Co-producing prudent healthcare: putting people in the picture

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Summary

Co-production will increase the impact of all the prudent healthcare principles. It is an approach where people and professionals share power and work together in equal partnership. Co-production values all participants as equals and is built around people, and not around systems. Instead of fitting people into existing services, professionals work with people to find the best way to achieve the outcomes that matter to them.

Co-produced projects and activities in Wales have had a significant impact on health, well-being and community cohesion. As a principle, co-production needs to be embraced across all healthcare settings and systems, to refocus the work of NHS Wales on people.

What is co-production

Co-production is an approach to public services which enables citizens and professionals to share power and work together in equal partnership, creating opportunities for people to access support when they need it and to contribute to social change.

The key features [1]

- **Value all participants as equals and assets**

Everyone has a contribution to make, whether as experts through experience or experts through training. We should acknowledge this in everything we do, and build from our strengths.

- **Develop and support peer networks**

Social capital – networks of friendship and support – are vital to our health and well-being. Peer networks help to build confidence and give people a voice, and the opportunity to help others.

- **Reciprocity**

The impulse to give back is universal. Wherever possible, we must replace one-way acts of largesse with two-way transactions. ‘You need me’ becomes ‘We need each other’.
Outcomes focus

The focus of co-production is on achieving the outcomes that matter to individuals, rather than on the process of delivering services. The role of the professional is to facilitate that journey.

What co-production isn’t

If you are doing all these things but citizens are not involved as equal partners with equal power, you aren’t co-producing. You’re collaborating. This may be an improvement but it still isn’t co-production.

People not systems

Prudent Healthcare principle 5 asks us to ‘remodel the relationship between user and provider on the basis of co-production’. This is a big ask and a vitally important one.

Co-production means that citizens and professionals share power and work together as equals. It’s an approach based on relationships of trust and reciprocity, on acknowledging that everyone is an expert in their own life, with something to contribute. These relationships create a culture within which professionals become willing to share power, and citizens in turn become willing to share responsibility. And that, not surprisingly, improves the outcomes for everyone.

Traditionally, service providers ask the ‘tick-box’ questions: what do you need, what are you eligible for? With co-production, the questions become a conversation: what does a good life look like for you, what strengths can we build on, and how can we work with you to achieve your goals? It’s about thinking less about fitting people into pre-determined services, and more about empowering people to contribute to achieving the outcomes that matter to them.

In other words co-production is led by people, not by systems.

What does this mean in practice?

If co-production became ‘the way we do things round here’, what would it look like? And what would we be doing differently?

Here’s one view from co-production practitioner Dave Horton.

"We move across the boundaries that exist between us and others and listen to, and value, those with different experiences.

Together we identify common needs and work in solidarity with others to meet these needs.

We develop relationships in which everyone receives what they need and in which everyone is able to make a contribution that is valued.

Through these relationships, and our co-operative efforts, we transform our society into one that is more just and equal." [2]

This isn’t blue-sky theorising. It’s what’s actually happening in a Cardiff suburb where Dave is development manager of ACE – Action in Caerau and Ely[3], delivering the Communities First[4] anti-poverty programme. A network of some 80 community groups and organisations co-produce projects and activities. Most are members of ACE’s Timeplace time bank (delivered in partnership with Spice[5]) providing over 31,000 hours of volunteering by the community for the community. There’s a community-designed health strategy, mentoring and befriending schemes, and volunteer Community Ambassadors helping others to have a voice and to make a
contribution, particularly in relation to services which improve physical and mental health.

**What’s the impact?**

In a word, extraordinary! A recent evaluation of Timeplace over a two-year period revealed significantly improved health, happiness and well-being for participants.\(^6\)

For example, 73 per cent reported feeling more positive about the future, 44 per cent felt healthier, 26 per cent said that they required less social care support than previously and 32 per cent reported a reduced need to visit the doctor. Networks are stronger with 86 per cent of participants having made new friends and 71 per cent visiting or seeing people more often.

There’s also been a positive impact on the public-sector organisations who work in the community: in this new context half of them been able to provide improved services with the same or fewer resources.

In addition, there are increasing levels of engagement beyond the community as confidence and involvement grows. For example, Ely-Caerau residents are working with NHS staff to co-design the new NHS Direct / 111 phone-line. Their input is helping to ensure that the new system will be both effective and innovative, and that delivery will involve the community in partnership with the NHS.

Connecting Communities, a similar co-production initiative, has been running in Falmouth since 1998. The outcomes were evaluated over a three-year period by Exeter University’s Health Empowerment Leverage Project (HELP)\(^7\). Post-natal depression reduced by 70 per cent; childhood asthma by 50 per cent; teenage pregnancy went down to zero and child protection rates down 42 per cent. In addition, the crime rate fell by 50 per cent, employment rose by 71 per cent, and educational attainment at key stage 3 was up 100 per cent – all outcomes which had a direct impact on health and wellbeing. Savings through early action have been estimated at between £3.8 (a conservative estimate) and £6.4 (a more generous estimate) for every £1.00 spent.

On a smaller scale, SUN, (Service Users Network\(^8\)) in Croydon is a co-produced, voluntary peer-support group for people with severe mental health problems. After just six months membership, planned hospital visits for this group were reduced from 725 to 596, unplanned visits fell from 414 to 286; hospital bed day use went from 300 to 162 days and Accident and Emergency attendance was down by 30 per cent.

This is what co-production can achieve, through a restoration of ‘warm humanity as the driving force for public services, rather than compliance with increasingly centralised and de-personalised processes and systems.’\(^9\)

**Prudence, principles and co-production**

So how does co-production fit with the Prudent Healthcare strategy as a whole?

The principles of Prudent Healthcare are:

1. Do no harm.
2. Carry out the minimum appropriate intervention.
3. Only do what you can do.
4. Promote equity on the basis of clinical need.
5. Remodel the relationship between user and provider on the basis of co-production.
Arguably these principles are universally applicable. However, their formulation within Prudent Healthcare documents (including this one) is specific. Principles 1 to 4 focus on the behaviour of health professionals and on a medical model of health. The application of these principles will certainly encourage a more thoughtful and effective use of resources, including staff resources. This is clearly important. But it’s not enough. Despite their merits, these principles on their own will not lead to equality and shared responsibility – the core ambition of Prudent Healthcare.

It’s possible to work with each of these first four principles to promote change that appears prudent and yet still retains existing power relationships – internally, with partners, and between those who provide healthcare services and those who use them. We can remain compliance-focused, maintaining “the distance between the professional and the ‘service user’ or ‘customer’” bound by our risk-adverse systems, many of which actually undermine human relationships.

Only principle 5 specifically obliges us to change, to refocus on people and our relationships with them, embracing the social model of health in all its complexity.

And only principle 5 offers the possibility of transforming the NHS from an organisation which treats ill people into an organisation which works in equal partnership with citizens to improve the health and wellbeing of all of us.

An assertion. If we rise to the challenge of co-production, it will increase the impact of the other principles. If not, at best we risk business as usual, albeit with some additional tick-box tasks. At worst we risk the collapse of the NHS.

Without co-production, we will continue to do harm, albeit unintentionally.

Here’s an example.

Carol Kaseleht is funny, kind, clever and interested in the world. For 10 years she lived in a sheltered housing complex in Abergavenny. Free to come and go with the aid of a mobility scooter, she had friends, a social life and the opportunity, that the rest of us take for granted, to make her own choices about what she did, what she ate, who she spent time with. Free to ‘sit in the sun and watch the world go by’. In other words, she had an ordinary life.

Then she had several falls and ended up in hospital – ‘a nice hospital, they were very kind to me there’. Carol was getting better and felt ready to go home. Then a consultant who hadn’t seen her before looked at her case notes. Without further discussion he told her that she had to move into residential care. ‘He wouldn’t let me go home. Not even to get a toothbrush or a change of underwear. It was a terrifying experience – I felt as if I had been arrested.’

Frightened that if she chose a residential care home she would have to move again if her condition deteriorated, and pressurised to make a swift decision, Carol now lives in a nursing home. The other residents have moderate to advanced dementia. The home is on a steep hill so she can’t use her scooter to get out and about. She is trapped. She has no-one to talk to, no-one to laugh with, no-one to share experiences with. ‘I feel like a prisoner’.

From a strictly clinical point of view, the consultant probably made the right decision. But, of course, medical/clinical decisions exist in an individual, human context. From that vantage point, the decision was disastrous.

Similarly, without co-production, we’d limit our capacity to carry out the minimum appropriate intervention since we wouldn’t fully appreciate the needs, hopes and assets of those we are treating, or the community assets, formal or informal, which might be available to support them – and us.
And unless we include the workforce in our co-production approach, we will be inclined to make decisions about ‘what you can do’ based only on established clinical hierarchies, ignoring the vital skills of communication, building trust, empathy, and all the capabilities and potential our staff possess that we haven’t thought to ask about or acknowledge.

Further, if the Prudent Healthcare principles are simply passed down from on high as yet another set of requirements on overworked staff, there will be no ownership, no engagement and no buy-in. The result will be tokenistic compliance.

There’s another reason why we should place co-production at the heart of Prudent Healthcare – the need to align culture and practice across both health and social care.

Co-production and personal outcomes underpin the Social Services & Well-being Act, and will be embedded in the regulations and code of practice. The Welsh Government intends to make personal outcomes the foundation for integration, and the cornerstone of regulation, assessment and improvement in social care. Speaking at the National Social Service Conference in July 2014, the then Deputy Health Minister said:

“We must make our commitment to a new relationship with people a reality... looking not just at what they need but what they can contribute, building on people’s strengths and abilities... and involving people in the design and delivery of services. The National Outcomes Framework sets the foundation.”

Integration requires the NHS to make a similar hearts and minds commitment.

**Sharing power, sharing responsibility**

Co-production exists in several forms, some less benign than others.

The New Economics Foundation offers two opposing scenarios:

- the cuts scenario which uses substitutive co-production,
- and the transformation scenario which focuses on additive co-production.

In the former the primary intention is to save money and/or reduce staff: the public sector hands responsibility for services over to service users and/or communities.

In the latter, public sector resources are combined with individual and community resources, providing new opportunities for participation and co-operation.

Co-production also operates at a variety of impact levels.

- **At a basic level** we are all co-producing. If I take more exercise, eat my 5-a-day, or take my medicine according to the prescription, I am helping to co-produce my health.
- The **intermediate level** recognises what people can offer services, but doesn’t address the underlying power imbalance between citizens and professionals. Good quality consultations and shared decision-making are examples of intermediate co-production.
- In **transformative co-production** citizens are equal partners in the design, commissioning, delivery and evaluation of services.
Transformative co-production leads to shared power and shared responsibility, key aims of the Prudent Healthcare strategy.

Co-production in the NHS in Wales
The good news is that co-production, both intermediate and transformative, is already happening in the NHS in Wales. The Powys Leg Clubs, Withybush Hospital signage system, the Learning Disabilities Zone’s Beginners Guide to the Health Service, and South Gwent’s Serennu Children’s Centre are among many examples of good practice.

So too is 1000 Lives ‘Stories for Improvement’ where mental health service users were trained as researchers, using people’s stories to improve service provision. In co-production terms, all participants were valued as equals and assets, peer networks were established, reciprocity and relationships of trust were established, and the focus was on personal outcomes. Not surprisingly, this had a powerful effect on participants’ sense of self, and thus on their health and well-being.

“We have moved from being service users to being researchers – a positive identity which has motivated us all. We are useful, we have a purpose, we are valued for helping to compile an incredible piece of work.

... confidence has returned, passion and purpose too, as well as an overwhelming feeling of pride to be part of such an incredible project. Being part of a team, sharing, supporting, discovering and importantly, laughing together, has been incredibly affirming.” [12]

The knowledge and understanding that has emerged from these and similar projects could provide an energising starting point for transformative co-production and genuine culture change.

So what’s stopping us?
A major barrier is a risk-averse, task-based approach to health and social care which allows, even encourages, us to ignore our common humanity, to actually stop caring for those we are expected to care for. Mid Staffordshire wasn’t primarily about medical failure, it was about failure of compassion, compounded by a ‘system which put corporate self-interest ahead of patient safety’. [13]

There’s another problem: not a lack of compassion but a lack of equity and reciprocity – often for the best possible reasons. Professionals are trained to be the experts and expected to be the authority, offering advice and providing solutions. Service users are viewed, by themselves and others, as passive recipients of this expertise, problems waiting to be solved.

“The world of helping others in need is now built around one-way transactions... and with the best of intentions, one-way transactions often send two messages unintentionally. They say: ‘We have something you need – but you have nothing we need or want or value.’ And they also say: ‘The way to get more help is by coming back with more problems.’”[14]

The result is passivity and dependence, undermining people’s confidence and self-belief, with negative impacts on health and well-being. Such perceptions can become self-fulfilling, leading to assumptions of people’s incapacity and inadequacy by both health professionals and people themselves.
‘Listen, I am nobody, only my name and what I have done... I would like to be involved and I would like to help you all. I can give you advice, but I think it is better not to involve me in this... because of my age and my failure in memory, whatever... because of my uselessness.’\[15\]

However, those who have been involved in co-production see a different reality:

“It is difficult to sum up in a few words what I have gained from undertaking participatory research. Perhaps the most important thing I have learnt is that we often confuse a lack of opportunity with a lack of ability. I have been reminded so many times of how if people are given the chance to engage in research and the support to participate it is their ability rather than a lack of ability that shines through. It has also taught me to be critical of my own practice, to seek for ways of doing things better, and to remember that I am always learning.” \[16\]

In Scotland The Good Life project is putting this realisation into practice. People with learning difficulties design and deliver training to health professionals. The group aim to change attitudes, to influence policy and planning, and to improve the way in which NHS staff communicate with service users. Their training has been universally acclaimed, changing both perceptions and practice, and the lives of its members. It has also served to make visible the knowledge and abilities of those with learning difficulties, acknowledging them as equal and valued contributors.

**From talk to action**

The 2014 report of the Commission on Public Service Governance and Delivery called for values-led services re-designed to meet real needs, based on:

- a shared vision and...common purpose between government...citizens and communities;
- a much greater focus on co-production with citizens and communities;
- a stronger emphasis on enablement, empowerment and prevention.\[17\]

In their response to the report, the WCVA argued:

“co-production is not just about the public sector, its structures ... and targets. Co-production ...will not work without mobilising, recognising and rewarding people and their contributions alongside those of the statutory services. ...there is not one right way of doing things and no universal delivery mechanism, except to start with the energy, passion, creativity and strength in communities and build from there.” \[18\]

Evidence from the Joseph Rowntree Foundation’s programme A Better Life supports this view, concluding that:

- We need to use the many assets, strengths and resources of ...people ...recognising and creating opportunities for them to both give and receive support.
- We must all be treated as citizens: equal stakeholders with both rights and responsibilities, not only as passive recipients of care.

However, there’s still someone missing from this picture – lost in the either/or categories of professionals and citizens. NHS staff are, of course, citizens too. Their energy, passion and creativity will provide an additional starting point, and the possibility of truly transformative co-production.
So what do we do?
The people who can make co-production a reality in the NHS are the people involved. That’s all of us, including government. We need to engage everyone – from the start. Then we begin.

1. **Map our assets** – What do we know, who do we know, what skills do we have, what resources can we use?

2. **Shared goals** – What do we want to do? What shall we prioritise?

3. **Co-design** – Creative problem-solving: how can we do it together?

4. **Do it!** – And do it co-productively.

5. **Celebrate, appreciate, share** – Repeat throughout.

Above all, we need to take this journey as equal partners, sharing power and sharing responsibility.

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