A co-production prototype

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I see barriers to mainstreaming and scaling co-production in health as a design challenge with rich opportunities for creative solutions once we understand the problem. Einstein said, *"If I had an hour to save the world, I would spend 59 minutes defining the problem and one minute finding solutions."* This response to *"how to overcome barriers to co-production in health"* sketches a frame to understand the problem, identifies design challenges and highlights innovative projects that support co-production in health.

A prototype sketch for co-production in health

Co-production in health seeks to shift the physician-patient relationship from a directive, passive dynamic into a partnership for health. To co-produce in health, patients and physicians need both tools and the capacity to collaborate effectively with each other. Co-production requires dialogue, shared decision making, ability to observe outcomes and ongoing modification of the care management plan.

In co-production in health, a critical layer of pressure arises from third party influencers. System pressures influence clinician interactions with patients; patients' personal context influences their participation in care management. To co-produce effectively, patients and clinicians also need tools and capacity to negotiate with these third parties.

Figure 1 shows a prototype sketch of the problem: How does this sketch fit with your experience and understanding? What's missing? How would you draw it differently?

Figure 1:

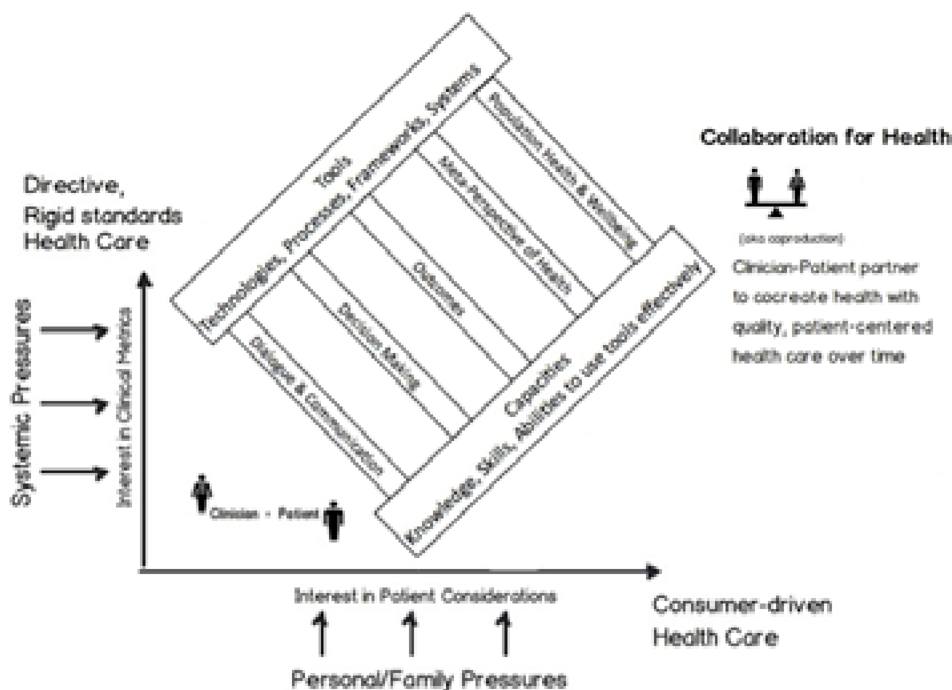

Figure 1 adapted from the Metacurrency Project.

Six design challenges in co-production in health

1. **How do we design to engage highly diverse users to co-produce?**
   - Patients' resources, needs, capacities, motivations vary as individuals, by condition, by geography, by age.

- Clinicians' skills, capacities, motivations vary as individuals, by disciplines, by specialty, by institution, by region.

2. **How do we design a meaningful interaction for both?**
   - Clinicians' needs and motivations differs from patients' needs and motivations.
   - Design restraint. How do we minimize the layers (people/technology) between a patient and their doctor unless it maximizes the value of their interaction.
3. **How do we design for adoption?**
   - Solutions must demonstrate utility and easily integrate into clinical practice.
   - Clinicians adapt their interactions to meet the needs of individual patients; if partnership is the goal, then tools/systems need to be easily customizable.
   - Patients have varying needs and resources; if partnership is the goal, then systems and standards need to have flexibility.
   - Support for building capacity to adopt tools needs to be integrated in tools.
4. **How do we design co-production to incorporate influencing third parties?**
   - The role of influencing third parties may not be visible or fully understood yet; incorporating them into the design of co-production is essential.
5. **How do we design capacity building to scale?**
   - Tools require the capacity to be used effectively. Efforts to scale need to ensure adequate support to building the capacity to support co-production.
   - Power dynamics in the healthcare system are a critical and potentially destructive force.
   - Concerns about patient privacy, confidentiality, malpractice and other ethical-legal issues need to be addressed to ensure adoption at a level of scale.
6. **How do we design to scale optimal care management strategies?**
   - Across communities with different and diverse resources.
   - Across specialties/institutions with different and diverse resources.

Innovative projects with promising elements to support co-production:

Example of capacity building for co-production:

- Foundations in Patient Care, UCSF School of Medicine*:
  - In 2009, a 'chronic care' patient who returns four times throughout the 18-month course was introduced to build capacity for developing outpatient and long-term partnership skills often missed in acute care settings.
  - With a faculty of 400 clinicians, this course provides medical students with communication and clinical reasoning skills while honing these skills among clinicians in the workforce to overcome the 'hidden' curriculum.

Examples of initiatives that support co-production:

- General Practitioners at the Deep End: GPs who provide care for the most socio-economically deprived in Scotland, formed a collaborative to address systems level issues for their patients and to partner with their patients and communities.
  - Example: A Deep End GP was represented in a community initiative to convert unused lots into green space within their patients' community.
- SHINE- Microenterprises in Social Care, International Futures Forum*: In Fife, this project facilitates connection between hospitals, social service workers and the

community to enable social and micro entrepreneurs to fill the gaps needed for isolated patients who no longer require hospital care to return home earlier.

- Positive Deviance: a method that empowers communities to partner with providers to build on the assets within a community to improve their health and well–being. Both a tool and capacity, Positive Deviance provides training for facilitators and facilitates application of the method in communities.

Lempp,H. Seale, C. (2004) The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. 'British Medical Journal.' 2 October. 329(7469): 770–773.

Nesta...

Innovation Unit

WORKING TOWARDS PEOPLE POWERED HEALTH

INSIGHTS FROM PRACTITIONERS

Working towards People Powered Health is one of a series of products from the People Powered Health programme alongside other practical tools and methods for practitioners and policymakers.

Introduction

We are living longer and many of our health outcomes are improving but we also face challenges from the increasing demand for health and social care services from an ageing population, many of whom have one or more long–term conditions. We know that the NHS spends 70 per cent of its budget on people with long–term conditions, and this figure is set to rise sharply in the coming decades. At the same time, the economic downturn and tighter spending constraints are putting immense pressure on the health system to find more efficient and cost effective methods of delivery, without compromising on quality.

In the second half of the 20th century innovations in pharmaceuticals, medical instruments and clinical procedures have delivered increases in life expectancy and improved healthcare. Yet, these innovations are no longer delivering the type of productivity gains that they once did. We therefore need to look elsewhere to find the types of radical solutions that will enable people to live well with their long–term conditions. For instance, can we re-imagine and reshape how clinicians and patients work together? How can we tap into the assets, skills, expertise and knowledge of both clinicians and patients, in order to create better health outcomes?

People Powered Health is about creating a healthcare system in which clinicians and patients collaborate to enable people to live better with their conditions. We know that ‘co-production’ is challenging for both professionals and for patients.[1] This resource focuses on the challenges for professionals and, in particular, how workforce culture needs to change to enable co-production to move from the margins to the mainstream.

We asked a range of experts – clinical, academic, policy as well as commissioners and service providers – to write down their ideas about the relationship between co-production and workforce culture. We were interested in the extent to which they thought culture is a barrier and what can be done about it. The responses are an interesting snapshot of the perspectives of experienced professionals working in and around co-production and health. Some focus on incentive structures, such as recruitment, training and appraisal systems, while others focus on less tangible changes to professional practice, culture and behaviour.

Across the varied contributions, three key themes have emerged. Firstly, many of the contributors focused on changing relationships. They argued that whilst transactional interactions were appropriate in some contexts, there would need to be a shift to more relational forms of care, in order to create more opportunities for patients and clinicians to collaborate and in order to help people find better ways of managing their long-term conditions. Secondly, it was clear that this would mean changing practice. This requires engaging with both how clinicians and patients think and feel about what healthcare should be, and a number of contributors suggest tools, methods and opportunities to make this possible. Thirdly, a number of experts focused on changing organisations. This involves working both within and across organisations and professional boundaries.

We hope you enjoy reading the different perspectives of this diverse group of professionals, all reflecting on how healthcare is practiced and what could be done differently to support more collaborative approaches to health.

Halima Khan
Director, Public Services Lab, Nesta

For more information about People Powered Health, co-production in health and this paper, please visit: **http://www.nesta.org.uk/areas_of_work/public_services_lab/people_powered_health**
Contact us at **pph@nesta.org.uk**, and contribute to the debate at #PPHealth

Summary

Changing relationships...

As you might expect, all our contributors agree that we need to **move beyond the dominant medical model in the NHS**. What is perhaps surprising is that some of the strongest advocates for this huge cultural shift are practicing clinicians. **Dr Alf Collins**, a consultant in pain management, captures both the progress achieved by modern medicine, and its limitations when faced with working with people who have long–term or chronic conditions:

> Doctors have been trained in bio–medicine – a taxonomic system which seeks to understand the basis for physiological dysfunction – pathology – in order to define a treatment. Steeped in scientific method, medicine is a reductionist, deterministic model which speaks the language of deficit and illness. The legacy, the inevitable by-product of medicine is that we now have an ageing population who live with multiple complex conditions that medicine cannot cure.

Not only does modern medicine face limitations in terms of providing a cure for people with long-term conditions, but – according to **Juliet Bouverie – it also devalues our human capacities and experiences:**

> A culture bound by technical expertise that is at ease with targeting treatment at body parts has often failed to **acknowledge the personal and social experiences of the person to whom the body part belongs.**

The medical model is still entrenched in the NHS, but **Alf Collins** believes it is important to think about **new ideas, paradigms, and philosophies** that could provide an alternative vision of the future:

> Now is the time then, to **look beyond bio–medicine** to ways of working with people – particularly people who live with long-term conditions – that supports them to keep well and to adapt to changing life circumstances. **This doesn't mean rejecting medicine as a philosophy – it means refining it or complementing it to meet the needs of our population in the 21st century.**

Adrian Sieff made similar comments:

> To be truly transformative, co–production necessitates a new relationship and different roles: clinicians changing from being fixers to facilitators, using their expertise to enable; patients changing from being passive recipients to active partners. It also requires the service infrastructure that constrains or enables the new relationship making self–management support their organising principle.

The majority of our contributors share this idea about the importance of changing **the culture of the NHS**. But **Paul Corrigan** remarks that **many clinicians are unconvinced** by co–production because:

> When they interact with medical staff most patients are at their most dependent. This means that if a medical professional sees 15 patients in a day, many of them will be experienced as very dependent for the time they are with the professional. This is not the easiest time to see people as containing assets.

However, as **Paul Corrigan** notes, co–production is about clinicians and patients working together, rather than leaving the patient to manage their own care on the one hand or completely taking over their care on the other.

Ian Wylie reflects that **there is a disjuncture between what is expected from us in everyday life, and what is expected from us by the health service.** He compares booking a restaurant online with getting a hearing test:

> I could actually contribute quite a bit to the outcome of my health problem were I allowed to do so.... Had I been asked to take [that great] responsibility I would have had the satisfaction of contributing to the fact–gathering and would have been better able to engage with the diagnosis, treatment options and outcomes.

This 'disabling' of the patient impairs clinical processes and outcomes. **Juliet Bouverie** points to the 70–75 per cent of breast cancer recurrences that are detected between routine hospital appointments. So it is crucial for clinicians and patients to work together in new ways, both during the diagnosis phase, and during aftercare.

Zoe Reed believes co–production is absolutely fundamental to the future of the health service, though recognises how many clinicians resist it:

> [Each] clinical encounter ... needs to generate in the patient a sense that they are valued and valuable and have a contribution to make to their own care and society at large. A co–production ethos and approach is the missing 'how' in a currently well trained and evidenced 'what'.

Changing practice...

Training and evidence are central to clinicians' professional identities and practice and and adapting these elements will be crucial to the success of co–production. **Glyn Elwyn** makes a strong argument for encouraging doctors to focus on what patients want in a consultation, rather than diagnosing what they think they need:

> Many doctors aspire to excellence in diagnosing disease. Far fewer aspire to the same standards of excellence in diagnosing what patients want... **there are wide gaps between what patients want and what doctors *think* patients want**

Nigel Mathers argues that an important first step is to get clinicians to **recognise that there is a problem:**

> One key issue is that many doctors already feel that they are delivering patient-centred care – unfortunately that is not what patients report.

And **Sue Roberts** argues that it is crucial to engage with how clinicians think and feel about co–production. She points to a series of failed attempts to 'train' clinicians to adopt new, patient-centred approaches in the past:

> When system components such as sharing test results with people before the care planning consultation were introduced without addressing the fundamental **philosophy** of the programme and the **mind–set** of staff, this proved ineffective in engaging, empowering or activating staff

Najabat Hussein, a GP from Stockport, lists some of the barriers and concerns colleagues have raised, but stated that:

> I have no easy short-term answers, but I have found that spending time to allay each fear and tackling the governance issues as well as demonstrating long-term benefits has helped to convert some of my clinical colleagues.

Professional appraisal and re–validation systems need to pay more attention to the ability of healthcare professionals to activate patients, particularly those who have low levels of health literacy, argues **Chris Drinkwater.**

Chris also suggests a that doctors should work more closely with and learn from the **voluntary and community sector** in order to better understand the needs of patients and

what the sector has to offer. In particular he sees a role for local people with long-term conditions as peer support workers, health champions, link workers, navigators and health trainers at local and neighbourhood level. However, **Mark Platt and Amanda Cheesley** argue that such initiatives will flounder if we fail to invest in **primary care** and specifically the role of nursing, which continues to be the main point of contact for people with long-term conditions.

Changing organisations...

It is important not to underestimate the challenge of changing culture in the NHS. Indeed, according to **David Dawes** the main difficulty is that Boards operate according to a **short-term command and control mentality**, but fail to make any real inroads into the culture of clinicians. Furthermore, he argues that front–line innovation is often quashed by managers who are responding to targets and short-term financial measures and reporting pressures:

> Senior medical staff...will have a dozen different Chief Executives and even more Boards throughout their career and can simply outwait any new top down initiative of new management programme that they do not support, particularly if they use their extensive networks to slow it down.

So, is culture change impossible? Not according to **Lynne Maher,** who points to **skill development** as a good place to start:

> Staff particularly need to be supported with new skills. This includes listening, not for symptoms to link with a particular diagnosis, but listening for new insights, new ideas and expertise that patients bring, not only from their experience of healthcare, but also from their own life/job skills in whatever form.

How services are commissioned and evaluated can also change in ways that promote co-production. **Paul Jenkins** points to the need for:

> Commissioners to work proactively in managing the market in a way which eases transitions and facilitates the arrival of new market entrants. One important strategy is to work with service users and carers at the collective level and not just see co-production as a manifestation of individual choices and preferences.

Beverley Collett calls for:

> Commissioners... to work proactively with people in pain and with professionals, to ensure that co-production can occur as a positive and enhancing step for every patient.

Stewart Mercer points to the importance of clinical teams working together *as* **teams**:

> No man is an island and staff work in teams and teams have leaders and managers and all of these people must be signed up for true co–production. Both staff and patients will need to go the extra mile.

And **Jim Thomas** argues that we need to look beyond clinical teams or even services to ask how practitioners can work together **across organisational** and **professional boundaries** in order to achieve co–production:

> If we spent less time inducting people into a particular professional group and more time examining the skills that individual workers require to deliver the right local outcomes we may find that co–production happens naturally.

Cat Duncan–Rees draws from her experience of co–production in Stockport to argue that new forms of facilitation and conversation are required both across existing organisational boundaries, and also within organisations, if co–production is to be scaled.

Kate Michi Ettinger, highlights a number of examples of **organisational change**, made possible through new types of curriculum and teaching, new ways for clinicians to work

with the community, and the use of a range of online tools that enable patients to engage with both their peers and clinicians in unconventional ways.

Don Redding, thinks about how to capture the value of co-production, through **business cases**, and other forms of social value and the importance of translating this into policy and practical action. He also argues that it is crucial to make the case for change on a number of fronts, including to commissioners, patient groups, clinicians and research organisations.

Conclusion

Working with rather than doing to…

Co-production **competes** against many other policy terms and concepts. Indeed, a number of contributors felt that the term was too **technical** and impersonal, and preferred phrases such as shared care or partnership. For others, co-production was important, because it explicitly valued the work doing being by the patient in **producing** their health outcomes. Clearly, for some people the term co-production served to open up new possibilities for practical action, for others it acted as a hindrance. It was noted that arguments over language reflected the reality of a health service in flux, and emerging conflicts between the bio-medical model and the aspirations and desires of patients.

There was overall agreement that co-production was about a new set of relationships with patients, new forms of practice from clinicians, and new forms of organisational change. None of this is easy to achieve and there was a realisation that co-production continues to be the exception rather than the norm, isolated to small pockets of practice. For this reason, a number of contributors argued that **systemic change** requires work on a number of fronts. This has to include working with clinicians to engage with how they think and feel, and the culture of the teams and organisations that they work in, as well as the introduction of tools, methods, and strategies to shape practice and organisational culture. Co-production needs to be promoted at all levels in the system; from top down policy and Health and Well-being Boards, to networks of radical clinicians and, of course, demand from patients for co-production with their clinicians.

Contributors highlighted a number of practical solutions such as the CARE approach, Care Planning, Year of Care and learning from the Health Foundation's Co-creating Health programme. It was also clear that there is plenty of scope for more radical innovation and experimentation, learning from international examples, and supporting existing and new health providers with cultures, models and metrics.

Creating a co-productive workforce and culture is an ambitious and complex endeavour, but we hope that the ideas presented here, based on the accumulated practical experience of the authors, will support further innovation and impact in this field.

Next steps…

Working for co-production is one of a series of products which will include further insights from People Powered Health and other practical tools and methods for practitioners and policymakers.

If you would like to join in this discussion about workforce and culture for co-production you can get in touch on **pph@nesta.org.uk**; or you can tweet at #PPHealth.

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