction should be grounded in the principles of RBC. However it is important to stress that a relationship based approach should not be seen only in the realm of Coproduction but should be integral to all aspects of our HSC system e.g. delivery of care, training and development, HR strategies and service planning, design and reform. Relationship based approach becomes a ‘way of being’ for HSC through multifaceted approaches (Brennan et al., 2013).

Drawing from the RBC model it is proposed that trust is one of the most important factors in transforming relationships to deliver world class outcomes. Brennan et al (2013), found that trust has been shown to be a critical factor influencing a variety of important therapeutic processes including service user and carer acceptance of therapeutic recommendations, adherence to recommendations, satisfaction with recommendations, satisfaction with care, symptom improvement etc.

In NI a number of high profile HSC challenges such as long waiting lists for elective surgery, delays in Emergency Departments and reports of ‘scandals’ and ‘crises’ have invariably damaged relationships with the HSC system and negatively impacted on public trust and confidence. Focused work is required to strengthen relationships and trust.

## RECOMMENDATIONS

1. A relationship based approach to HSC should be adopted to strengthen relationships between individuals themselves (with a focus on self-care) relationships between colleagues and relationships with service users and carers.
2. Transformation of relationships should be given equal status to transformation of systems, structures and processes in any change process.
3. Work should be undertaken to ascertain the level of trust and confidence and health of relationships between service users, carers, the wider public and the HSC system in order to identify actions to strengthen.
4. Redefining the relationship between service users and carers and the HSC system is necessary to effect the philosophical change from service users and carers as passive recipients of care to owners and coproducers of their own care and HSC system.



# ENABLER FOUR – UNDERSTANDING AND EMBRACING COPRODUCTION IN THERAPEUTIC AND STRATEGIC RELATIONSHIPS

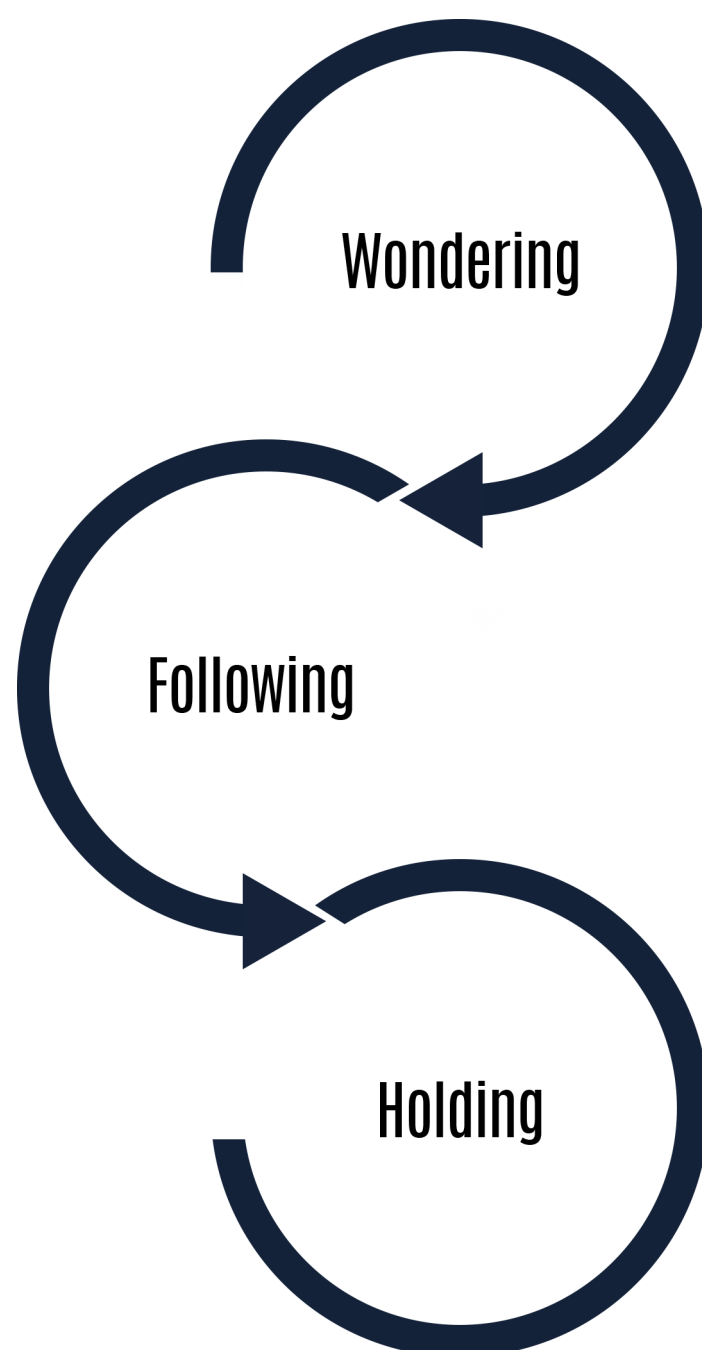
Linked to Enabler Three, Enabler Four explores deeper the application of Coproduction in therapeutic relationships. The therapeutic relationship is not like any other relationship. It's where HSC staff offer service users and carers support, care, compassion, therapeutic touch and anything else that assists them but uniquely clinicians are trained to expect nothing in return (Koloroutis & Trout, 2016).

The 'CHCM See Me as a Person' training programme delivered at the Indian Health Service, Phoenix, supports staff to refresh and reconnect their understanding of the therapeutic relationship and learn approaches to assist the strengthening them. The approach facilitates the Coproduction approach at the clinician – service user/carers level.

'See me as a person training' outlines that in therapeutic relationships, clinicians facilitate three key elements in service user and family care.

1. The ability to cope with their circumstances
2. The ability to understand the meaning of the episode of illness or injury in their lives
3. The desire to take ownership of their own healing.

These elements underpin the Three Therapeutic Practices of See Me as a Person (Koloroutis & Trout, 2016)





## WONDERING

Wondering is based on the principle that the service users and carers always have something to teach us. Wondering is the elimination of our own agenda. Rosemary Heibach, Director, Health and Social Services, North Slope defines this as '**meeting the person where they are not where you are**'.

When a healthcare clinician enters into a state where they no longer wonder they become overly focused on the service user or carers presenting problem. There is no element of wondering about what the problem or treatment plan really means to the service user or their family. This approach can lead to inaccurate conclusions, poor treatment outcomes and a state of non-compliance.

Training the brain to wonder is a necessity. Research illustrates that our brains are hardwired to detect patterns based on what it knows and has already experienced. Siegel, D (2007) *The Mindful Brain*, states that clustering these patterns help us deal with huge amounts of data we receive every single second of every single waking hour. The result is that before we actually even really focus on what is in front of us, our brain has already started to draw conclusions. This is particularly evident in pressurised environments (Siegel, 2007).

## FOLLOWING

In the clinical environment we can either lead or follow the service user or carer. Leading is when clinicians lead clinical conversations based on what they need to know and record in clinical case notes. This type of approach is more likely to be experienced in organisations which have an underlying blame culture or where there is a strong defensive practice approach.

Following is the practice of listening to and acting on what we learn from the service users and carers based on who they are and what they need. It means that we continually adjust our questions and care to what we are hearing and learning. The approach allows the service user and carer to bring us to where they want to go. This approach does not take away the need for good clinical history taking or note taking but it uses appreciative enquiry to facilitate the clinical journey from where the service user is now and where they want to be in their wellness journey.

## HOLDING

Holding is when the clinician wants to protect and defend the person they are looking after. It's about wanting the very best for them and being prepared to make personal sacrifices to ensure they get what they need. Katherine Gottlieb, SCF, describes this approach as '**standing in the gap for your customer-owner**'. It's really about preparing to advocate for the service users in order to walk alongside them on their journey to wellness. One action that typifies the Holding approach is the clinician behaving professionally in a non – judgemental way even in the face of strong emotional responses from the service user/carer.

**“Trading even one drop of presumption for a moment of pure curiosity opens us to operate with limitless data at our fingertips”**

**- Koloroutis & Trout, See Me As a Person, 2012, P.115**

When I spoke to clinicians that are supported to embrace and implement the Wondering, Following and Holding Approaches they reported they are undoubtedly in a better position to coproduce the individual care plan with the service users and carers. I witnessed that this approach motivates staff, service users and carers and improves outcomes. I observed that implementing the Wondering, Following, Holding approach strengthens therapeutic relationships.

From the observations about the relationship based approach and RBC model there are actually two distinct relationships at play in the successful delivery of Coproduction. The first is the Coproduction of care plans in the clinical environment i.e. within the context of the therapeutic relationship. The second is the Coproduction in the planning, commissioning, reform and strategy development of HSC i.e. within the context of a strategic relationship.

## RELEVANCE AND OPPORTUNITIES FOR NI

As the organisation with responsibility for overseeing the implementation of PPI policy our focus has been largely on implementation of the Coproduction and Involvement approaches at the level of strategic relationships i.e. involving service users and carers in service planning, commissioning, delivery of services and more recently a real drive at policy development level.

My Fellowship study has highlighted the need to pay attention to the two distinctive Coproduction relationships in order to achieve a system wide culture of Coproduction – Therapeutic Coproduction and Strategic Coproduction. These distinct relationships are fundamentally different in their function and it is no longer sufficient, from a Coproduction implementation perspective, to prioritise enhancing the strategic relationship only.

The implementation of Coproduction in NI could be enhanced through the use of relationship based caring models such as Wondering, Following and Holding to ensure relevance and understanding amongst clinical staff. Coproduction would then be seen as integral to the caring process as opposed to an additional requirement.

## RECOMMENDATIONS

1. Coproduction and Involvement approaches should focus on the two distinct types of HSC relationships i.e. Coproduction at the therapeutic level and at the strategic levels.
2. Implementation of Coproduction approaches with clinical staff should be enhanced with the use of caring models such as Wondering, Following and Holding.

**“Healthcare organisations exist to provide compassionate care and service to people in times of illness and suffering. This is the core of the business - the purpose of the organisation and what matters first, last and most in healthcare”**

- Taken from pg4 Relationship Based Care A Model for Transforming Practice, Mary Koloroutis,

Editor ISBN

# ENABLER FIVE - BUILDING RELATIONAL CAPACITY

The Fellowship has challenged my preconceived idea that there is no need for enhanced relationship building skills training for HSC staff given that relationships are so fundamental and permeate every aspect of our lives. From the Fellowship journey I have an increased understanding of the complexities of HSC relationships, their critical role in Coproduction at all levels and their impact on health and well-being outcomes. It is clear there is a need for building relational capacity in healthcare and training is an important aspect for all staff and should be made available to service users and carers.

Patient experience systems such as complaints, surveys and feedback demonstrate that we are not always getting relationships right. Patient reflections often centre on not feeling listened to, not feeling in control of their own care and not feeling respected;. On a similar strand staff often report similar feelings such as not being listened to within their organisations, not feeling in control of their working days and not feeling valued (10,000 More Voices, 2018).

All of the organisations visited as part of the Fellowship stressed that the fundamental shift to relationship based approaches cannot be underestimated for clinicians who ascribe to the traditional approach and would be sceptical of the change. This may also be a challenge for the service users and carers as it may be difficult to accept responsibility for making informed decisions about your own health as opposed to being 'fixed' or 'cured'. For these reasons it's critical to invest in relationship building as an enabler to Coproduction.

The organisations I visited demonstrated that when there is clarity on the expectations and processes of the relationship based approach, morale increases, experience improves, outcomes improve and risk decreases. SCF has the relationship based approach embedded in its culture and has a range of ways of enhancing relational capacity for staff.

One example is SCF Core Concepts Training. They describe this as their 'secret sauce'. Appendix 5 contains a link to my blog about this training. In essence this is corporate induction with a number of key unique characteristics.

- Top leadership support
  1. The CEO and key members of SCF leadership deliver the training programme over a three day period.
- All new staff must attend the full three day session
  1. When first introduced all existing staff were required to undertake the training.
- Training focuses on
  1. Vision, Mission, Values etc.
  2. Understanding relationships – your relational style, how you impact others.
  3. Articulating your personal story.
  4. Methods for good dialogue and productive conversation.

Training breaks down position barriers – people are placed in learning circles for three days. The membership of the learning circles come from a range of grades, professions etc.

Core Concepts (Figure 5 Pg. 24) training is the first 'formal' encounter with the organisation with a focus on building capacity to improve relationships and underpinning this with the agreed values and principles of the organisation. This training gives the staff clarity in terms of what is expected from them in terms of commitment and behaviours and also offers them support to deliver. This introduces new staff to the culture of SCF.

The Indian Health Service provides ongoing relationship based 'refreshers' through the delivery of its 'Re-igniting the Spirit of Caring' training (Creative Healthcare Management Programme). The purpose of this programme is to;

- Inspire and reconnect staff with the purpose of being in health care.
- Experience the healing power of relationships.
- Provide protected time away for self-reflection and dialogue on the value and meaning of our work.
- Provide a safe space and practice area for being in relationship with each other.
- Enhance self-awareness as a foundation for personal health and for being in healthy and effective relationships.
- Discover the meaning and power of intentional caring in action.

Both these programmes are inspiring and thought provoking methods to reinforce relational capacity.

From my journey it is clear relationship based culture is a culture where the providers of care and services have developed a strong relational skill set and that this is only achievable if it is supported by strong organisational leadership. It is essential senior leaders are champions for the importance of relationships throughout every part of their organisation. This includes building relationship based approaches, providing relational competency programmes, supporting practices that reinforce the ethos and evaluating success and impact.

The most successful organisations I visited in this Fellowship e.g. SCF and Penn Hospital have developed a relationship based way of being.





## RELEVANCE AND OPPORTUNITIES FOR NI

My Fellowship learning indicates that an induction centred on the relationship based approach (such as Core Concepts), coupled with clarity on values and behavioural expectations of an organisation can act as the foundation stone of promoting the organisation's philosophy of care.

In NI a set of common HSC values have been agreed, there is a clear set of Coproduction principles and the opportunity exists to create a bespoke NI HSC induction model. The benefit of such an approach is that new employees connect with the philosophy of the HSC system in a similar manner even if it is delivered by individual organisations.

The DoH has in place 'Improving the Patient and Client Experience' Standards (2012) outlining five core standards;

- Respect.
- Attitude.
- Behaviour.
- Communication.
- Privacy and Dignity.

It also has PPI standards 'Setting the Standards' outlining five core standards 2015.

- Leadership.
- Governance.
- Opportunities to support Involvement.
- Knowledge and Skills.
- Measuring outcomes.

These standards form the basis of an ongoing monitoring responsibility (PHA, 2013). The opportunity now exists to weave these standards into an induction programme in order to support staff to deliver the approaches to effectively Coproduce and enhance the experience of the service user and carer. It would also be timely to review the standards in light of the Transformation Agenda in NI to ensure that they are still as relevant and meaningful in their current format and also enhance the relationship based approach.

In NI we have the opportunity to consider the type of capacity building programmes that would work with our own culture and in addition push the boundaries by having service users and carers join us to learn

together. This culture shift has already begun in the development of the PPI Leadership Programme where staff and service users and carers are learning about leadership together.

## RECOMMENDATIONS

1. A HSC Induction model should be developed based on building relational capacity and embedding HSC values, PPI and Patient Experience Standards.
2. Building relational capacity should be integral to all staff training including undergraduate and post graduate training.
3. 'Improving the Patient and Client Experience' standards and 'Setting the standards' PPI standards should be reviewed.

# ENABLER SIX - EMBRACING VULNERABILITY IN LEADERSHIP – THE STORY BEHIND OUR EYES

Embracing vulnerability in HSC workplaces is a new and challenging concept. Showing vulnerability can be perceived as weakness and can result in people feeling they have to hide their true selves. This situation is very much exacerbated in organisations that have entered into a culture of blame or a performance only focus.

Some individuals I met in organisations told me they felt that they had to hide their vulnerabilities resulting in a sense of exhaustion. It was described by one staff member as **'like having embarrassing secrets you just cannot disclose'**. Staff reflected upon the need to deny their true self out of fear of being judged, laughed at or scared of losing credibility.

The behaviours I witnessed during my Fellowship taught me that showing personal or even organisational vulnerability is the driving force of human connection and it's extremely difficult to really connect with another person without it. It is therefore unfortunate that organisations and individuals can view vulnerability as a weakness.

Michelle Tierney, Vice President Organisational Development and Innovation, SCF told us at Core Concepts training 2018 **'You can't leave yourself at the front door if you all want to grow together as an organisation'**. Inspirationally Katherine Gottlieb modelled this behaviour at this training programme through the telling of her own personal story about her life, her challenges, weaknesses and failures. Her story 'warts and all' was mirrored by other senior executives from SCF in the telling of their personal stories.

The reaction from the international audience present at the training was an absolute respect for her courage to be real. There was a genuine emotional connection with Katherine and her colleagues and all of us talked about the liberating feeling of knowing that it was ok to be who we are and be proud of that. This illustrated that genuine connections are made when someone

is open about experiences and as a leader being publically vulnerable is the bravest and boldest act of all.

SCF staff reported that seeing their most senior leader being very comfortable saying 'I don't know' 'I was wrong', 'I could have managed that better' and sharing aspects of her personal struggles alongside her failures fosters a culture that imperfection is the norm. As a workforce they are comfortable that they don't have all of the answers and recognise the importance of engaging the perspectives of their peers.

It is important to clarify that vulnerability and sharing your personal story is not about telling everyone everywhere your deepest secrets. For the individual it's about getting to a place where they can feel confident in telling their story at whatever level they feel comfortable with. For an organisation it's about creating a safe culture and safe space for staff to open up dialogue and to receive an effective response whether as quick emotional support or at the other end of the spectrum the help to recover from a loss or crisis. Staff need to be supported and prepared to fail.

SCF is reflective as an organisation that encourages vulnerability and demonstrates a responsibility to provide staff and service users with safe environments to be vulnerable and a range of accessible and timely supports. SCF coined this first line support process as 'Check-In'.

Check-in is a tool often used in meetings (typically at the beginning) that allows colleagues an opportunity to share how they are doing and what may be impacting upon them that day. The check-in may only last 10 or 15 minutes. During this time staff have the opportunity to speak in a safe space and share feelings, frustrations and anything that may have a negative impact on them. In effect check-in offers an opportunity to off load prior to focusing on the task in hand.

Staff reported that this kind of support allows them to verbalise issues quickly and often this 'settles' them for the day ahead or helps them to better manage the remainder of the day better.

SCF also provides more formal coaching and mentoring supports using the Gestalt International Study Centre (GISC) Approach which;

- Takes an optimistic stance.
- Supports what is working well.
- Recognises that growth and development comes through interacting with others (Co-created).
- Is additive – builds on competence and expanding range – not on changing anyone.
- Advocates learning and growth is maximised when we account for others perspectives.
- Recognises resistance is normal and healthy.
- Based on a biological process of how work gets done.

Whilst the GISC approach is a coaching approach used to support staff it is also an approach that is used to support clinical interactions i.e. enables the asset based approach where you build on the capabilities

and strengths of the service user or carer.

In the organisations I visited the skill of personal story telling assists with the move to vulnerability. The Alaska Native & American Indian Communities recognise story telling in their culture as a method to showcase their values, pass on skills and explain why something is or came to be. Storytelling is used in SCF to support service users and carers share their stories and vulnerabilities.

An important observation from my visits was that HSC staff were also given the opportunity to coproduce in a service user/capacity. Staff reported that this was very important to them as it recognised that they had lives outside work and they too had experiences as service users or carers. Staff felt that this illustrated that the organisation valued all aspects of them as employees and it gave them the opportunity to display another type of personal vulnerability.

From the Fellowship journey I engaged with successful organisations that understand and embrace the power of vulnerability, who give their staff permission to take off the armour and mask and be real. These organisations successfully build the most genuine relationships and loyalty resulting in vibrant innovation and learning cultures. Permission to be vulnerable improves performance, enhances positive risk taking, improves morale, impacts on staff sickness levels and helps bring more success to organisational performance and the outcomes for service users and carers.

**“If interested in the person within, introduce me to the real you and that will impact me. Relationship will have a nest to be birthed”**

**- Katherine Gottlieb**

## RELEVANCE AND OPPORTUNITIES FOR NI

NI HSC recognises the importance of Collective Leadership as a means of securing the Transformation agenda. Aligned to Health and Wellbeing 2026: Delivering Together, the HSC Collective Leadership Strategy sets out a vision for leadership in HSC and the need for a new leadership culture, a culture that recognises service users and carers also as leaders and moves away from command and control to collective leadership responsibility which;

- Values both informal and formal leadership.
- Takes risks and learns from mistakes.
- Supports continuous improvement Recognises that leadership comes from all levels.

There are Four components of effective and sustainable collective leadership:-

- Leadership is the responsibility of all.
- Shared leadership is found in and across teams.
- Requires Interdependent and collaborative system leadership.
- Compassionate leadership.

Compassionate leadership reflects the principles of relationship based approach and is described as;

- Attending – paying attention to our people – being present and listening with intent.
- Understanding – finding a shared understanding of the situation.
- Empathising - using emotional intelligence and engaging with our people.
- Helping – taking intelligent action to help (DoH, 2017b).

My reflections suggest another component of Collective Leadership is vulnerability and the opportunity exists within the Collective Leadership implementation programme to recognise and elevate the concept as a key indicator of successful leadership. In addition, confidence building programmes on sharing personal stories and demonstrating vulnerability should be developed and promoted. The concept of bringing 'all of you to work' should be embraced.

Vulnerability within leadership is being debated much more frequently now in clinical circles. However a Diva subculture in HSC is apparent. In a recent report 'How doctors in senior leadership roles establish and maintain a positive patient – centred culture (Research Report for the General Medical Council (March 2019) Dr Suzanne Shale writes about the risks associated with the Diva subcultures.

**'Diva subcultures where powerful and successful professionals are not called to account for inappropriate behaviour. Left unchecked, divas come to be viewed as untouchable, and colleagues accommodate and work around them to reduce their detrimental effect. In some cases divas seem impervious to criticism or direction. Their profile makes it difficult for those who work with them to raise concerns about them or about their behaviour and has deleterious effects across the wider organisation.'**

Diva cultures are in direct conflict with the idea of vulnerability within leadership. Coupled with this is the challenge of top down leadership. Dan Cable (2018) Business Harvard Review (April 23rd 2018) references work carried out by Ena Inesi, Associate Professor of Organisational Behaviour, Stanford, who found that power can cause leaders to become overly obsessed with outcomes and control and therefore treat employees as a means to an end. He states that **'this type of top down leadership is outdated, and more importantly counterproductive. By focusing too much on control and end goals and not enough on their people, leaders are making it more difficult to achieve their desired outcomes'**.

## RECOMMENDATIONS

1. Vulnerability in leadership should be recognised as a key leadership strength in HSC and be integrated into the approaches to secure the vision of the HSC Collective Leadership Strategy and HSC Coproduction Guide.
2. Senior leaders should model vulnerability in leadership behaviours.
3. There should be a commitment to addressing Diva subcultures.
4. Safe and respectful environments and a range of supports to encourage staff and service users and carers to be vulnerable should be created within HSC organisations.
5. Supportive, responsive, healing approaches to support staff and service users and carers should be established in organisations.



# ENABLER SEVEN - POSITIVE RELATIONSHIPS IMPACTING ON PLANNING AND STRATEGIC DECISION – MAKING

One of the most frequent criticisms in the area of Involvement and Coproduction is closing the loop i.e. being able to demonstrate that the opinions and experiences of service users and carers actually impacts change particularly at a strategic level.

At SCF I learnt about a robust strategic planning process which not only reviews the corporate objectives on an ongoing basis but also facilitates the updating of local plans for local teams and the individual member of staff.

The strategic planning process relies on mechanisms to hear the opinions of the staff, customer-owners and wider public to inform the changes required. It's important to stress that there is no hierarchy in relation to the opinions or experiences of service users and carers or staff in a relationship based approach. Everyone in the relationship has an equal 'voice' and the frequency by which their voices are heard are equal. In SCF I observed how they use three fundamental components that assists them to hear and act on all of the voices (figure 8).

- Customer satisfaction and engagement.
- Staff satisfaction and engagement.
- Incident and accident reporting and complaints.

This information, informed by a very rich data set (activity, performance etc.) in the organisation, is used to make timely changes to;

- The care process.
- Behaviours.
- Training and development programme content.

Figure 8 - Voices Drive Improvement





Figure 9 shows how voices can impact on all areas of the health and social care organisation.

The ongoing engagement processes facilitate very timely changes to all the components as the whole system is tuned into what is important to staff and customer-owners, what is actually being experienced by both and how this all translates in terms of activity and outcomes. The impact of this approach is that customer-owners, the public and the staff can clearly see that their opinions and experiences are affecting real change building loyalty to the organisation's commitment and trust. The approach adopted by SCF resonates with the application of a true Evidenced Based Practice (EBP) approach to strategic planning.

I explored EBP and its relationship with Coproduction with Linda Hatfield, Associate Professor of Evidence-Based Practice, University of Pennsylvania. Linda spoke of the challenges of convincing systems to coproduce in cultures that are driven very much by the need to prove cause and effect as a stimulus for change. In true research methodology only Randomised Control Trials can prove cause and effect therefore imposing the cause and effect argument for Coproduction or any other level of Involvement is poor

measure of its impact. However, there is an absolute legitimate and compelling argument for Coproduction and Patient Experience in the context of a system embracing a genuine EBP approach.

Figure 9 - Making a difference through hearing the voices



Figure 10 illustrates the three components required to deliver an Evidence Based Practice Approach.

Figure 10



Linda also stated that many systems focus primarily and often solely on research evidence and explained that these systems are therefore in the practice of research utilisation as opposed to Evidence Based Practice.

I learnt that formalised decision making processes should be underpinned by the three tiered EBP approach to ensure that the experiences, views and expectations of staff and service users, carers, staff and the public infiltrate and impact the system on an ongoing basis. This is reflected on how SCF can make linkages of their evidence of Involvement and Patient Experience for example a serious incident affecting a service user, this organisation can see immediately if there are higher levels of staff and or customer-owner dissatisfaction in this particular area and whether there have also been incidents impacting the staff. The organisation is in a much better position therefore to make informed decisions about actions required which are multifaceted by nature.

Another important factor in hearing the voices is the frequency by which SCF engage with its staff and

customer-owners. They historically carried out 'point in time' engagement exercises e.g. every 12 months and used this data to make changes. However they found the changes they made as a result of the engagements were not really impacting on outcomes in the way they anticipated. In talking to their communities they identified that this approach was really only reaching those who wished to report extremes of experience of care i.e. very good or very poor experiences as those were the experiences that stuck in their minds. The changes being made by the organisation were therefore really only impacting on those in this category as opposed to the greater population of customer-owners who had 'ordinary experiences'.

They took the decision to introduce ongoing feedback mechanisms which gave them the opportunity to capture the experiences of the wider group of customer-owners with 'non-extreme' experiences. In SCF this initially generated a level of anxiety with the staff as they anticipated that it would prove to increase negative responses however the opposite was true. The following table outlines a comparator of responses from 2012 to 2016.

## Making changes to improve feedback process

2012	2016
2500 responses	27000 responses
800 complaints (32%)	1750 complaints (6.5%)
700 compliments (28%)	3600 Compliments (13.3%)
1000 Other (40%)	21650 Other (80.2%)

The proportion of compliments to complaints in 2012 was 28% and 32% respectively. This changed significantly to 13.3% and 6.5% respectively in 2016. This illustrated that the experiences of the majority of the customer-owners was positive. Perhaps more importantly is that 40% of the responses in 2012 were deemed neither positive nor negative and this dramatically climbed in 2016 to 80.2%. (Southcentral Foundation 2018)

Often in the debates relating to Coproduction there is an anxiety that it will be no more than a mechanism for service users and carers to complain about services and further challenge the staff as opposed to an opportunity to partner to make change. However, this is not evident in my observations of practice and I believe the shift from 40% to 80.2% in the 'other' category evidences that service users and carers are prepared to provide robust feedback that is not related to complaints.

HSC experiences of Involvement or Coproduction are not always successful and, at times, we still witness adversarial conflict as opposed to shared responsibility and partnership. The SCF approach is in direct contrast to cultures that consult service users/carers and the public only on their plans and approaches. These observations reinforce that effective Coproduction

can only be realised when there are robust, long term relationships with the staff and public. The relationship dynamic needs to shift from services users partnering to drive change.

**“In a clinical setting, authentic human connection cannot be mandated. It can, however, be a clearly articulated expectation, a shared purpose, a goal and a standard”**

**-Mary Koloroutis and Michael Trout**

## RELEVANCE AND OPPORTUNITIES FOR NI

HSC NI recognises the importance of service user/ carer feedback and utilises a range of strategic initiatives such as 10,000 More Voices, compliments and complaints and the imminent launch of NI Online User Feedback (OUF) system. The OUFG system will provide a mechanism for service users and carers to provide immediate and ongoing feedback on HSC services. In addition to these strategic approaches individual clinicians, services and organisations have mechanisms to hear service user, carer and staff feedback. The emphasis is primarily focused on securing the feedback from service users and carers.

Staff surveys are also issued on a regular basis across the organisation, but in a more ad hoc manner. It is important to consider how we robustly harness the experience of the staff. Cable, (2018) highlights one of the key ways of helping staff feel purposeful, motivated and energized is adopting the stance of the humble (vulnerable) servant leader who views their key role as serving employees as they explore and grow, providing tangible emotional support as they do. He states the way this is achieved is to listen. He stresses that the employees who do the actual work of the organisation often know better than senior leaders how to deliver positive outcomes. Therefore it is important for staff feedback to make an impact in the same way as service user and carer feedback is used (Cable, 2018).

Whilst service user, carer and staff feedback is collated in NI locally and regionally it is not always evident how this feedback informs and changes the strategic plans and importantly how the feedback highlights other necessary developments such as training. This alignment is very important in the NI context given the organisations primarily providing training and programmes across all of the HSC

organisations sit separate to the HSC Trust structures.

A dual approach embracing feedback from service users and staff is key to Coproduction. Analysis of the various feedback avenues should be in tandem to provide a strong evidence base to guide improvement. Such a strong evidence base could be used to inform the key areas identified in figure 9.

### RECOMMENDATIONS

1. Organisations should pursue service user, carer and staff feedback in equal measure as a key component of Evidence Based Practice.
2. Organisations should be able to demonstrate how service user, carer and staff feedback impacts on Strategic Planning.
3. Processes should be developed for the sharing of service user, carer and staff experiences with training organisations.



JUJIRO WADA  
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2016

# CONCLUSION





Tremendous work continues to be actively carried out by very committed HSC staff, service users and carers in NI on the Involvement and Coproduction agenda. It has created a strong foundation, has built a critical mass of staff, service users and carers whose knowledge, experience and expertise in Involvement and Coproduction is bringing about tangible improvements in outcomes including quality, effectiveness, safety etc. Challenges however remain.

The underpinning motivation for undertaking this Churchill Fellowship – ‘Changing the Conversation with the Public - from passive recipients to active owners of Health and Social Care’ is the recognition that our HSC system in NI needs to progress in a timelier manner on widespread implementation of Involvement and to reach the goal of Coproduction. The expectation was to visit the organisations across the USA and find the answer. The one brilliant model, protocol, guide or method that would fully take Coproduction into the culture of HSC; however I found the answer to be much more complex.

The epitome of my learning was when I realised the ability to coproduce effectively is actually an outcome of strong effective relationships. These are the relationships between the HSC system and service users, carers and the public and also the relationships between colleagues within the HSC system and the staff have with themselves. I learnt that good Involvement and Coproduction can't be mandated through more and more sophisticated rules and regulations.

My learning and observations from the Fellowship on how other healthcare systems have achieved this culture shift to effective Coproduction are presented in the form of ‘Seven Enablers to Coproduction’.

There are;

1. A compelling Motivation for Change
2. Simplicity and Clarity
3. A Relationship Based Approach
4. Embracing Coproduction in Therapeutic and Strategic relationships
5. Building Relational Capacity
6. Embracing Vulnerability in Leadership – The Story Behind Our Eyes
7. Positive Relationships Impacting on Planning and Strategic Decision-making

The application of the seven enablers will push the boundaries of the role of the service user and carer, their relationships with HSC staff and the HSC system and results in improved services and experiences for the population of NI. In turn this will impact positively upon staff satisfaction.

I embarked on my Fellowship to undertake a period of experiential learning however what I actually experienced was a change in myself which brought me through a different learning experience and ultimate destination. I developed relationships, I made friends, I listened more than I spoke, I allowed myself to be led, I trusted when I wasn't quite sure I should, I took risks I wouldn't normally, I stood in the gap for my passion, I heard the stories behind people's eyes and I shared the story behind mine. I am indebted to the Winston Churchill Memorial Trust. I will make a difference.

# BIBLIOGRAPHY

Brennan, N., Barnes, R., Calnan, M., Corrigan, O., Dieppe, P. and Entwisle, V. (2013) Title of paper International Journal for Quality in Health Care, Vol 25, Issue 6, Pp 682-688

Cable, D (2018) How Humble Leadership Works. [online] Available at [https://hbr.org/2018/04/how-humble-leadership-really-works?referral=03758&cm\\_vc=rr\\_item\\_page.top\\_right](https://hbr.org/2018/04/how-humble-leadership-really-works?referral=03758&cm_vc=rr_item_page.top_right). [Accessed 14th February 2019]

Department of Health (2017a) Health and Wellbeing 2026-Delivering together. Belfast: Department of Health

Department of Health (2017b) HSC Collective Leadership. Belfast: Department of Health

Department of Health (2018) Coproduction Guide for Northern Ireland. Connecting and Realising Value through People. Belfast: Department of Health

Duffy, J., Gillen, P., Agnew, C., Casson, K., Davidson, G., McGlone, A and McKeever, B. (2017) Personal and Public Involvement and its impact - Monitoring, measuring and evaluating the impact of Personal and Public Involvement (PPI) in Health and Social Care in Northern Ireland. Belfast: Public Health Agency

Fitzgerald, L. and McDermott, A. (2017) Challenging Perspectives on Organizational Change in Healthcare, 1st Edition. London: Routledge

Koloroutis, M & Trout, M. (2016) See me as a Person. Philadelphia: Creative Healthcare Management

Legislation. Gov (2009) HSC Reform Act Northern Ireland (2009) [online] Available at <http://www.legislation.gov.uk/nia/2009/1/contents> [Accessed 22 December 2016]

New Economics Foundation (2013). Co-production in mental health, a literature review. [online] Available at [http://b.3cdn.net/nefoundation/ca0975b7cd88125c3e\\_ywm6bp3l1.pdf](http://b.3cdn.net/nefoundation/ca0975b7cd88125c3e_ywm6bp3l1.pdf)[http://b.3cdn.net/nefoundation/ca0975b7cd88125c3e\\_ywm6bp3l1.pdf](http://b.3cdn.net/nefoundation/ca0975b7cd88125c3e_ywm6bp3l1.pdf) [Accessed 22 December 2016]

Public Health Agency (2013) Patient Client Experience Standards Annual Report: April 2012 to March 2013 [online] Available at [https://www.publichealth.hscni.net/sites/default/files/Patient%20Client%20Experience%20Standards%20Annual%20Report%20April%202012%20to%20March%202013\\_0.pdf](https://www.publichealth.hscni.net/sites/default/files/Patient%20Client%20Experience%20Standards%20Annual%20Report%20April%202012%20to%20March%202013_0.pdf) [Accessed 22 December 2016]

Public Health Agency, (2015) Regional Report of Experience of Nursing & Midwifery Care Key Performance Indicators. Belfast; Public Health Agency

Realpe A & Wallace L.M (2010) What is co-production? on behalf of the Coventry University Co-Creating Health Evaluation Team. London: The Health Foundation.

# APPENDIX 1 - SPECIAL THANKS!

Thanks in particular to Peggy Morgan .... Relationship Based Care Lead for Indian Health Services, Phoenix for hosting me for two weeks and sharing her home and family with me. Thanks also to Jayne Felgen, Creative Healthcare Management, for making the Phoenix and Philadelphia phase of my trip happen in the first place.

Thanks to Rosemarie Habeich, Director North Slope Healthcare who gave me the opportunity to experience the itinerant building accommodation and the culture at the 'top of the world' what an experience that was!

Thanks to Steve and Michelle Tierney who shared not only their expertise but also their warm Irish-Alaskan hospitality.

Thanks to Brett Brown and her beautiful twin babies Tuc and Danica for welcoming me into their lives and driving me around for miles.

Thanks to Karen Leach Churchill Fellow 2018 who made the first two weeks of my Alaskan experience an absolute pleasure and laugh!



# APPENDIX 2

Taken from page 9 Coproduction Guide Connecting and Realising Value Through People

<https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

‘Coproduction is a highly person centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery and experience of health and social care. It is deeply rooted in connecting and empowering people and is predicated on valuing and utilising the contribution of all involved. It seeks to combine people’s strengths, knowledge, expertise and resources in order to collaboratively improve personal, family and community health and wellbeing outcomes. Coproduction is not just a word it is not just a concept, it is a genuine partnership approach which brings people together to find shared solutions. In practice co-production involves partnering with people from the start to the end of any change that affects them. It works best when people are empowered to influence decisions making and care delivery processes’.

# APPENDIX 3



Southcentral Foundation's Nuka System of Care (Nuka) is a relationship-based, customer-owned approach to transforming health care, improving outcomes and reducing costs. It serves American Indian and Alaskan Native populations.

Recognized as one of the world's leading examples of healthcare redesign and a twice recipient of the Malcolm Baldrige National Quality Award, SCF offers health care organizations value-based solutions for data and information management, integrated care, behavioural health, workforce development, improvement, innovation, and more. SCF serves a population of around 65,000. <https://www.southcentralfoundation.com/>



North Slope Department of Health and Social Services is located in Utqiagvik. This is one of the northern most communities in the world. It is 327 miles north of the Arctic Circle. North Slope Department of Health and Social Services has a primary responsibility to responsibility is to provide culturally safe care to the residents of the North Slope Borough through the following programs: Community Health Aide Program, Children & Youth Services, Integrated Behavioural Health, Gathering Place, Sober Living Environment, Public Health Nursing, Senior Program, Veterinary Clinic/PHO, Women, Infant & Children Program, AWIC, Barrow and Village Day-care Services, and the Prevention Program, in addition to contracted services of Assisted Living, Mental Health Group Home, Home Makers Program, Tribal Doctors, and PHO Senior Centre for Elders/Youth Nutrition Services. North Slope Borough serves a population of around 10000. <http://www.north-slope.org/departments/health-social-services>



The mission of the Department of Health and Social Services is "to promote and protect the health and well-being of Alaskans" <http://dhss.alaska.gov>



The Veterans Health Administration is America's largest integrated health care system, providing care at 1,255 health care facilities, including 170 medical centers and 1,074 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year. <https://www.va.gov>



The Indian Health Service, an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 573 federally recognized tribes in 37 states. <https://www.ihs.gov>

Phoenix Indian Medical Centre provides direct health care services to over 140,000 patients. The Tribes that comprise the Phoenix Service Unit are The Fort McDowell Yavapai Nation, the Salt River Pima-Maricopa Indian Community, and the San Lucy District of the Tohono O'odham Nation, the Tonto Apache Tribe, the Yavapai-Apache Indian Tribe, and the Yavapai-Prescott Indian Tribe. Tribal members who receive care at PIMC are often residents of the greater Phoenix area and hail from Tribes throughout the U.S. PIMC also provides specialty care to rural and remote reservation health care facilities in Arizona, Nevada, and Utah.



Penn Medicine

Pennsylvania hospital's history of patient care began more than two centuries ago with the founding of the nation's first hospital, Pennsylvania Hospital, in 1751 and the nation's first medical school at the University of Pennsylvania in 1765. Penn Medicine has pioneered medical frontiers with a staff comprised of innovators who have dedicated their lives to advancing medicine through excellence in education, research and patient care. Penn is consistently recognized nationally and internationally for excellence in health care and is consistently ranked amongst the top hospitals in the US. <https://www.pennmedicine.org>



CREATIVE  
HEALTH CARE  
MANAGEMENT

Creative Healthcare Management partners with health care organisations to improve quality, safety, patient experience, staff and physician satisfaction and financial performance by improving relationships.

Creative Healthcare Management provides thought leadership not only through consultation, but through the publication of numerous award winning books. <https://chcm.com>



Burdett Trust  
for Nursing

The Burdett Trust for Nursing is an independent charitable trust established in 2002 with the aim of making charitable grants to support the nursing contribution to healthcare. The Trustees target their grants at projects that are nurse-led and that empower nurses to make significant improvements to the patient care environment.



# APPENDIX 4

## Some of the wonderful people who took time to share their experiences and learning


James Harryman Program Manager Integrated Behavioural Health North Slope Borough Department of Health and Social Services	Coy Smith Associate Director Patient Care Services Nurse Executive U.S. Department of Veterans Affairs Corporal Michael J. Crescenz VAMC	Commissioner Department of Health and Social Services Anchorage Alaska	Michelle Tierney Vice President of Organisation Development and Innovation Southcentral Foundation
Monica Lee Improvement Advisor Southcentral Foundation	Patricia O’Kane Director U.S. Department of Veteran Affairs Veterans Health Administrate VA Portland Healthcare System	Christy Lawton Child welfare Director Department of Health and Social Services Anchorage Alaska	Katherine Gottlieb President and CEO Southcentral Foundation
Doug Eby Vice President of Medical Services Southcentral Foundation	Matthew McGahran Chief Social Work Service U.S. Department of Affairs Philadelphia	Karen Forrest Deputy Commissioner Department of Health and Social Services Anchorage Alaska	Glenn Sheehan Program Coordinator Community Health Aide Program (CHAP)
Rosemarie Habeich Director Northslope Borough	Holly Greever Corporate Director Professional Practice University of Maryland Capital Region Health	Neil Chandler Manager Soldier’s Heart Southcentral Foundation	Virginia Walsh Program Coordinator Arctic Women in Crisis North Slope Borough
Peggy J Morgan-Griffan Relationship Based Implementation Lead Indian Health Service Phoenix	Danielle M. Wilson Director Nursing Innovation and Evidence Based Practice University of Maryland Capital Region Health	Denise Bingham Event Specialist Public Relations Southcentral Foundation	Elizabeth Madsen Program Manager Children and Youth Services North Slope
Linda Hatfield Associate Professor of Evidence – Based Practice University of Pennsylvania	RADM Michael Toedt Assistant General Surgeon USPHS Chief Medical Officer Indian Health Service	Darlene Shackler Clinician North Slope Borough Department of Behavioural Health and Social Services Uktiaquvak	Valerie Nurr’araaluk Davidson Commissioner of the Alaskan Department of Health
Debi Ferrarello Director Family Education Pennsylvania Hospital	Caroline Patanovich Magnet Coordinator Hospital Educator Chestnut Hill Hospital Tower Health Philadelphia	Brenda Cook Nursing Director Southcentral Foundation	Ellen Sovalik Deputy Director Behavioural Health North Slope
Sunilka Thompson Assistant Nurse Manager Pennsylvania Hospital	Monique R. Martin Health Care Policy Advisor Office of the Commissioner Department of Health and Social Services Anchorage Alaska	Karen McIntire Director of Human Resources Southcentral Foundation	Jayne Felgen President Emeritus Creative Healthcare Management Indianapolis
Timothy P.Kelly Patient Advocate U.S. Department of Veterans Affairs CPL Michael J.Crescenz VA Medical Centre	Erin E. Shine Special Assistant to the	Letisha Secret Nutaqsiivik Clinical Coordinator Southcentral Foundation	
Bernard G. Deazley U.S. Department of Veterans Affairs Veterans Health Administration VA Portland Health Care System		Lisa Olsen Assistant Chief Pharmacist Indian Health Service	
		Steve Tierney Director of Quality Improvement and Chief Informatics Officer Southcentral Foundation	

# APPENDIX 5 - BLOG

<https://michelletennysonchurchillfellow.wordpress.com>

Michelle Tennyson - Churchill Fellowship Travels 2018/19

HOME    A WEE BIT ABOUT ME    USEFUL PRESENTATIONS




Working with Veterans and First Responders who have been experiencing Post Traumatic Stress -The Power of

READ MORE

Power of Sharing a Story

- Data gives us information about the issues.
- Sharing story shows us the impact and makes the data real.



Southcentral Foundation Core Concepts Training - Getting Started and the Learning Circles.

READ MORE

Do bears and moose really come into the city???

When one of the locals asked me if I had purchased my bear spray I honestly thought they were kidding until I read this article.

READ MORE

# GLOSSARY

Term (abbreviation)	Definition
Allied Health Professionals (AHP)	A collective term for a group of 13 professional those are; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Orthoptics, Podiatry, Dietetics, Art Therapy, Music Therapy, Drama Therapy, Orthotists, Prosthetists and Paramedics.
Clinicians	Within this report the term clinician refers to any healthcare professional actively engaged with delivering patient care. This is inclusive of medical, nursing and allied health professional teams.
Codelivery	A partnership approach which aims to empower multidisciplinary team to deliver integrated care solutions for their population.
Codesign	A partnership approach which seeks to establish a representative co-design team of people, who come together to design care pathways, develop new and revise existing services models.
Coproduction	A highly person centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery and experience of Health and Social Care.
Creative Healthcare Management (CHCM)	An independent organisation which partners with health care organisations to improve quality, safety, patient experiences, staff and physician satisfaction, and financial performance by improving relationships.
Customer-owner	This term refers to the partial or complete ownership of a public utility – in this context health service, by those who use its output.
Department of Health (DoH)	The Department of Health is one of 9 Northern Ireland Government Departments. The organisation is responsible for policy and legislation for health and social care, public health and public safety.
Evidence Based Practice (EBP)	The conscientious use of current best practice in making decisions about the care of the individual patients or in the delivery of health services.
Health & Social Care (HSC)	The designation of the publicly funded services which provides health care and social care services in Northern Ireland. It encompasses Public Health Agency, Health and Social Care Board and six Health and Social Care Trusts.
Online User Feedback (OUF)	A tool to support patients, carers and relatives to share personal experience of the health service using an online platform.
Personal and Public Involvement (PPI)	A term used to describe the active and meaningful involvement of service users, carers and the public in the planning, commissioning, delivery and evaluation of Health and Social services, in ways that are relevant to them.
Public Health Agency (PHA)	Regional organisation in Northern Ireland which works towards health protection and health and social wellbeing improvement. The organisation is also committed to addressing the causes and associated inequalities of preventable ill-health, and lack of well-being. It is a multi-disciplinary, multi-professional body with a strong regional & local presence.
Relationship Based Care (RBC)	A model which outlines a new way of caring through establishing relationships – with self, with colleagues, with patients and families.







“ I am only one, but still I am one. I cannot do everything, but I can still do something; I will not refuse to do the something I can do.

- Helen Keller