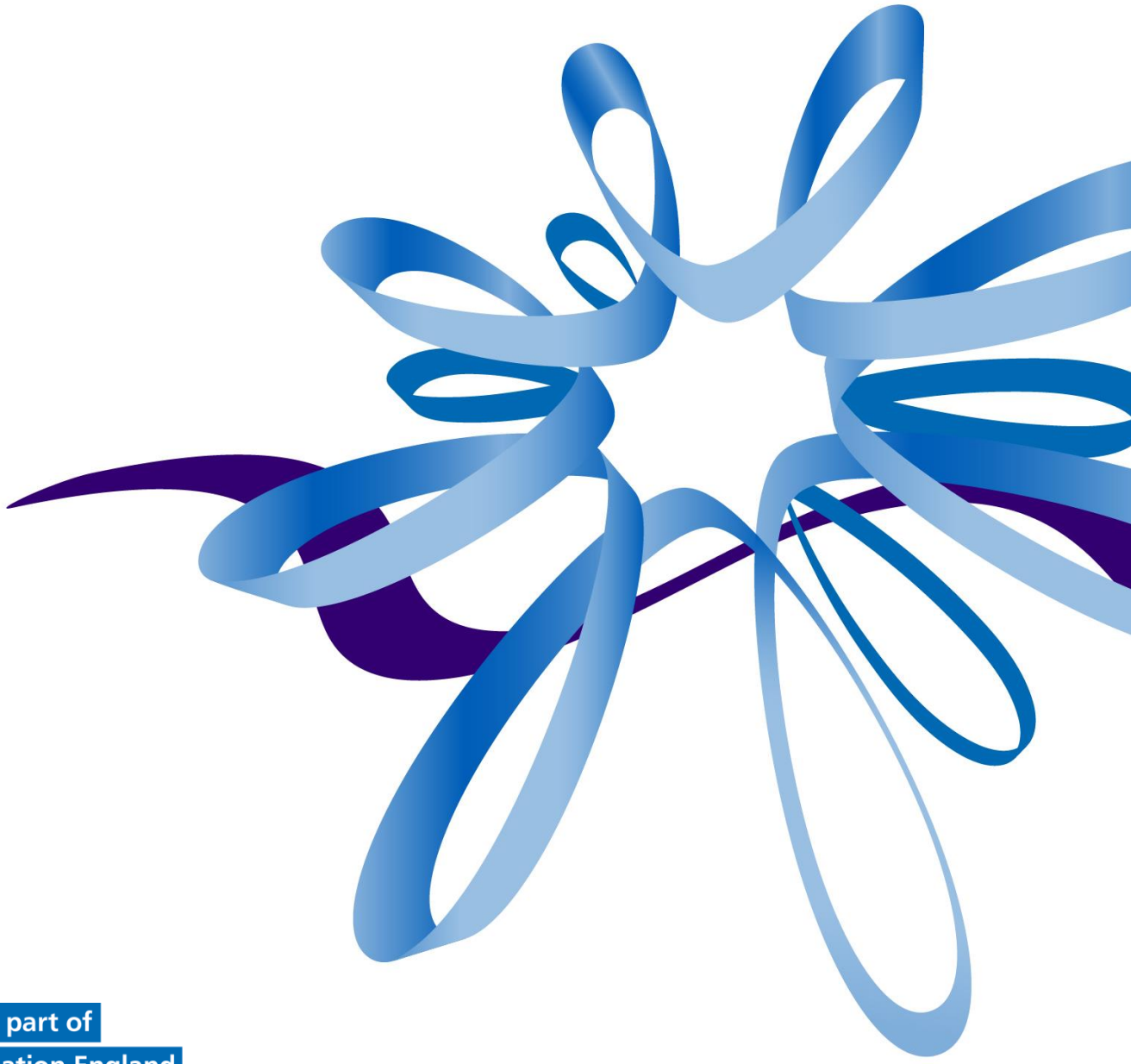
NHS
Leadership Academy

Personalised care, co-production and strong communities– a primer



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Background and context

The Leadership Academy has commissioned a project to explore how it can maximise the potential of 'people power' through its work, ensuring that participants in its programmes are equipped to work in co-production, across boundaries, and focus on health creation and community capacity, not just how to lead services or organisations.

This short primer sets out the theory and context around community development and co-production and what this means for NHS leaders and leadership development. Recommendations from the project will build on what's already working well across the country and highlight opportunities for change, in order to build an even stronger Academy offer into the future.

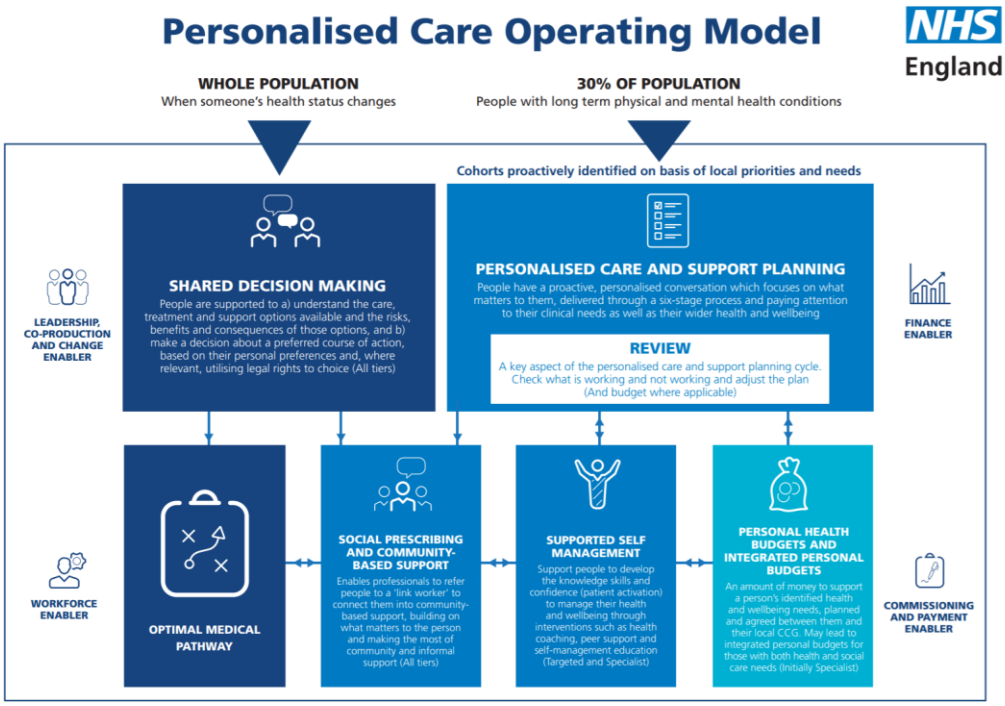
What is personalised care?

Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out the recently published Long Term Plan. The plan signifies an intention to 'roll out' personalised care to reach two million people by 2023/24 and to double that again within a decade.

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. Personalised care means a new relationship between people, professionals and the health and care system. It provides a shift in power and decision-making that enables people to have a voice, to be heard and be connected to each other and their communities.

Personalised care takes a whole-system approach, integrating services around the person including health, social care, public health and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers and the voluntary sector. For many people, their needs arise from circumstances beyond the purely medical, and personalised care is a means to support them by connecting them to supports in their communities.

The NHS will be expected to adopt the operating model as follows:



The Long Term Plan sets targets for personalised care including:

- 200,000 people will benefit from a personal health budget by 2023/24
- 1,000 social prescribing linkworkers will be in place by the end of 2020/21, rising further by 2023/24, ensuring 900,000 people are connected to their community to improve their health and well-being
- A roll out of training for front-line staff in shared decision-making and care and support planning.

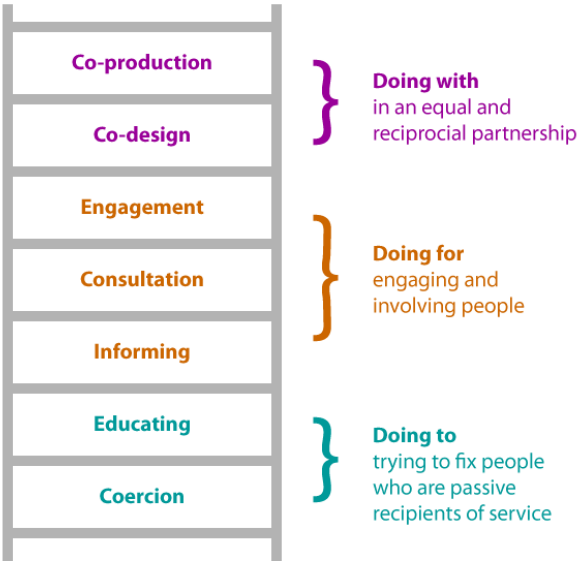
What is co-production?

The word 'co-production' was first used in the 1970s by Elinor Ostrom, an Economist at Indiana University to explain why crime rates rose when police stopped walking the beat and started patrolling in cars instead. The relationships that police developed with people and the informal knowledge that they exchanged with the community when they walked the beat were critical in preventing and solving crimes. She argued that the police need communities as much as communities need the police in order to increase community safety, and used the term 'co-production' to describe this relationship.

Co-production was defined more recently by Nesta, the New Economics Forum and the Innovation Unit in 2012 as: 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.' The report stressed that public services and neighbourhoods become far more effective 'agents of change' when they work together.

Co-production in the true sense is more than just consultation or involving people as consumers of services. It is not another word for 'patient and public involvement' or volunteering. It is not about professionals or organisations working together (though the term is often misused in this way to describe partnership working). It is not about inviting people into professional meetings as a 'representative' or just to tell their story. It means a genuine partnership between publicly-funded services and those that use them.

The ladder of participation (this version taken from the Think Local Act Personal (TLAP) website) shows the difference between 'patient involvement' and genuine co-production. As you move up the scale there is potential to move from surface level, one-way engagement to having a more profound and radical impact on systems and places and ultimately people's health and wellbeing.



See here for examples

In practice, co-production means involving people with lived experience as equal partners in all aspects of commissioning, service design and in the way services are delivered.

At a 1-2-1 level that means ensuring that person-centred conversations happen, and that people with long-term conditions have the opportunity to co-create a care and support plan with someone from their GP practice – often a nurse or in the future, asocial prescribing linkworker. These conversations start with the question, 'What matters to you?' not, 'What's the matter with you?' This happens in some places but not everywhere. The number of people satisfied with their involvement in decisions about their care has remained static for many years – about a third of people want to be more involved.

At a strategic level, co-production means having people with lived experience on decision-making groups and sharing power with them. Done properly this means building capacity and support for a wide range of people to participate and ensuring that they are representative of the local community.

Co-production also means working at a community level and engaging with what matters to local people, through community development.

What is community development?

Community development is the practice of working with people at a neighbourhood level to recognise and develop their ability, potential and power to make change happen for the greater good. Done well, it strengthens the capacity of local people and groups and that of local agencies - private, public and voluntary - to deliver things that matter to people and build local resilience and wellbeing, growing trust and relationships at a local level from the ground up.

Asset-based community development (ABCD) further defines the practice as 'building on the strong and not the wrong,' by facilitating conversation and effort framed around the strengths and assets in a neighbourhood or place, rather than bringing people together to solve a problem.

Community 'assets' that exist in an area, adapted from the ABCD Institute definition include:

- The skills, knowledge and interests/passions of local people
- The range of local informal groups, clubs and networks and their collective reach
- The resources – staff, money, connections and power - of public, private and non-profit institutions
- Public space and buildings, housing and economic productivity
- The shared stories, culture, history and heritage of local places.

In practice, community development means ensuring there are conversations with people at a neighbourhood level, asking questions such as, 'What makes this a good place to live?', 'What do people and the community do to help each other or improve things around here?', 'What helps us feel independent/in control/in good health?', and 'What would make a good life for you round here?', 'What skills and talents do you have that (could) contribute to making this an even better place to live?', 'Who else do you know who would be useful to talk to round here,' and 'Could you help us by asking a few people these questions too?'

The questions aren't part of a 'consultation' that is communicated out. ABCD starts with a skilled community development worker identifying the 'connectors' in an area. Connectors are found by door knocking, asking people in the street and being in the neighbourhood. The paid worker plays a role of convenor/host/facilitator/navigator and works with the connectors to shape a project and conduct the asset-mapping. Once this is done and a convening group is formed and functioning, themes can be identified for collective action and the magic starts to happen.

Using this approach, neighbourhoods can be turned around, relationships between statutory services and local people improved, health improved, health-creating behaviours and the social determinants of health improved – better diabetes control, more physical activity, increased educational attainment, crime rates reduced, pride, social connectedness, feeling you have a voice – it's about growing and nurturing local social capital for local communities.

Fig 1 – A community 'asset' map - building on the strong and not the wrong. See also https://www.cvalive.org.uk/abcd/our-abcd-projects/new-addington-fieldway-asset#

ABCD in action in Croydon

Local agencies have invested money into community development in Croydon over the past seven years. It is one of the exemplar sites for ABCD practice across Britain. Taking the ABCD approach, Croydon Voluntary Action have been identifying connectors in the community and conducting comprehensive asset-mapping across the borough.

Since the work began in 2011, more than 1750 people have been recruited to speak with others in their community, to find out what interests them, and to make connections and help them set up new activities. More than 208 new community-led projects have been run, some of which have secured funding and some which have been able to operate completely with the time and resources donated by local people and organisations.

37 GP practices now signpost people to community supports and activities that grew out of the ABCD work. The NHS calls this social prescribing, but that's

just the bit you can see on the surface – the conditions were created way before then through community development. GPs now report that community development is lifting a load from doctors. According to the Guardian, in the year to July 2018, there was a 20% reduction in hospital outpatient referrals and a 4% drop in emergency hospital admissions from the Parchmore medical centre, in Thornton Heath, which pioneered the scheme and 30,000 social 'prescriptions' have been made at a cost of £50,000.

See more at https://www.cvalive.org.uk/abcd/abcd-projects-2015-16

Why is this important for the NHS?

At a policy level, the arguments for personalised care, co-production and community-centred approaches have been won. There are not many |NHS staff who would argue against people being involved in decisions about their care. Indeed, many clinicians know that they need to get people to take responsibility and control for their own health. We know that informed, activated patients can get better health outcomes at lower cost (Wagner, 2001). More activated patients are less likely to visit emergency departments, less likely to be obese, less likely to smoke, and less likely to have breast and cervical cancer (Greene and Hibbard 2012). There is also general agreement that peer support and voluntary groups working with and in communities have a better chance of promoting health-creating behaviours than professionals have by just telling people to change their habits.

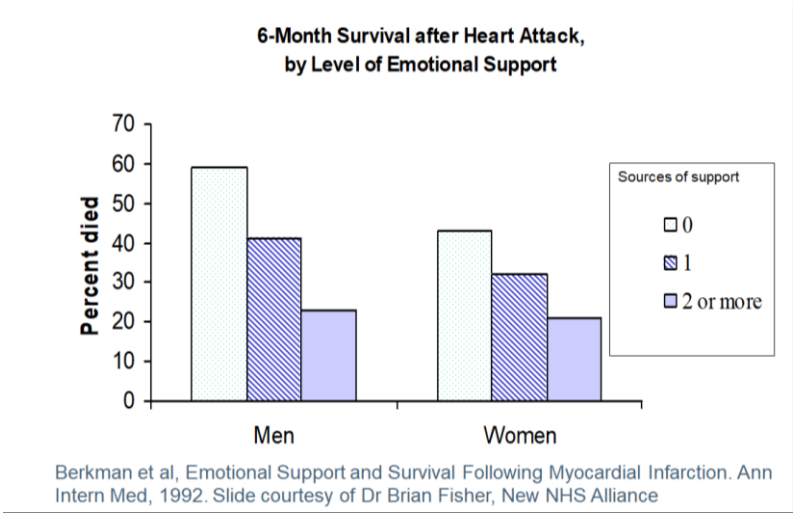
At a policy level, the NHS Long Term Plan makes a commitment to prevention, and a focus on healthy populations/communities as well as a concerted effort to reduce health inequalities. Personalisation runs through the plan, with a commitment to roll out a comprehensive personalised care model, as detailed earlier. The plan commits the NHS to place-based working, through Integrated Care Systems and Primary Care Networks.

Chapter 2 of the Five Year Forward View stated, 'we have not fully harnessed the renewable energy represented by patients and communities,' and stated that the NHS needs to do more to support people to manage their own health, to engage with communities and citizens in new ways and to build stronger partnerships with the voluntary and community sector. It recognised the 'powerful consensus and shared desire' of people across health, social care and the public sector who want to see organisations and services run differently and better for and with the people who use them, and for organisations to work together better, with long-term wellbeing goals for places, rather than short-term financial ones for organisations. These include #socialcare future, the network of Leadership for Empowered and Healthy Communities alumni, NHS Alliance, Think Local Act Personal's Building Community Capacity network and the 3000+ people who have engaged with the Coalition for Collaborative Care (C4CC).

When people have good social support networks, are involved and included in their communities are valued for their contribution they experience better health. Being lonely or lacking social contact and connection can kill you – as much of a risk to your health as smoking 20 cigarettes a day. Co-production and community building are not just 'nice to have' things - they are crucial and often overlooked factors that impact on health outcomes, community wellbeing and the efficiency, quality and sustainability of NHS services. Embedding the principles and practice of co-production and community development into the way the NHS works can reduce demand, save money and enable the NHS to focus on the things that really matter to people.

Why we all need community connections

- Social networks are consistently and positively associated with reduced illness and death rates (Fabrigoule et al 1995, Bassuk et al 1999 and Berkman and Kawachi 2000)
- An international meta-analysis of data across 308,849 individuals followed-up for an average of 7.5 years, indicates that individuals with adequate social relationships have a 50 per cent greater likelihood of survival compared to those with poor or insufficient social relationships, consistent across age, sex, cause of death (Holt-Lunstadt et al (2010).
- People with stronger networks are healthier and happier (Bennet 2002)
- Social relationships can reduce the risk of depression and dementia (Morgan & Swann 2004 and Fratiglioni 2000).



Berkman et al, Emotional Support and Survival Following Myocardial Infarction. Ann Intern Med, 1992. Slide courtesy of Dr Brian Fisher, New NHS Alliance

What does this mean for NHS leaders and the Academy?

If we want healthier, happier citizens who are supported to stay well in their communities and to manage their conditions well, we need NHS leaders to

develop a 'literacy' of community (RSA, 2015). We need NHS leaders now and in the future who can see the big picture and develop common purpose with others around wellbeing, think much wider than the service or organisation in front of them, who are skilled and willing to work with people at a grassroots level, who are prepared to share power, drive transformation, develop others and ensure that co-production and community building become part of the DNA of the NHS.

This involves setting up and leading partnerships for wellbeing, working across boundaries, harnessing social movements and activism, seeking out and nurturing community connectors, building a vision and narrative for change with local people, delivering services collaboratively and in co-production, commissioning with communities, ensuring that resources are spent on prevention and not just on services to treat ill health. Leaders need to prioritise co-production and community development and make it everybody's business.

For more information on the leadership qualities that are needed, see the Leadership Framework for Empowered and Healthy Communities, developed with TVWLA.

There are implications in this for the Leadership Academy. Its aims, actions and the purpose and content of its programmes will need to reflect a 'big picture' focus on wellbeing. This might include:

- Core programme content at all levels around co-production and community, networks, the concept of 'new power', local democracy, host leadership and system leadership
- Leadership skills development in working with large groups and communities, asset mapping, appreciative and participatory approaches, generative listening, better conversations
- Opportunities to build confidence and change agency through place-based projects, secondments and shadowing, partnerships with voluntary sector in delivery and commissioning of programmes
- Ensuring the learning environment reflects and facilitates leaders' development – developing leaders in mixed, multi-sector groups, cross funding and building joint offers with social care, education, local government, housing, police and the voluntary and community sector (making the case that such an approach will improve health outcomes), and opening access to leadership development to citizen leaders
- Co-delivery – ensuring providers of the Academy's programmes delivering the programme in co-production with people who use services, and have facilitators who understand and are skilled in the co-production and community development agenda
- Commissioning differently – opening up the market to include smaller providers and specifying that all providers engage a community sector partner
- Evaluating the impact of programme on local social capital and wellbeing.

Conclusion

Co-production and community development are essential building blocks to community wellbeing and the NHS of the future. The Leadership Academy is uniquely placed to contribute to the agenda by ensuring that the next generation of NHS leaders are community-literate and see the growing of social capital and wellbeing as part of their core mission.

A full report and recommendations will be available at the end of 2018/19. To contribute views and ideas please contact Catherine.wilton@nhs.net .

Catherine Wilton, updated February 2019