

RAISING THE BAR: DRIVING CO- PRODUCTION THROUGH CLINICAL COMMISSIONING

Report from
13 June 2011 Event

Hosted by: NHS Alliance PPI Group, National Voices
and Turning Point



nhsalliance

RAISING THE BAR: DRIVING CO-PRODUCTION THROUGH CLINICAL COMMISSIONING

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Forword

This initiative is the brainchild of the NHS Alliance's Patient and Public Involvement (PPI) Network – a coalition of willing organisations who work together to drive people-centred approaches across the NHS.

Led by PPI Network members Turning Point, The NHS Alliance and National Voices, this report aims to put co-production centre stage at a critical time in the development of health policy .

The pause is over. The modified direction of travel for the NHS and commissioning is emerging. We now need a robust debate about how best to integrate care around the person and their community.

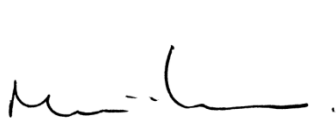
Lord Adebowale, Chief Executive of Turning Point defines commissioning as “the means by which you understand the needs of an individual or a community in order to build a platform for procurement”.

Co-production is very much part of an effective commissioning system. For those who are new to the concept, it is defined as:

“Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change”¹

Co-production can be an important contributing to achieving integration – a key quality marker in health. As our case studies show, co-production not only delivers improved quality, innovation and better outcomes for the individual, the community and the care system – it does so at lower cost² and so is an essential element of the delivery of Quality, Innovation, Productivity and Prevention (QIPP) across the NHS.

Over the next twelve months as the newly formed clinical commissioning groups (CCGs) work with their partners and residents to develop a shared vision of the future they plan to create, we hope that this report and the ensuing work programme will inspire CCGs to put co-production at the core of that vision.



Dr. Michael Dixon
Chair
NHS Alliance



Lord Victor Adebowale CBE
Chief Executive
Turning Point



Jeremy Taylor
Chief Executive
National Voices

¹ Boyle, D, and Harris, M. (2009) The challenge of co-production: how equal partnerships between professionals and the public are crucial to improving public services. NESTA, London.

² Turning Point (2010) *Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care* <http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Documents/Benefitsrealisation2010.pdf>
Bauer A Fernandez J Knapp M & Anigbogu B (2010) *Economic Evaluation of an "Experts by Experience" Model in Basildon District* London School of Economics at http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Documents/Basildon_LSE_Report.pdf
Turning Point (2010) *Citizen Advisors: Linking Services and Empowering Communities* http://www.turning-point.co.uk/commissionerszone/centreofexcellence/Documents/Citizen_Advisors_Final_Report.pdf

Background

This report is the output from a half day policy workshop chaired by Lord Victor Adebawale CBE, Chief Executive, Turning Point held in June 2011. The event was supported by NHS Alliance and National Voices and by The Department of Health (DH). Policy leads from across DH and other government departments came together with GP organisations, the voluntary sector and NHS leaders to consider how we encourage clinical commissioning groups (CCGs) to engage and reach out to communities in the face of so much uncertainty and how by supporting the new commissioning community to learn new behaviours and skills, we can now scale up and leverage the full benefits of co-production approaches.

Workshop participants are listed and their valuable contribution acknowledged on pages 11 and 12.

The decision to set up this event was built on two premises:

1. Policy makers from across Government need to work more closely together and formulate policy in a joined up way that supports clinical commissioners with partners such as local authorities, education and police to drive co-produced care.
2. If clinical commissioners understand the benefits and adopt a joined up co-production approach to commissioning and service delivery that sees local communities as an asset and an integral part of service provision and health improvement, clinical commissioners could lead significant system change and have a profound impact on outcomes and cost.

As well as being part of the solution that will deliver unprecedented efficiency savings - through QIPP (Quality, Innovation, Productivity and Prevention priorities) in health and Best Value in local government - we know that community development approaches and co-production is an effective way to tackle health inequalities and improve, most especially, mental well being by building and reinforcing social networks that reconnect people.³ This is one of the most enduring challenges the NHS, local government and policymakers face.

We are aware of the size of the challenge ahead. Enabling and scaling up co-production means sharing power between statutory bodies and local people and communities. This challenges deep set cultural norms; and yet it is also the big prize.

Within the NHS it is also a necessity. Supporting people to take control over their lives so they are less reliant on formal health and related services is the only way that we will ensure the survival of an NHS free at the point of delivery. Otherwise, the NHS will collapse under the strain of the future demands people will place upon it, as Wanless and others have predicted.

Our work draws inspiration from the stories of communities who have experienced working with co-production and community development approaches and who have successfully delivered significant improvements in health and well being outcomes as a result (presented in this report as case studies). We have considered how to overcome the biggest barriers to mainstreaming co-production and devised some very practical solutions.

As a next step, those present and NHS Alliance, Turning Point, the National Voices, the Royal College of General Practitioners and the Local Government Association are keen to move beyond ideas and into action. We want to stimulate debate:

- at Government level about how to create cohesive, integrated policy thinking to support co-produced solutions in neighbourhoods to improve health and well being; and

³ Jenkins, R., Meltzer, H., Jones, P., Brugha, T. and Bebbington, P. (2008) 'Mental Health and Ill Health Challenge.' London: Foresight & Morgan E and Swann C (2004) Social capital for health: Issues of definition, measurement and links to health. London: Health Development Agency.

- at local level about how new local commissioning partnerships can create a shared vision of future care and support co-produced services, designed and delivered with local people.

There is good evidence that co-production works for communities to foster health protection⁴, tackle health inequalities⁵, promote behaviour change⁶ and promote effective patient and public involvement⁷⁸. Today's challenge is to scale up the co-production approach in health and to harness the opportunities offered by the current changes in health commissioning. We want to encourage clinical commissioners to work with their partners and communities to work together on a journey where co-production in health is 'the way we do things around here'. This aligns with the remit of the NHS Commissioning Board which will "promote innovative ways to integrate care for patients".

To meet this challenge, we have identified four big things that need to happen very soon. They are:

- creating local community resources;
- changing culture and behaviours;
- joining up planning through Health and Well Being strategies and the JSNA; and
- building evidence, transparency and accountability to communities

⁴ Capability and Resistance: Beating the Odds. Ed M. Bartley UCL Department of Epidemiology and Public Health on behalf of the ESRC Priority Network on Capability and Resilience. (2003 – 2007) Project number RES-337-25-0001 W: www.ucl.ac.uk/capabilityandresilience

⁵ *Am J Public Health*. 1997 Sep;87(9):1491-8. Social capital, income inequality, and mortality. [Kawachi I, Kennedy BP, Lochner K, Prothrow-Stiith D. http://www.ncbi.nlm.nih.gov/pubmed/9314802?dopt=Citation](http://www.ncbi.nlm.nih.gov/pubmed/9314802?dopt=Citation)

⁶ <http://guidance.nice.org.uk/PH9>

⁷ The Challenge of Co-production. Discussion paper Boyle D. NESTA Dec 2009

⁸ LinkAge Plus: Capacity building – enabling and empowering older people as independent and active citizens Martin Willis and Robert Dalziel Department for Work and Pensions Research Report No 571

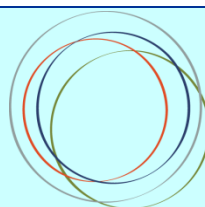
Creating local community resources – place-based budgets

Joint working is best supported by well defined, people-centred outcomes and aligned resources and accountabilities. We want to experiment and explore the value of creating shared resources and joint budgets as the rule rather than the exception.

To date, the focus of joint budgeting has generally been narrow and controlled mainly by statutory organisations. We believe there is an opportunity to push the boundaries of what was previously thought possible; dismantle the silos of funding across Whitehall and create a place-based approach.

We also want to see local communities able to prioritise the issues that matter most to them now and resources aligned to address these priorities. Experience from HELP shows that even where the ultimate goal is to improve health, listening to communities may mean focusing first on issues like anti- social behaviour, crime and on solutions such as creating more facilities and activities to engage people and build social networks across the community. In the long run, this early listening and solving relevant problems leads to improvement in health outcomes..

Case Study 1



Health
Empowerment
Leverage
Project

Helping communities heal themselves

Health Empowerment Leverage Project (HELP) is part of the solution that enables a change towards becoming responsive and flexible health commissioners, local authorities and other service agencies.

It provides an accelerated form of community development and achieves significant outcomes swiftly. Consolidating 15 years of experience across 6 deprived rural and urban estates, HELP focuses on the issues that matter most for local residents so that agencies work together to deliver more responsive services through resident-led partnerships.

A facilitator leads the residents and agency staff through a seven step programme called C2 <http://www.healthcomplexity.net> - the HELP field work model of choice.

These are some of the outputs achieved through HELP within one year in Dartmouth (Townstal):

- a new dental service established;
- a derelict area - the estate's only central open space - transformed into a play park;
- well attended social events and football sessions held regularly;
- relations with the local housing associations improved and tenants more satisfied;
- summer holiday activities for all ages put in place;
- anti-social behaviour reduced;
- a plan for social renewal through further activities agreed;
- community partnership provided citizenship lessons at its community college;
- youth community forum established; and
- new weekly community 'hub' for activities at community hall created.

A review of the longer term effects of a C2 project run on the Beacon Estate in Penwerris, Cornwall found major improvements between 1995 and 2000 in education, health, employment and crime^{9 10} Attempts to substantiate these statistically remain uncertain since numbers were small and chains of cause and effect complex, but improvements appeared to outstrip National trends at the time.

⁹ Stuteley and Cohen, 2004

¹⁰ Durie et al, 2004

Comparable results have been seen in Balsall Health, an estate in Birmingham that independently developed a similar method¹¹.

www.healthempowermentgroup.org.uk

Systematising HELP through training

HELP continues to run a small number of local projects directly and provides training based on the C2 7-step method to enable local people - both lay and professional - to apply the system in their locality and link with the growing network of HELP and C2 projects.

We would like to test this new approach to community led budgeting in a small number of areas where there is existing capacity in the community and supportive statutory bodies who recognise the benefits of the co-production approach. We also would like to see health fully integrated into existing place initiatives, including Local Integrated Services and Community Budgets.

These new generation pathfinders need to test and share learning about a system that looks like the next stage in the evolution of public services; a world where communities are supported to heal themselves; address what matters most and instigate and drive change in partnership with responsive, supportive local statutory bodies and services.

This integrated community resource would change the incentives for providers and push the boundaries of what has previously been regarded as possible. Pilots would have the specific purpose of testing how having integrated resources facilitates community development and provide a fertile ground for co-produced services.

If it works, there will be a very big win. If it fails, we can learn from it.

We believe that organisations like those involved in this work have a key leadership role to play in calling for 'total community resource' pilots of this kind. We recognise that there would also be important roles for local professional and statutory organisations to help bring down barriers.



¹¹ Atkinson, D. (2004) *Civil Renewal, Mending the Hole in the social Ozone Layer*. Studley, Warwickshire, Brewin Brooks

Changing culture and behaviours

Clinicians explained in the workshop that they are sometimes nervous of asking people what they want. They fear opening a 'Pandora's Box' of need and raising expectations that they will be unable to meet. Primary care clinicians have been trained almost exclusively to deliver care through face to face work. Group support and community led approaches are new to many.

Most GPs regard themselves primarily as providers of care. If GPs can be supported to change the way services are delivered within their own practice, it may change the mindset about commissioning and have a broader impact on the health system too.

An example of this might be group consultations in general practice where the clinician becomes a facilitator who supports a group of patients to work together to improve their health. This requires a shift in the balance of power as the clinician supports the group to help themselves and others like them. Pathfinder Healthcare Development (PHD) is working with its local GP practices to systematise group consultations. Spreading this approach more widely could prove a powerful driver of cultural change in general practice.

Case Study 2



Rewriting the book on primary care

Pathfinder Healthcare Development (PHD) has rewritten the way primary care services are delivered at Smethwick Medical Centre, a GP practice in the West Midlands.

Among a long list of initiatives, they have introduced risk stratification across the patient population, Signposting resources, self assessment tools, a responsive triage process and group consultations for specific long term conditions. The centre has been working with Pathfinder and Aetna Health Services UK on a care management programme to improve patients' confidence, compliance and self care. This service seeks to ensure patients see the right person at the right time in the right place, to take care to patients on their terms, and to promote self management. The model moves away from dependency on health professionals. These and other interventions have already started to reduce use of secondary care services.

Pathfinder is a community interest company (reinvesting its profits for social good) owned by the Smethwick Medical Centre. It raised £200,000 to support the care management work in the form of a loan from social investment fund Big Issue Invest - the fund's first ever loan in the health sector. The Smethwick GPs used the mortgage on their building to underwrite the loan. This enabled Sandwell PCT to invest in a number of Pathfinder initiatives.

Total investment has been over £500,000 to date, with Pathfinder anticipating a full return on investment after five years. Financial modelling over the coming years indicates roll out costs of £3m and net benefits of just over £6m, with the potential for even greater savings when the care management programme can be geared up to reach across the whole of Sandwell.

The programme and company have been recognised for their inspirational proactive and strategic approach; its focus on disease areas and the whole patient - and its investment in workforce and competency development.

We would also like to see an explicit strategy, led by RCGP, NHS Alliance, Turning Point, National Voices, LGA and others - and supported by policy makers across the board to create a social movement amongst clinicians towards co-production. This requires a compelling narrative that engages the hearts and minds of clinicians and explains 'what is in it for me?'. We believe this narrative will have three key elements:

- Patient stories of how co-produced solutions have changed individual's life and health;¹²
- Hard outcomes data from existing best practice that shows the tangible benefits and cost savings co-produced solutions deliver¹³; and
- Great information systems and data at practice level that enable clinicians to quantify the benefit – in their own practice and the wider community – of investing in co-produced services.

Many of these things already exist. They just need to be brought together as part of a focused, integrated change programme to embed co-production as a key part of the solution in the minds of general practitioners and clinical commissioning partners.

We also recognise that strong clinical leadership within the profession is key. We want to nurture a group of inspiring clinical leaders who will help us to recruit people to the idea and practice of co-production. Pathfinder clinical commissioning groups will be an important source of leadership and the opportunity exists to use the planned pathfinder programme to drive this change.

Finally, we recognise the power of financial incentives in changing provider behaviour. We believe that the current capitation based remuneration system in general practice provides a strong incentive for GPs to support self care and co-produced services that foster reduced reliance on formal services like their own. The same is not yet true of the financial incentives driving secondary care provider behaviour in the NHS.

The current changes mean that there is the opportunity for CCGs to join with other commissioners and local communities to introduce new and compelling incentives for secondary care providers work to integrate services and support community resilience. For instance, what if CCGs only paid hospital trusts if a recognised list of 'frequent flyers' remained well in the community and paid nothing when they were admitted as an emergency? How might such an incentive change secondary care provider behaviour?



Pathfinder volunteers demonstrating Tai Chi

¹² http://www.healthcomplexity.net/content.php?s=c2&c=c2_main.php

¹³ http://www.healthempowermentgroup.org.uk/files/project_papers/help_literature_search.pdf

Joining up planning through health and well being boards and the JSNA

In the drive towards co-production, we believe that joint strategic needs assessment (JSNA), the work of Health and Well Being Boards and their commissioning approach will be key. As well as being a technical process involving data collection and analysis, completing the JSNA is also a driver for behaviour change and a platform for community engagement. We believe that CCGs will be open to and welcome information that paints a rich picture of their population.

We want to see the JSNA becoming a reflection of people's lived experience in the local community. The JSNA should build a vision for the future and involve the community from the outset and at every stage so that local people take and feel ownership of it and so that it provides all stakeholders with a common, shared purpose. The ultimate goal would be that commissioners work with communities to co-produce the JSNA.

To ensure full engagement, there is a need to educate both health and well being commissioning partnerships and local people (including the community and voluntary sectors) about the potentially key role the JSNA can play in driving local public service development.

By redefining the JSNA process as a vehicle for community engagement, we ensure that all important groups have a voice in its development. We would like to see two or three health and well-being board pathfinder areas working to create 'gold standard' co-produced JSNAs and share their learning.

We also see the JSNA as a chance to identify what is already happening that is contributing to improvement of health and well being. It is essential that we build on what is already happening within communities. By evolving the JSNA into a map of local community assets, it ensures that commissioners spot opportunities to support existing and fledgling co-produced services. This will open commissioners' minds about the range of potential providers and help them to nurture innovation through co-production.

It is also essential that public health and other relevant data is used to its full potential to inform commissioning and the JSNA. Key to this is ensuring that organisations share data freely. This requires a cross government push to improve data sharing.

Case Study 3

Connected Care



Connected Care in Hartlepool

Turning Point have delivered Connected Care, their model of community led commissioning, in 11 places since 2006. The first pilot was in Owton ward in Hartlepool. Owton is a community of 6,757 people and 2,905 households predominantly living in social housing that is within the 5% of most deprived neighbourhoods nationally ranked according to the Index of Multiple Deprivation (IMD). There is a strong sense of community and a thriving voluntary sector in Owton with residents' associations and community organisations delivering a range of services. The Connected Care project set out to build on this existing social capital and resilience to improve health and social care outcomes for local people.

Community Researchers were recruited from the local community supported by Turning Point and local agencies. 251 local residents participated in an audit via one to one interviews, focus groups and a community “have your say” event.

The results of the audit informed the development of the Connected Care service that is delivered through a local community social enterprise, incorporated as a Community Interest Company. The service includes: a navigators, a debt and benefits advice service, support for older people to stay in their own homes for longer, supported housing for young people as well as a gardening and handyman service. The service includes a time bank to utilise the skills of local residents and co-ordinate volunteering between local people. There is also a Benefits and Welfare Advice service. Connected Care is now managing 32 flats in Glamis Walk that are owned by Accent Foundation. On the back of the success of a pilot of Connected Care management and tenant support, Accent have now refurbished the whole estate and have commissioned Connected Care to manage the whole estate.

This year the Connected Care service is being rolled out across the town of Hartlepool. This builds on the service delivered in Owton ward and community research activity across the town over the last 18 months. This has been led by the Connected Care navigators from Owton, and has identified needs and priorities across the town as well as further building community capacity to develop neighbourhood services. Connected Care is also working with the Council on Welfare Notices – a way for people to log requests for support and services which are then actioned by the appropriate Connected Care service.

The SAILS programme has also expanded from 100 people receiving support to over 500 people benefiting from the range of services – including benefits and welfare advice, luncheon clubs, social activities, gardening and handyman services, and meals on wheels. This service is expecting to triple again the number of people in the SAILS programme over the next year. On the back of this expansion the Council has awarded Connected Care the contract to provide luncheon clubs and reablement support for elderly people leaving hospital across the town.

An independent evaluation has been carried out by the University of Durham in order to assess the effectiveness of the Connected Care service to date. The evaluation concluded that services are now more accessible to the community, take-up of services has improved, a range of needs are being met and people are less likely to disengage with the system.



The Connected Care Team in Hartlepool

Building evidence, transparency and accountability to communities

We believe that it is essential that we communicate the evidence base for co-production in line with what matters to the NHS. This means describing health outcomes and impact on e.g. readmission rates; clinical indicators that indicate good control in long term conditions etc. We need to measure the impact of co-produced services in these areas.

We also see transparency as essential. We believe that all providers and commissioners need to operate so that everyone including local people can judge services based on evidence of cost effectiveness. This needs to cover both commissioning and decommissioning decisions.

Ultimately, we want to see inclusive and diverse local communities holding commissioners and providers to account. This process will need to incorporate and be consistent with equality requirements, including the Equality Delivery System for the NHS. We believe this could be achieved by moving towards 'community created quality accounts' within health where the community defines what quality means and providers are held to account for delivering against these standards.

We see Health and Well Being Boards as key assets in driving evidence-based approaches. We want to see them focusing on doing a small number of really difficult things well. Making a big impact in these few areas will be really valuable. We would like to work with the Health and Well-Being pilots to explore how they can drive co-produced solutions.

Conclusion and next steps

This report contains some very concrete next steps that can be taken to drive and scale up co-production in health:

- Creating local community resources by developing place-based approaches to resources and budgets that cover the full gamut of public services within a community.
- Changing culture and behaviours in the NHS by supporting GPs to work differently in their practice; by supporting clinical commissioners to work with partners and communities to develop co-production; and by creating an effective communications campaign that helps commissioners understand in respect of co-production – “What’s in it for me?”
- Joining up planning with and in communities through Health and Well Being strategies and the JSNA by creating accessible examples of best practice in informing commissioning.
- Showing commissioners and those co-producing services the power of collecting and building evidence based practice; of being transparent; and how encouraging accountability to communities can help put co-production and community development to work .

We, the NHS Alliance, Turning Point and National Voices, look forward to receiving feedback about how we can work together with Government and local and national stakeholders to take this agenda forward.

Attendees at Co-Production for Health and Well-being in Communities and Commissioning – held on 13 June 2011

First Name	Surname	Job Title	Organisation
Victor	Adebowale	Chief Executive	Turning Point
Sally	Brearley		
Gemma	Bruce	Assistant Director, Connected Care	Turning Point
Jon	Burke	Social Care Advisor	NAVCA
Gabriel	Chanan	GP	
Georgina	Craig	Co lead of PPI Network	NHS Alliance
Mark	Davies	Director, Health Inequalities and Partnerships	Department of Health
Mike	Desborough	Neighbourhoods Policy Team	Department for Communities & Local Government
Nick	Dexter	Deputy Director, Community Budgets	Department for Communities and Local Government
Rosie	Farrer	Public Services	NESTA
Joanne	Fearn	Senior Policy Advisor	Cabinet Office
Jose-Luis	Fernandez	Deputy Director, Personal Social Services Research Unit	London School of Economics
Brian	Fisher	Advisor on Patient and Public Involvement	NHS Alliance
Ed	Garrett	Deputy Director - Commissioning	NHS East of England
Frances	Hasler	Healthwatch Development Lead, Strategic Communications and Marketing Directorate	Care Quality Commission
Peter	Hay	Strategic Director Adults & Communities	Birmingham City Council
Julia	Holding	Programme Specialist – Engagement and Consultation	NHS West Midlands
Deborah	Jamieson	Cross Government Health, Work & Wellbeing Strategy Unit	DWP

Mina	Jesa	Assistant Director, Inclusion and Cohesion	Luton pct
Sarah	Kennedy	Public Affairs Manager	Turning Point
Dee	Kyne	Director	Pathfinder Healthcare Developments
Andrew	Larter	Deputy Director, Local Government & Regional Policy	Department of Health
Freya	Lock	JSNA & JHWS Development Lead	Department of Health
Claire	McEneaney	Projects Manager, People Powered Health Programme	NESTA / Innovations Unit
Ralph	Michell	Head of Policy	ACEVO
Alyson	Morley	Senior Advisor (Transforming Health)	Local Government Association
David	Paynton	Clinical Lead	RCGP Centre for Commissioning
Claire	Philips	Deputy Director, Violence, Social Exclusion, Military Health and Third Sector Programme Health & Inequalities Partnerships	Department of Health
Don	Redding	Director of Policy	National Voices
Gail	Richards	Director, GP Commissioning Development	Department of Health
Hilary	Samson-Barry	Director Statutory Relations	Turning Point
Jonathan	Stead	Royal College of GP's Commissioning Champion	
Jeremy	Taylor	Chief Executive	National Voices
Kathryn	Tyson	Director International Health and Public Health Policy Development	Department of Health
Patrick	Vernon	Chief Executive	Afiya Trust
John	Wilderspin	National Director for Health and Wellbeing	Department of Health