South East Clinical Senate

South East

Clinical

senate

Putting people at the heart of service change

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Edgar Cahn

"No society has the money to buy, at market prices, what it takes to raise children, make a neighbourhood safe, care for the elderly… The only way the world is going to address social problems is by enlisting the very people who are now classified as 'clients' and converting them into co-workers, partners and rebuilders of the core economy."

Maya Angelo

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

Foreword

Co-production is becoming increasingly relevant and manifest within healthcare; planning, design, implementation, review, evaluation and of course research. The National Institute for Health Research (NIHR) and other major national funders of health and social care research require patient and public involvement (PPI) to be meaningful; non-tokenistic, integrated throughout protocols and involving people with relevant lived experience and diversity. The ethical argument for people to be involved in service change is clear; 'nothing for us without us', but PPI and co-production can offer so much more than a means of attaining moral virtue. People with real world experience of health conditions and services, including the family and friends of patients and other carers, form a missing piece of the informational jigsaw required to be able to piece together and complete the picture of what may be the best option for service change in terms of meeting the needs of the end user and other stakeholders. Co-production has been positioned as the gold standard for PPI; requiring equitable power-sharing in decision and other processes related to planning and assessing options for service change. There is no one blueprint for what might work best in a given set of circumstance in enacting co-production. Trial and error has been evidenced as the best way to learn, and no one should be afraid of not getting co-production right every time. We all live and learn. However, much can be learnt from instances where co-production has been carried out. This report provides many valuable and informative cases of co-production in action and what has been achieved as a consequence of enabling people with lived experience to be equitable team members.

S.Markham

Sarah Markham
South East Clinical Senate, Patient and Public Participation Member

Top 10 Takeaways

If you have limited time to read this document, here are the top ten takeaways.

1. Start the conversation early – right at the beginning!
2. Share the power – everyone has valid expertise/experience.
3. Co-production takes time – don't try to 'squeeze it' into an existing agenda.
4. Be honest – we have £X to spend, we must save £Y.
5. Don't have preconceived ideas – we need to do things differently, what do you suggest?
6. There will be resistance – but do it any way. What have you got to lose? And what will you gain?
7. Pay people for their time – in a way that is acceptable to them (ask them!).
8. Go to where people are – don't expect them to come to you.
9. Use people's stories (journeys) to illustrate (map) what the current process is and what it will change to – co-design and co-produce these with those affected.
10. Keep the conversation going – use your community assets!

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1. Introduction

The aim of this report is to provide guidance to systems, local people, and communities to achieve the ambition as stated by the UK government in 'joining up care for people, places, and populations',[1] putting people at the heart of all aspects of healthcare and healthcare delivery.

It is divided into the following sections.

- Background and context
    - Legal duties of the NHS.
    - What is service change.
    - Who clinical senates are and their role in service change.
    - Summary of current NHS England (NHSE) guidance in working with people and communities.
    - Summary of local systems ambition to work with people and communities.
- Complex systems
- Community power
    - Explanation of community power.
    - Case studies of systems utilising community power to improve community health and wellbeing in service change.
- Co-production
    - Explanation of co-production.
    - Case studies of systems utilising co-production to improve community health and wellbeing in service change.
- Conclusion
- Acknowledgements
- Further information, resources, and tools.

[1] Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)

2. Background, and context for this report

The white paper on 'Joining up care for people, places, and populations'[1](2022) highlights people being at the heart of their own healthcare journey.

> 'The storms we have weathered over the past 2 years have been a great test, but also a great teacher.
>
> We have learned, most notably from our world-leading vaccination programme, that we are stronger when we work together and are united in our purpose and resolve.
>
> We have also seen the moral outrage of persistent health disparities, mirroring other disparities in our society, illuminated as never before in our lifetimes. We have been reminded, once more, of the inextricable link between health services and social care.
>
> So, as we recover and level up, it is right that we draw on our experience of the pandemic to bridge the gaps between health and social care, between health outcomes in different places and within society that are holding us back.
>
> This is what our white paper aims to achieve by bringing together the NHS and local government to jointly deliver for local communities.
>
> It sets out a new approach with citizens and outcomes at its heart instead of endless form-filling, unnavigable processes and a bureaucracy which sees too many people get lost in the system, not receiving the care they need. It is the start, not the end, of a new wave of reform which will both put power and opportunity in the hands of citizens and communities and build a state that is sustainable and just.'
>
> [Sajid Javid and Michael Gove, Joining up care for people, places, and populations]

Both the Five Year Forward View[2] and Long Term Plan[3] for the NHS talk about a shift of power to people and communities, with more control over their own health and more personalised care when they need it.

> 'The landscape is changing - The NHS will increasingly need to dissolve traditional boundaries. In effect the NHS will need to manage systems, networks of care, not just organisations and recognise the wider range of community and care and support services as key partners in recovery.'
>
> [Simon Stevens, Five Year Forward View]

There has been a change in terminology over the years from patients and the public to people and communities and both terms are used interchangeably in this report. The report also discusses public services rather than just health and social care services as the problems and potential solutions are universal across public services.

When the NHS and local communities, including Voluntary, Community and Social Enterprise (VCSE) organisations work together, considerable progress is made in reducing health inequalities and other disparities that people living with disabilities and long-term conditions experience. An example of shifting power to people and communities would be co-production as defined:

[2] Five Year Forward View (england.nhs.uk)
[3] NHS Long Term Plan » The NHS Long Term Plan

> "Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities."
>
> Co-production critical friends' group, 2012

The NHS has the following legal duties as set out in the National Health Service Act 2006[4] (as amended by the Health and Social Care Act 2012[5] and 2022[1]) when considering service change:

- Section 242 requires the NHS to make arrangements to involve patients and the public in planning services, developing, and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.
- Section 244 requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees).

Current expectations for systems starting major service change, can be found in the NHS England (NHSE) Major Service Change Interactive Handbook.[6]

Clinical Senates

Clinical Senates work collaboratively to provide a source of clinical leadership and impartial clinical advice to support Integrated Care Systems (ICS) and other stakeholders to deliver the best health and care outcomes for patients, their families and communities at a system and place-based level. The South East Clinical Senate[7] does this by:

- Providing independent clinical advice on major service change to support the NHSE assurance process.
- Acting as a clinical critical friend across the southeast region.
- Enabling leadership development.
- Supporting learning and sharing across systems regionally and nationally.
- Through our strong patient and public partnership model.

With a vision supporting:

- Patient needs, patient choice, and personalised coordinated care.
- High quality, sustainable and equitable healthcare.
- A values-based approach.

Clinical senates are primarily involved in major service change, which would encompass 'substantial development or substantial variation' and aid with the NHSE service change assurance process[8] to provide independent clinical advice, specifically against the clear clinical evidence base

[4] National Health Service Act 2006 (legislation.gov.uk)
[5] Caring for our future: reforming care and support (publishing.service.gov.uk)
[6] Major Service Change Interactive Handbook (2023) - Service Change and Reconfiguration - Integrated Care (future.nhs.uk)
[7] https://secsenate.nhs.uk/
[8] NHS England » Planning, assuring and delivering service change for patients

test and the test introduced in 2017 concerning a reduction in the number of beds provided.[9] However, they are also a valuable resource acting as a critical friend, a sounding board for smaller variations and able to provide independent clinical advice during any part of the life cycle of a transformation programme.

The May 2022 'Addendum to Planning, assuring and delivering service change for patients (March 2018)'[10] considers successful proposals for service change are those that build on the wider considerations of the health and wellbeing needs of their people and communities. Best practice would be to co-design proposals and assessment criteria with patients, the public and other key stakeholders.

As part of the assurance process systems are required to develop a case for change and a pre-consultation business case (PCBC). The case for change and PCBC sets out the systems proposals on the need for the service change, the proposed options and the mitigations for people affected by the service change.

Previous reviews of the cases for change and PCBCs have noted that co-production with local systems, people and communities is frequently limited and often more akin to engagement rather than co-creation.

As part of the review process Senates receive an Integrated Impact Assessment (IIA)[11] which provides evidence for how the proposal will improve inequalities specific for the locality being considered. Frequently the evidence contained within the IIA lists engagement with local populations through on-line, postal or face to face surveys. However, when considering the ladder of co-production (Figure 1) this would fall towards the middle of the ladder – Doing For.

[9] planning-assuring-delivering-service-change-v6-1.pdf (england.nhs.uk)
[10] B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf (england.nhs.uk)
[11] Explanation of IIA from Improving health Together, What is the integrated impact assessment? - Improving Healthcare Together

The ladder of Co-Production

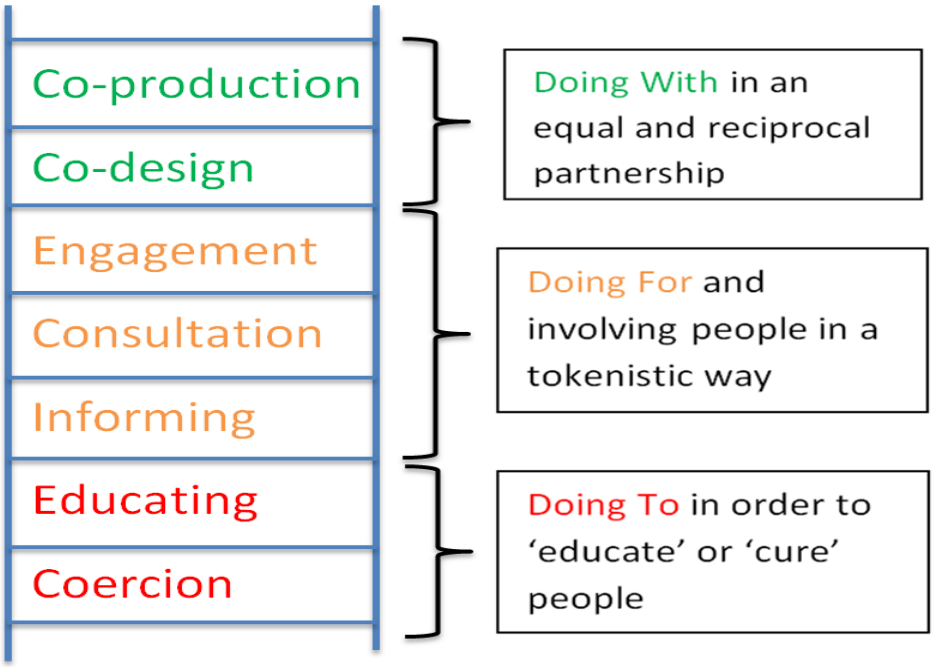


Figure 1[12]

Clinical Senates are ideally placed to facilitate co-production in service change helping both the NHS and people within each region to achieve the ambition of putting people at the heart of their healthcare (Doing With).

[12] What makes co-production different? - In more detail - Co-production - Co-production in commissioning tool - Think Local Act Personal

Summary of current national guidance

In the last five years NHS England (NHSE) has produced statutory guidance for working with people and communities. Originally for clinical commissioning groups (in line with the 2012 legislation[5]) and more recently for Integrated Care Systems and Boards (ICS/ICBs) (in line with the 2022 legislation[1]).

The following principles are found in the ICS Implementation guidance on working with people and communities.[13]

1. Put the voice of people and communities at the centre of decision making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feedback to people and communities about how their engagement had influenced activities and decisions.
3. Understand your communities' needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Health Watch and the VCSE sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight, and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on it.

NHSE also has specific policies on patient and public participation[14] and patient and public voice.[15]

Both these policies set out how NHSE will work with people and communities. The patient and public participation policy explains the ways that people and communities can interact with NHSE and the statutory duties that are placed on NHSE to work with people and communities. The patient and public voice policy sets out the four different roles that patients and the public can adopt when working with NHSE, from contributing to ad hoc surveys and attending the annual general meeting to being part of a group or committee that utilises the person's strategic leadership and accountability.

The NHS England website Integrated Care System: guidance,[16] contains many documents relevant to this report, some examples of which are statutory guidance on involving people in their own health and care[17] and ICS guidance on working with the voluntary, community and social enterprise groups.[18]

[13] ICS working with people and communities
[14] ppp-policy.pdf (england.nhs.uk)
[15] patient-and-public-voice-partners-policy-july-2017.pdf (england.nhs.uk)
[16] NHS England » Integrated care systems: guidance
[17] ppp-involving-people-health-care-guidance.pdf (england.nhs.uk)
[18] VCSE and ICS Partnerships

The ‘2022/23 priorities and operational planning guidance’[19] has a section on delivering more elective care (section c) with part c1 looking at how to improve the delivery of services. To enable systems to achieve this ambition, the guidance talks about a more personalised approach to outpatient follow-up appointments, with an emphasis on patient-initiated follow-up (PIFU). This entails patients being able to decide when they want a follow-up appointment and having systems in place for them to arrange those as necessary.

Some of this guidance has not always been co-produced with people and communities and hence it falls in the middle of the co-production ladder (Doing for). For many people and communities this may be their preferred way of interacting with the NHS. However, the ‘Building strong integrated care systems everywhere – ICS implementation guidance on working with people and communities’[11] involved local government as well as members of the public in its formulation. This guidance includes the 10 principles, as stated on page 10, as well as a ‘what good looks like’ table and practical steps on co-production and it would be beneficial to read in conjunction with this report.

[19] NHS England » 2022/23 priorities and operational planning guidance

South East Integrated Care Boards

The following excerpts are from the southeast systems websites (accessed November 2023), and specifically mention their individual ambitions in relation to working with people and communities.

NHS Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care Board

> BOB ICB is committed to working with patients, the public and other stakeholders to maintain, develop and design services that deliver the outcomes that matter for patients. This includes developing services which are high quality, affordable and sustainable, whilst also promoting self-care and helping people stay healthy.
>
> .....[Cont.] BOB ICB website.[20]

NHS Frimley Integrated Care Board

> We are committed to being an organisation that delivers the best possible health and wellbeing outcomes for people who live within our local communities. This means adapting to new ways of working, ensuring a local focus but with the additional benefits of support, sharing good practice and learning across NHS Frimley and the wider Frimley Health and Care Integrated Care System (ICS).
>
> Working in partnership with people and communities, and our colleagues across the ICS brings a different perspective to our understanding - sometimes challenging our view of how we think services are responding to your needs.
>
> .....[Cont.] Frimley ICB website.[21]

NHS Kent and Medway Integrated Care Board

> When it comes to commissioning services, we know the best results come from working together with our local communities.
>
> | | |
> |---|---|
> | Have Your Say | Community Researchers |
> | Citizens Panel | Involving Medway and Swale |
> | Community Development Model | Kent and Medway Health Network |
>
> .....[Cont.] Kent and Medway ICB Website.[22]

NHS Hampshire and Isle of Wight Integrated Care System

> Hampshire, Southampton, Portsmouth and the Isle of Wight is diverse with a range of different communities, not just based on where they live, with varying experiences of services and different health outcomes.

[20] Get Involved | BOB ICB
[21] NHS Frimley - Get Involved (icb.nhs.uk)
[22] Ways to get involved :: NHS Kent and Medway (icb.nhs.uk)

We know that working together with our communities, we can tackle a range of issues to improve health outcomes and reduce inequalities.

We have a strong history of engagement, ….. To help us do this we have worked with a range of people - members of the public, NHS staff, the voluntary sector, Healthwatch and local authorities, to co-design a Community Involvement Approach (read our full Community Involvement Approach here) for the Integrated Care System.

…….[Cont.] Hampshire and Isle of Wight ICS website.[23]

Surrey Heartlands Integrated Care System

We are proud of the variety of ways in which we work with people across Surrey and of the expanding collaborations we have with our partners in the voluntary, charity and faith sector and wider communities.

Draft involvement principles:
Putting the voices of people and communities at the centre of health and care decision-making, using insight and lived experience
Developing trusted relationships to understand people's experiences and aspirations, particularly those most affected by health inequalities
Building a culture of co-production, insight and involvement across the ICS as 'our way of doing business'
…..
Involving people and communities at an early stage when developing strategies and plans
……..
Working in partnership with local communities to empower people, particularly at local level
Being proactive, going to where people are rather than expecting them to come to us
…[Cont.] Surrey Heartlands ICS website. [24]

NHS Sussex Integrated Care System

Our people and communities across Sussex are at the heart of the NHS; we want to hear from and involve as many people as possible to help us plan and shape health and care services.

There is a history of strong public involvement across Sussex, and many established networks and methods to reach and hear from our population. …[Cont.] NHS Sussex ICS website. [25]

All systems wish to involve their local populations with their plans, statements need to take care not to appear too 'corporate'. It is important co-production language is explicit, and inclusive. Cheshire and Merseyside Integrated Care Board,[26] talk about their local partnerships and how they wish to build on these strengths and assets and is a good example of a different way of working.

[23] Get involved :: Hampshire and Isle of Wight ICS (hantsiowhealthandcare.org.uk)
[24] How we work with people and communities - ICS (surreyheartlands.org)
[25] Get involved - Sussex Health and Care (ics.nhs.uk)
[26] Involving people and communities - NHS Cheshire and Merseyside

For people and communities who would like to start working with their local ICS or ICB, NHS England has a peer leadership development course[27] that will develop the skills to work collaboratively with systems on strategic co-production.[28]

The pockets of excellence report[29] showcases how seven ICS's have worked together to improve inclusion health issues for a small minority of their populations. Both Sussex ICS and Hampshire and the Isle of Wight ICS were part of the seven and contributed to the Inclusion Health Route Map. The route map covers some of the topics in this report from community power and working with local people and communities as well as providing ideas on how to go about these practices.

[27] Peer Leadership Development Programme: NHS England » Peer leadership and video: Peer Leadership Development Programme video - YouTube

[28] NHSE Strategic co-production - NHS England » Strategic co-production

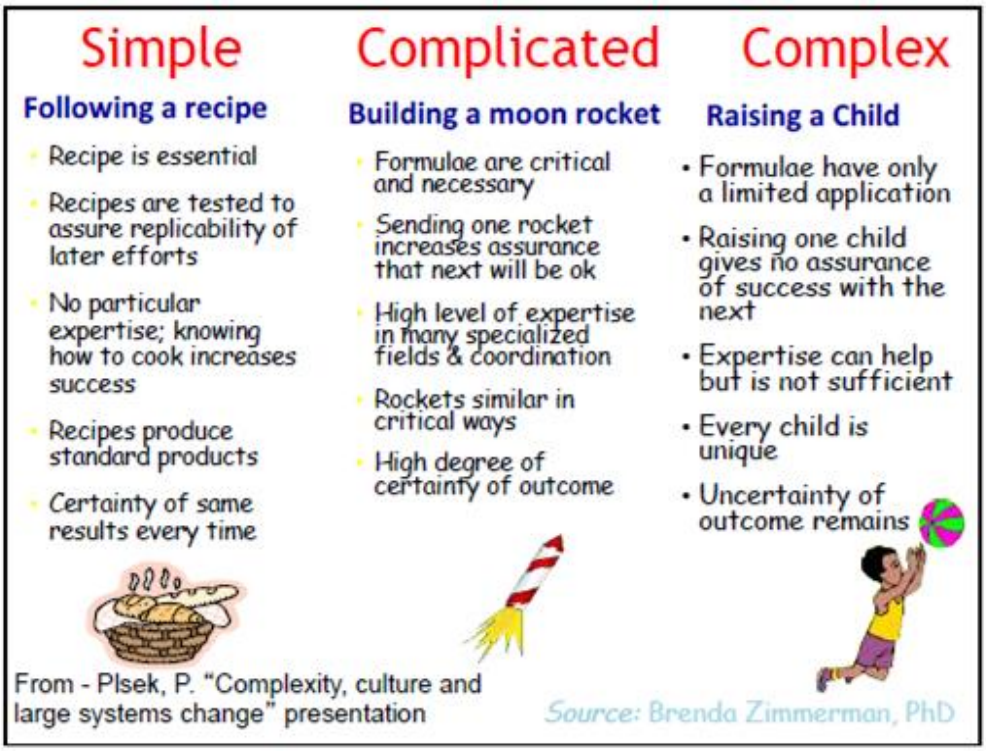
[29] Pockets-of-Excellence.pdf (pathway.org.uk)

3. What are complex systems?

Major service change can be considered as a complex process. It is frequently a once in a lifetime occurrence for the system with the aim of trying to solve issues that have been ongoing for many years.

The definition of a complex system[30] is a system for which we cannot predict with certainty the result of actions, there is no definite cause and effect, and the same actions may produce a different effect each time. Complexity is characterised by unpredictability and interconnectivity, the need for flexibility and adaptation and is underpinned by potentially dynamic relationships. The consequence for leaders and people is the need to be able to work with constant change and the emergence of the challenges such a system produces.

A complex situation is not simply a more complicated one but a very different kind of situation. A workplace example is working with many people and organisations crossing organisational and professional boundaries on issues that keep changing. At home an example is raising a child; the child is continually learning and evolving and exhibiting new perspectives and behaviours. This is pictorially presented in figure 2.



[31]

Figure 2

[30] NHS England » Complexity
[31] From Leadership for Personalise Care, Day 4 slides. Leadership for Personalised Care | Leadership Framework | Programmes for leaders in healthcare, social care and beyond

The other issue is one size doesn't necessarily fit all and the same change that some may consider to be logical and the only thing to do may be considered absurd by others. The co-production trick is to find the common ground. Whilst there is statutory guidance to follow, systems and communities are dynamic and therefore co-production plans need to embrace this fluidity.

Both community power and co-production can aid in understanding the issues created by complex systems and are also part of the solution.

Figure 3 helps visualise, where you are, where you want to be and how to get there.

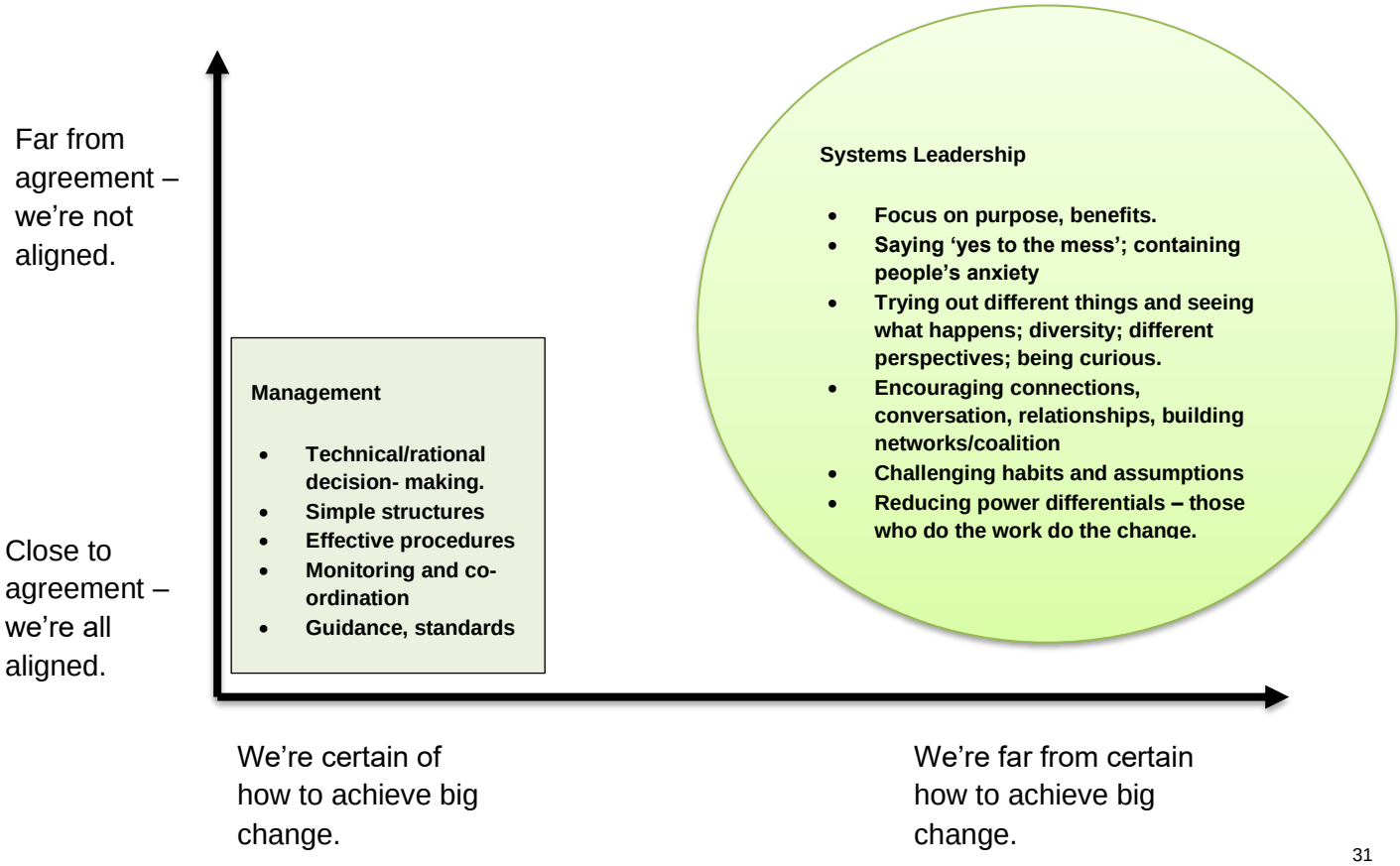


Figure 3

4. Community power

Community power is a phrase coined by New Local, who are a think tank and network of over 70 local councils that believes that local communities should have greater influence and control over the plans, decisions, and public services that affect their lives. It is seen as an alternative to the status quo where big business and the state have the greatest power.[32]

'Community Power - The Evidence' report[33] highlights the impact that giving power to communities can have on the health and wellbeing of the local population.

The Evidence report demonstrates six ways that community power has been found to have real, tangible impact for people, communities, and public services:

1. **Community power can improve individual health and wellbeing.** There are lots of ways people are getting involved in efforts to improve their health and wellbeing. For example: Local Conversations Programme from the Peoples Health Trust,[34] which is trying to improve health outcomes for some of the most disadvantaged people in Britain.
2. **Community power can strengthen community wellbeing and resilience.** Involving people in decision-making processes, resources and social infrastructure enables community action to improve wellbeing and resilience. For example: Building Community: An evaluation of asset-based community development (ABCD) in Ayrshire.[35] Here locally based community builders worked with people to understand what mattered to them, and together they put solutions in place. Self-reported health improved and there was a reduction in the use of prescription drugs, amongst other benefits.
3. **Community power can enhance democratic participation and boost trust.** Intentional and hands-on methods can be used to navigate difficult socio-economic challenges and to reinforce the validity of decision-making. It is at the local level that this dialogue and engagement can be most meaningfully realised. For example: Romsey Citizen Assembly.[36] Here the formation of a citizens assembly enabled Romsey council to realise the benefits the community would get from redevelopment of part of the town.
4. **Community power can build community cohesion.** Community-anchored approaches demonstrate that cohesion is most sustainably built from the ground up, rather than top-down.
5. **Community power can embed prevention and early intervention in public services.** Innovative people in communities and the public sector are coming together to solve challenges and build sustainable services that stop crises from happening and address underlying issues. For example: The Wigan Deal,[37] where healthy life expectancy has improved, smoking prevalence has decreased, and suicide rate has reduced faster when compared to other comparator sites or the NHS England average.

[32] What is Community Power? FAQs, answered - New Local
[33] Community-Power-The-Evidence-1.pdf (newlocal.org.uk)
[34] PHTLocalConvs FINAL_0.pdf (peopleshealthtrust.org.uk)
[35] Final approved Report May 2018 (nurturedevelopment.org)
[36] IiDP_case_studies.pdf (publishing.service.gov.uk)
[37] A citizen-led approach to health and care: Lessons from the Wigan Deal | The King's Fund (kingsfund.org.uk)

6. **Community power can generate financial savings.** There is growing evidence that investing in community power approaches can generate greater impact for existing spend and save money in the longer-term. For example: Whole-Place community budgets.[38]

The Fuller Stocktake report[39] highlights working with people and communities and mentions that primary care networks (PCNs) who work in partnership with people, communities and local authorities were the most effective in tackling health inequalities and improving population health. Fuller explains that these improvements happen through utilising personalised care, genuine co-production and bringing local people into the workforce. A local case study from Surrey Heartlands, 'Growing Health Together', in east Surrey,[40] showcases a place-based approach to prevention and health creation.

Placed based partnerships[41] are collaborative partnerships that involve local councils, VCSE organisations and local health commissioners delivering health, social care and public health services and other initiatives whose aim is to improve the health and wellbeing of local communities. These partnerships are ideally placed to embed their work with people and communities by systematically involving professionals, people, and communities in their programmes of work and decision-making processes. These partnerships were established as part of Sustainability and Transformation Plans and are the foundation of Integrated Care Systems.

Placed based partners can establish a shared understanding of the community's needs, build relationships with all communities, including excluded groups and those affected by inequalities in access, experience, or outcomes, and use continued engagement to measure if partners are improving people's experiences of care and support. This can also include supporting PCNs and neighbourhood teams to work with people and communities to strengthen health promotion and treatment.

Health and Wellbeing boards were established as part of the 2012 legislation,[5] their membership includes political, clinical, professional and community leaders and the remit is to develop joint strategic needs assessments (submitted as part of a case for change or PCBC) and to agree on the joint health and wellbeing strategy for a place. They may have developed approaches to engaging and co-producing with people and communities and could be a first point of contact for anyone wishing to be more involved in this area.

For service change where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, people who use services and carers across health and social care. Partners should ensure they provide clear and accessible public information about the vision, plans and progress of the place-based partnership to build understanding and trust, and to start engagement early when developing plans and feed back to people and communities how their views have influenced activities and decisions.

> **'An empowered community shares the challenges and the opportunities – and finds new and creative ways of providing care and support IF we really know and respect our communities.'**

[38] Case study on integration: Measuring the costs and benefits of Whole-Place Community Budgets - National Audit Office (NAO) report
[39] Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)
[40] About the Programme – Growing Health Together
[41] ICS-implementation-guidance-on-thriving (england.nhs.uk)

'Co-production is about sharing the risk as well as developing solutions - it's about honesty between commissioners, professionals, the services and most of all the users and carers.'

'Let's be ambitious – we invented Beveridge's Welfare State when we had no money, we were recovering from a World War. That in the end gave us permission to think differently.'

[Comments from TLAP's discussions on building community capacity, 2022)[42]

Placing communities at the heart of public health can:

- Reduce health inequalities.
- Engage those at most risk of poor health.
- Empower people to have a greater say in their lives and health.
- Create connected, resilient more cohesive communities.

The following case studies showcase how systems are utilising community power with people and communities to put people at the heart of service change.

Case Study One

Community Powered Edmonton[43]

Background and aim Health inequalities are an indicator of a whole range of other negative circumstances that impact on communities, from poor housing and areas where it is difficult to buy affordable or good quality fresh food, to a lack of access to education and poor work and job prospects. In Enfield, the local authority, NHS, and voluntary sector have long recognised the interrelationship between these issues, the impact of poverty and its resultant strain on local services and poor outcomes for local people.

Approach

The Health and Wellbeing Strategy 2020 to 2023 explicitly seeks to "prevent the preventable", by taking a system wide approach, using effective partnerships as the primary means to address inequalities and improve health outcomes.

Community Powered Edmonton

Recently, the advent of the Integrated Care Boards, which bring together health and care services across regions (like North Central London) and at borough level through place-based work, has provided an opportunity for the NHS, Enfield Council, and local voluntary sector partners to come together, share learning and build on the existing inequalities work. This work seeks to ensure that local people are heard, listened to, and included in the development and delivery of services and programmes; this in turn seeks to make sure that services are as effective and relevant as possible. The NHS North Central London Integrated Care Board (NCL ICB) recognises that Enfield has a long history of working with communities and community groups to improve local services. Resident and patient engagement is being recognised as critical at a regional and local level, and as a result, governance structures have been developed to ensure that engagement is understood and supported from the top down. In addition, specific and dedicated funding is being sourced and distributed, and resources are being applied to engagement activities, researching the patient experience, and supporting service redesign. Enfield Borough Partners recognise that healthy behaviours and lifestyles of our population are critical to improving outcomes, but without a new relationship with our communities this cannot be achieved. In Enfield, the Edmonton area has some of the worst health

[42] Think Local Act Personal
[43] Community-Powered-Edmonton-Report-Final.pdf (newlocal.org.uk)

outcomes and greatest inequalities and as a result, Community Powered Edmonton was created, using local assets to understand the challenges, find out what is important to people, speak to their aspirations and generate outcomes based on their strengths.

Working as a pathfinder programme for more effective community engagement and collaboration between service providers and service users, each partner brought unique expertise, local connections and understanding. We used an exciting range of engagement methods and techniques to reach out to communities in Edmonton.

Overall, we sought to deliver against the following four objectives:

1. To strengthen the local voluntary and community sector (VCS) infrastructure by addressing current gaps in representation.
2. To understand local needs and the barriers different communities face to accessing local healthcare and support services.
3. To explore ways in which a strengthened communities and VCS network could work alongside statutory agencies to share insights and engage in local decision making.
4. To consider how the local NHS and council could further collaborate with a strengthened communities and VCS network to improve health outcomes, and any changes that might be needed to support this. This includes consideration of the systemic changes required in how local public service organisations work to enable a more community powered approach to become embedded.

Outcomes

The following recommendations were agreed by all parties involved as being the most urgent issues, but also the most easily actionable.

Ongoing community conversations: Service providers should have ongoing open conversations which bring together residents, the VCSE, and public sector. There is a demand for this within the community and it will contribute to a shared understanding, trust, and sense of ownership of local services. These events should be frequent, accessible, held in different venues and formats and feed directly into regular service level feedback. It would be helpful for NCL ICB and Enfield Borough Partnership to identify a lead to coordinate and resource these community conversations.

Longer term voluntary, community, and social enterprise (VCSE) partnerships and resourcing: VCSE organisations play a critical role in expanding the reach of the public sector into diverse communities, helping to build greater understanding and reduce current barriers to collaboration and healthcare access (e.g., knowledge of available services, language barriers, targeting of services). This takes time and resource so more consistent partnerships, and resourcing are needed.

Shared accountability: North Central London ICB should report back on the findings and outcomes of this work and, working collaboratively with the Enfield Borough Partnership, explore ways to develop the 'working together' commitment displayed throughout this project. This would ideally involve a public commitment from decision makers to longer-term and better resourced engagement and collaboration, with clear accountabilities for public sector organisations, VCS organisations, people, and communities in taking action forward.

Test and learn approach: The NHS and local authority should identify one thematic priority or targeted community with whom to initially apply the learning and recommendations of this work including active listening, collaboration with community partners, involvement in decision making, learning by doing, while sharing the lessons with the wider system. There is scope to grasp the opportunity to use this new way of working to also address the economic, workforce and general wellbeing of local residents, especially young people and marginalised parents.

Training and development: Professionals, front line staff and anyone involved in the design, development and delivery of community and health services should receive training in active listening, empathy, and different forms of engagement. This should have a particular focus on community facing roles in the public sector.

Case Study Two

Nesta's People Powered Health Programme[44]

Background and aim People Powered Health was an 18 month programme across England that involved teams from local hospitals, GP practices, community organisations and patient groups to look at ways to improve the health and wellbeing of people with long-term conditions.

Approach The People Powered Health approach is based on the knowledge that patients do better when they are involved in developing and delivering their own care.

- the health and social care system mobilises **people** and recognises their assets, strengths, and abilities, not just their needs.
- the ability to live well with long-term conditions is **powered** by a redefined relationship, a partnership of equals between people and health care professionals.
- the **health** and care system organises care around the patient in ways that blur the multiple boundaries between health, public health, social care and community and voluntary organisations.

Outcomes

- We think the People Powered Health approach could reduce the cost of managing patients with long-term conditions by up to 20 per cent.
- The financial business case for People Powered Health rests on two key areas of benefit. The first is the ability to mobilise the asset base that is patients, service users and their communities. Joining up these individual efforts allows them to add to far more than the sum of the individual parts.
- The second area of benefit is reductions in unplanned admissions and the requirements for expensive, acute care.
- The NHS in England could realise savings of at least £4.4 billion a year if it adopted People Powered Health innovations that involve patients, their families and communities more directly in the management of long-term health conditions.
- These savings are based on the most reliable evidence and represent a 7 per cent reduction in terms of reduced A&E attendance, planned and unplanned admissions, and outpatient admissions. There is therefore both a social and financial imperative to scale the People Powered Health approach.

Case Study Three

Creating Community Powered Care: Sussex MSK Partnership Central[45]

"You should always ask me (the user) and not just once, but throughout my journey in a service because my needs might change over the course of that." – Big Conversation Attendee

Background and aim Creating exceptional care is all about working in partnership with the people in our communities, recognising that people are more than what's troubling or paining them.

Our work connecting to communities and bringing the views and knowledge of people with experience of needing care is vital to ensuring our services really are community powered and led.

Approach The Big Conversation is our bi-monthly community event where we come together to listen to the voices of people from different parts of the population we serve. We get to understand more about what they want and need to develop individual and community MSK health. Guided by our Health

[44] The Business Case for People Powered Health | Nesta
[45] Case study written by Lucy Phillips, SMSKP Communications and engagement lead, Email: lucy.phillips23@nhs.net SMSKP: www.sussexmskpartnership.co.uk Here: www.hereweare.org.uk

Builders, our experts with lived experience, we encourage open dialogue, delve into specific issues, collaboratively plan for service development, and create a feedback and accountability loop.

Outcomes

These events, held in areas our data tells us we most need to connect with and attended by a diverse group of people from the community, have resulted in key service improvements including implementing self-booking systems, revisions to correspondence, and enhancing information for citizens about what we offer.

At the Big Conversation in January 2023, we trialled offering informal physio consultations and on-the-spot advice. This proved effective and well-loved by people from the community and became the cornerstone of our new model of care - Community Appointment Days (CAD).

The CADs had a unique objective: to break away from traditional healthcare boundaries and experiment with a new model; no squeezed appointment slots, no closed doors. Instead, we provided a comprehensive range of MSK services, including assessments, advice, health promotion, rehabilitation and community and voluntary sector support, all in a non-medicalised environment.

Insight from attendees of the Big Conversation and input from our Health Builders were crucial for the design, development, and delivery of the Community Appointment Days.

As a result:

We saw 550 people across two days in two different locations. 50% of people were discharged from the waiting list, getting what they needed in one hour and supported to self-manage their condition.
30% of the people who attended accessed further community services that were in the room.
There was an immediate reduction in average waiting times of around five weeks. This has remained steady, with only 10% of those discharged on the day returning.
People reported that we enabled them to take an active role in their care, leaving with the tools needed to be able to self-manage.
Our work and learning have fed into the national programme on MSK Hubs in leisure centres. The extraordinary success of the CADs is pushing the debate further as people see how highly personalised, de-medicalised care can be safe, effective, and efficient.

Case Study Four

New Local – Building a Community Powered NHS[46]

Background and Aim Earlier this year we launched a call for evidence for a forthcoming report on community centred approaches to health. Among the many brilliant examples shared were several initiatives championing the Community Connector model. Delivered by communities, for communities, this model focuses on what matters to a person, not what is the matter with them.

Approach Recognising that people are best placed to make decisions about their own lives and that communities have assets that can enable positive change, this approach is gaining traction, from the well-established Local Area Coordination Network[47] to smaller scale pilot projects.

Leeds neighbourhood networks[48]

The network comprises 37 voluntary organisations across the city working with members and volunteers to improve health and wellbeing. Through a range of activities like advice and information, help around the home, and healthy living activities, the network promotes community participation, social connection, and healthy aging at a local level.

Outcomes

- Preventing ill health through community-based activities and support, helping people to manage long-term conditions.
- Delaying illness severity and maintaining a good quality of life, as well as easing demand on health and social care services
- Reducing demand pressures on healthcare providers by assisting individuals with significant support needs, including frail older people or those with chronic or multiple conditions such as dementia or cancer.

As the grid below shows, these approaches benefit people, communities and the health and care system, leading to reduced GP appointments, lower A&E attendance, and less demand for a range of other services that are under pressure.

People and Communities	Health and Care System
Increased social contact, reduced isolation, and loneliness	**Reduced A&E Attendance**
Increased connection with the community	**Reduced GP Attendance**
Increased prevention and early intervention	**Reduced referrals to mental health services**
Better control over own life and health and wellbeing and better informed about choices	**Increased vaccine uptake**
Improved mental health and wellbeing	**Reduced smoking and alcohol consumption**
Improved access to specialist services and greater access for underserved populations	**Reduced dependence on health and social care services including through delayed severity of long-term illness**
Reduced pressure and increased capacity of families and friends as carers	**Reduced reliance on day services**

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[46] NHS at 75: why the workforce plan should start with communities - New Local
[47] LAC Network
[48] Neighbourhood Networks - Leeds Older People's Forum (opforum.org.uk)

5. Co-Production

What is co-production?

The word ‘co-production’ has become a buzzword and there is always a risk that the term can be overused, thereby distorting, and weakening its meaning and purpose. Here are three different definitions, all cited by the Social Care Institute for Excellence (SCIE).[49]

> “Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.”

> “Co-production is not just a word, it’s not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included, and working together from the start to the end of any project that affects them.”

> “A way of working whereby citizens and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value-driven and built on the principle that those who use a service are best placed to help design it.”

All definitions allude to the fact that for co-production to work it needs to be part of an equal relationship, where power is shared and the aim of the project is to improve the situation of interest or concern for people and their communities, Doing With rather than Doing For or Doing To. (Figure 1, page 9, The ladder of co-production.)

For the purpose of this report the following definition of co-production will be used:[50]

> “Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and service evaluation. Co-production acknowledges that people with ‘lived-experience’ of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.”

To ensure true co-production it will be necessary for systems, people, and communities, when working together, to initially define what co-production means to them and to keep coming back to this definition and their purpose over the course of the work, for power to remain equally shared.

Now 15 years old, but still highly relevant The New Economics Foundation (NEF) publication, ‘Co-Production, A Manifesto for Growing the Core Economy’[51] sets out to define co-production, to explain it, to offer a range of possibilities for making it happen and to paint a picture of what public services might look like if they embraced it. They refer to the paper by Chapman on Systems

[49] Co-production: what it is and how to do it | SCIE
[50] Definition from ‘Shine a light on co-production’. Experience of Care Co-production team. Contact: england.eoccoproduction@nhs.net
[51] Co-Production, A manifesto for Growing the Core Economy

Failure[52] who explains why command and control, setting narrow delivery targets or a market system doesn't work for delivering public services. Chapman further discusses how using soft systems methodology can improve public services by explicitly considering the goals and expectations of the people using the service.

During the 1990's an internal market was introduced into the NHS, this involved splitting the commissioning and provision of NHS services.[53] The reason behind this was ostensibly to increase competition and improve patient choice.

Market logic applies to narrow deliverables but misses out the crucial dimension that allows doctors to heal, and the relationship with the patient. Professionals need their clients as much as the clients need professionals. In practice, the consumer model of public services – where professional systems deliver services to grateful and compliant clients – misses out what is most effective about their 'delivery': the equally important role played by those on the receiving end, without which, doctors are almost powerless to heal. The point is not to consult more or involve people more in decisions; it is to encourage people and communities to use the human skills and experience they have, to help deliver public or voluntary services.

The Five Year Forward View[2] and more recent legislation have reduced the focus on competition, with an emphasis on integration of services to deliver sustainable high-quality healthcare for the future.

Co-production actively involves communities in the commissioning, design and delivery of services which are genuinely responsive to their needs. It provides a meaningful way for communities of both place and interest to contribute their expertise, alongside that of professionals, to design and deliver services that genuinely address people's needs. NEF has set out six principles of good co-production. These include embedding reciprocal relationships, breaking down some of the distinctions between professionals and service users, and making use of facilitative, asset-based approaches.[54]

1. Recognising people as assets: People are seen as equal partners in designing and delivering services, rather than as passive beneficiaries or burdens on the system.
2. Building on people's capabilities: Everyone recognises that each person has abilities and people are supported to develop these. People are supported to use what they are able to do, to benefit their community, themselves and other people.
3. Developing two-way reciprocal relationships: All co-production involves some mutuality, both between individuals, carers, and public service professionals and between the individuals who are involved.
4. Encouraging peer support networks: Peer and personal networks are often not valued enough and not supported. Co-production builds these networks alongside support from professionals.
5. Blurring boundaries between delivering and receiving services: The usual line between those people who design and deliver services and those who use them is blurred with more people involved in getting things done.

[52] Chapman, J (2002) System failure: Why Governments Must Learn to Think Differently, (London: Demos) System failure (demos.co.uk)
[53] Competition - NHS Providers
[54] In more detail - Co-production - Co-production in commissioning tool - Think Local Act Personal

6. Facilitating not delivering to: Public sector organisations (like the government, local councils, and health authorities) enable things to happen, rather than provide services themselves. An example of this is where a council supports people who use services to develop a peer support network.[55]

In this way, co-production can embody the principles of community power through building the capacity and confidence of communities to inform and shape the services they access. These principles are being put into practice in many localities, see case studies on page 37.

Co-production transforms the dynamic between people, communities and public service workers, putting an end to 'them' and 'us'. Instead, people pool different types of knowledge and skills, based on lived experience and professional learning. It goes well beyond the idea of 'citizen engagement' or 'service user involvement' to foster the principle of equal partnership, shifting the balance of power, responsibility, and resources from professionals towards individuals, by involving people in the delivery of their own services. It recognises that "people are not merely repositories of need or recipients of services" but are the very resource that can turn public services around.[56] Co-production also means unleashing a wave of innovation about how services are designed and delivered by expecting professionals to work alongside their clients. As Chapman[45] states the following generic change will arise because of systems practice:

- Interventions would introduce learning processes rather than specifying outcomes or targets. The key to establishing learning systems is an increased tolerance of failure, continuous feedback on effectiveness and a willingness to foster diversity and innovation.
- The emphasis would be on improving general system effectiveness, as judged by the clients or users of the system. This cannot be accomplished by using simple quantitative measures of performance; it needs to take account of a range of qualitative as well as quantitative features chosen and assessed by the end-users.

Things to be mindful of when considering co-production.

- Co-Production needs space and time.
- The shift in power is key.
- Co-production is not simply a tool.
- There will be resistance.
- Beware the political environment.
- Beware the landscape changing.
- Competitive tendering versus co-production.

[55] From Jenny Scott, Interim Head of Commissioning, Cheshire and Wirral Partnership
[56] The Challenge of Co-production | New Economics Foundation

Principles of Co-Production

For co-production to work it needs to adhere to the following principles:[49]

- Equality
- Diversity
- Accessibility
- Reciprocity (or getting something back for putting something in)

Equality

There is no hierarchy within the group, no one person or group of people are more important than the others. Everyone is equal and everyone has assets to bring to the process. Assets can be classed as skills, abilities, time, or any other quality that a person has. It is important to recognise that everyone within the group brings their own assets, be they a patient, carer, doctor, nurse, or allied healthcare professional. They will all have different experiences of being part of the system and all have different assets to bring.

For true equality to occur, it will be necessary for the professionals to shift power from themselves to those who utilise the system. It is important for people to get to know and trust one another, as co-production doesn't work in a time pressured situation.

Diversity

The main groups likely to experience exclusion are:

- People from Black, Asian and minority ethnic communities
- People from Lesbian, Gay, Bisexual, Transgender, Queer and others (LGBTQ+) communities
- People who communicate and perceive differently
- People with dementia
- Older people who need a high level of support
- People who are not affiliated to any organised group or 'community'.

If a person does not live in a 'traditional' community they can also experience exclusion, i.e., live in a residential home, are part of the Gypsy and Traveller communities, are in prison or are experiencing homelessness.

It should never be the expectation that 'they' will come to 'us'. It should always be considered either how 'we' go to 'them', or where best to meet them to enable us to have the conversation.

It is also important to consider intersectionality, as people often fit into more than one of the groups mentioned.

Accessibility

The process needs to be accessible to everyone, if the first principle of equality is to be maintained. This means ensuring everyone has the same opportunity to take part in an activity fully, and in a way that suits them best.

It is more than just physical access; information also needs to be accessible and therefore it is important to consider language and the use of jargon or abbreviations.

All parties need to have enough accessible information to take part in co-production and decision making. There may be issues around confidentiality and information sharing, which will need to be resolved for co-production to be successful.

Time and timing are also important, the impact of time on co-production and the need to allow time for co-production to develop are important issues.

Reciprocity

This is a key concept of co-production and has been defined as ensuring people receive something back for putting something in. It builds on the human desire to feel needed and valued. Putting reciprocity into practice can help to create a sense of belonging and togetherness.

Commissioning Co-Production[54]

Co-production can play a significant role in developing service innovations when services are commissioned in the right way. When commissioners build co-production into the commissioning cycle, and try to procure co-produced services, they enable providers and service-users to play a much more important role in designing and delivering services that work. This is even more relevant for service transformation, when patients will have a greater understanding of the service being transformed and can co-design and co-produce an improved service.

For healthcare commissioning to work with co-production in place it needs to adhere to the following process:

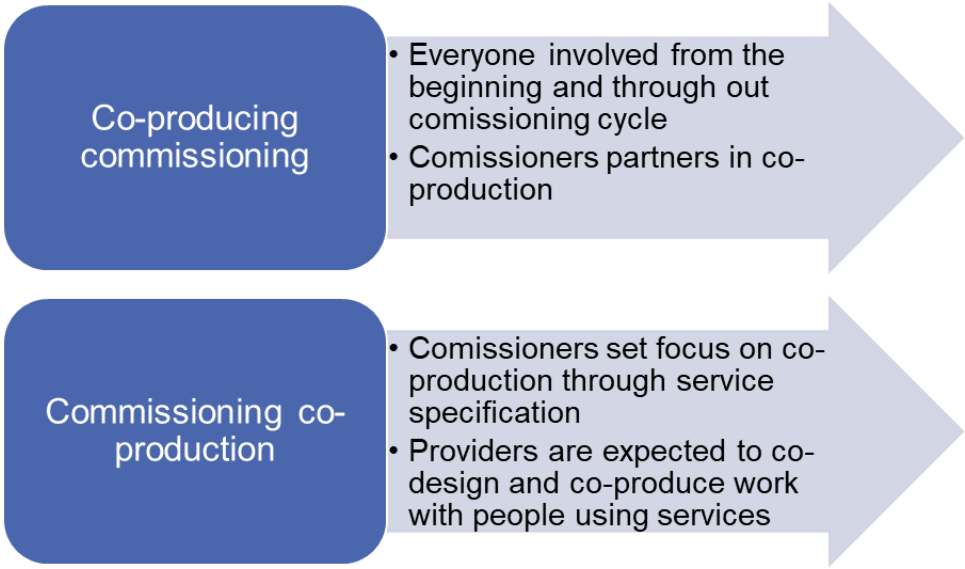

Figure 4[57]

[57] From Leadership for Personalise Care, Day 6 slides (Helen Sharp). Leadership for Personalised Care | Leadership Framework | Programmes for leaders in healthcare, social care and beyond

Table one highlights the difference and benefits between conventional commissioning and commissioning with co-production.

Conventional commissioning	The new approach
Very tightly defined services	Focus on broad outcomes
Focus on unit costs and short-term efficiencies	Long-term value and prevention
Poor level of insight	Involves people in exploring needs and assets
Hierarchical and paternalistic	People are seen as part of the solution
Closes down spec for innovation	Promotes innovation
Rigid and inflexible contracts, targets, and plans	Iterative and adaptive
Competitive and in silos	Collaborative – promotes strong relationships

Table 1[57]

Commissioning co-production involves looking at both the processes and outcomes of the commissioned service, rather than just the numbers of people moving through the service. It has been found that when health services are commissioned in this way the key driver for change is the focus on outcomes for people and communities.[58]

What isn't co-production?

As well as clearly defining co-production it is important to understand what it isn't.

We may think that we are co-producing with people and their communities by doing the following:

- Partnership working
- Third Sector Provision
- Personal Budgets
- Engagement
- Volunteering
- User Involvement

These are all valid ways of working with people and communities and each has its own benefits, but none fall under the previous definitions of co-production.[49]

NEF's report 'The Challenge of Co-Production',[51] gives more details on what it considers true co-production to be and not to be, the following are examples of the differences between co-production and consultation or volunteering.

- Co-Production is not consultation: Co-production depends on a fundamental shift in the balance of power between healthcare professionals and people. This is what makes improved effectiveness possible. It is the antidote to the idea that we endlessly need to ask people's opinion, before handing the service back to the professionals to deliver, since people will be involved in delivery as well.

[58] Camden and Co-production (citizen-network.org)

- Co-production is not volunteering: Co-production is certainly about activity and giving time. It emphasises mutual support and networks of relationships rather than a clearly defined line between professionals and people. But it requires a new generation of mutual exchange for everyone, the transformative force comes when people who are usually on the receiving end of volunteering or services are invited to help.

Table two presents what co-production is and isn't regarding service change and its design or delivery.

		Responsibility for design of service	
		Professionals as sole service planner	Professionals and service users/community as co-planners
Responsibility for delivery of service	Professionals as sole service deliverers	Traditional professional services	Professional service provision but users/communities involved in planning and design
	Professionals and users/communities as co-deliverers	User co-delivery of professionally designed service	**Full Co-Production**
	Users/communities as sole deliverers	User/community delivery of professionally designed service	User/community delivery of co-planned or co-designed services

Table 2[51]

Maybe the best way to start the conversation is to start sharing stories. Telling stories is about users, developers and deliverers sharing stories, moving towards common understanding and solutions, with an equal and reciprocal relationship.[60]

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[60] SE Clinical Senate Patient and Public Partner
[61] LCGW - Cormac Russell - Nurture Development

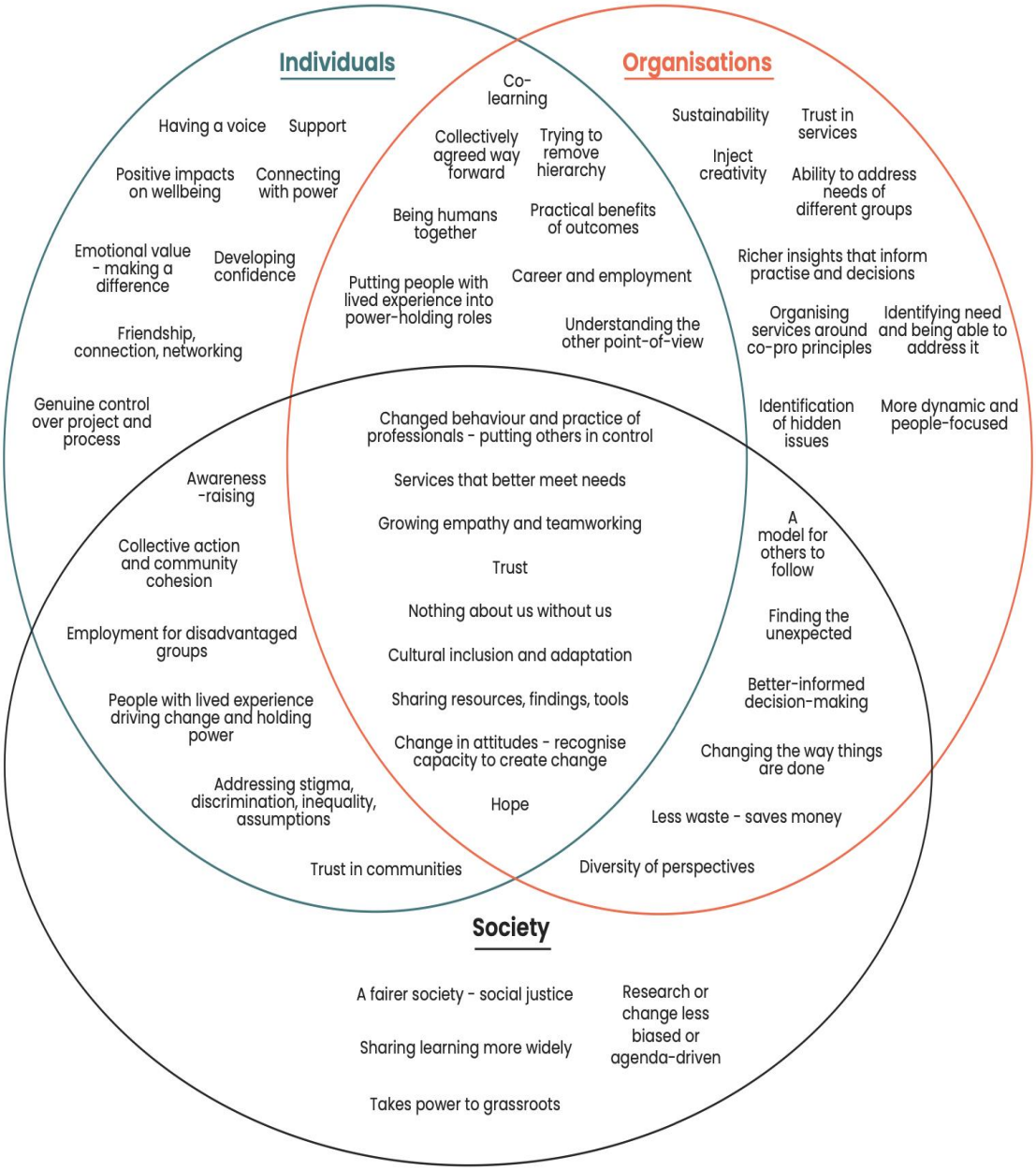
Co-Production and personalisation

Personalisation or personalised care is about people having the choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences.

It has grown out of an approach developed by people living with disabilities and the independent living movement, that over time has been aligned with co-production, although they are not one and the same. It is a part of NHS England’s long-term plan and has the following six components:

- Personalised health budgets – giving people with the most complex needs direct control over the money spent on their care.
- Care and support planning – so everyone with a long-term condition has the chance to have a conversation about what matters to them, in the context of their whole life.
- Shared decision making – better conversations for all, based on equal partnerships between people and those supporting them.
- Social prescribing – connecting people to their communities and non-medical supports.
- Support for self-management – health coaching, education, peer support.
- Choice – legal rights.

Figure 5 was developed to illustrate the value of co-production to individuals, organisations, and society and to understand the impact of co-production on policy, services, and research.



[62]

Figure 5

As can be seen from the centre of the diagram the benefit of co-production regarding major service change is a service that better meets the needs of people, communities, and systems, engenders trust and hope, and changes the behaviour and practice of professionals by putting others in control.

[62] People's Voice Media and Curators of Change (2020) *Community Reporting: Summary of Findings*, The Value of Co-Production Research Project, Co-Production Collection https://uploads-ssl.webflow.com/5ffee76a01a63b6b7213780c/63595598ca9e4b688b7f540a_ValueCoPro_CommReportingFull31Oct22.pdf

Co-Production and service change

Service change within the NHS constitutes any change to the provision of an NHS service that involves a shift to the way front line health services are delivered. There is no legal definition of 'substantial development or substantial variation', however it can encompass anything from a change to the geographical location of services to a change in the type or range of services provided. Both service reconfiguration and service decommissioning are types of service change.

Usually, for a service change to be regarded as 'substantial development or substantial variation' it requires public consultation and approval from NHS England. Effective service change will involve full and consistent engagement with stakeholders including (but not limited to) the public, patients, clinicians, staff, neighbouring health systems and local authorities.

The May 2022 'Addendum to Planning, assuring and delivering service change for patients (March 2018)'[10] considers successful proposals for service change as those that build on the wider considerations of the health and wellbeing needs of their people and communities. Best practice would be to co-design proposals and assessment criteria with patients, the public and other key stakeholders.

The 'Clinical Senates in England – Single Operating Framework'[63] is the framework that the regional clinical senates were established against. It states that the purpose of Clinical Senates, in the context of this report, are to bring together a range of health and social care professionals, with patients, to take an overview of health and healthcare for local populations.

Some of the guiding principles are:

- Patients and citizens will have a voice in the Clinical Senates work.
- Through their members, Clinical Senates will support commissioners to put outcomes and quality at the heart of commissioning, to increase efficiency and promote the needs of patients above the needs of organisations or professions.

Each regional Senate does this in slightly different ways. Two examples of this are:

- The South East Clinical Senate[7] has patient and public partners as part of their Clinical Senate council and have a minimum of two patient and public partners on their independent clinical review panels.
- The London Clinical Senate[64] has a patient and public voice (PPV) group, who meet monthly to discuss issues relating to patients' interests in London and then these are brought to the London Clinical Senate Council. Members of the PPV also take part in the independent clinical review panels.

The South East Clinical Senate publications have made the following recommendations to systems around major service reconfigurations and working with people and communities. Many emphasise the need to involve patients and the public earlier and adopt true co-creation of services.

[63] Single-Operating-Framework.pdf (secsenate.nhs.uk)
[64] London Clinical Senate | Providing independent, strategic advice and leadership (londonsenate.nhs.uk)

Engagement/Involvement

R1. The public engagement report provides rich information, we would recommend including pertinent information from this in the PCBC to give a clear message that a significant number of either current users, past users or carers and family members of users of the service have contributed. This would significantly strengthen the PCBC.

R2. 80 interviewees were unable to attend the workshop, we recommend an accurate representation of those views in the PCBC narrative in order to convey the robustness of the approach. Broad public dissemination was also mentioned on questioning (newsletters, social media). Clarity and ensuring that the objectivity of the process is clearly described would strengthen confidence in patient and public involvement to date.

R3. In the pre-engagement work do the patient and user views and opinions include those who would normally be seldom heard including those with hearing difficulties, learning disabilities, those who either have no access to or choose not to use IT and those with poor health seeking behaviours? Have you reached those users of the service who will be most affected by the changes?

R4. The Senate panel were unclear how well the Black, Asian and Minority Ethnic (BAME) population were represented in the patient and public engagement. The PCBC clearly details both the vulnerability of this population and the association of the BAME population with increased deprivation. Their engagement and involvement are therefore paramount and a description of how the BAME population and the wider patient population were involved in the co-design and development of the proposals would strengthen the PCBC.

R5. The NHS constitution states, 'the NHS belongs to the people' and it is responsible for working in partnership with people to plan healthcare. It is clear from the PCBC, appendices and related documents that work has taken pace to engage stakeholders. The PCBC and EHIA provides some information concerning engagement with seldom heard groups. Plans for further work to engage with these groups, how the programme plans to engage those who have not been part of the initial groups and how this will be possible within the current timeframes needs to be detailed.

R6. Provide a summary of the views received from the public from engagement to date, and how these have influenced the development of the proposals.

R7. Whilst the PCBC reflected some evidence of patient and public engagement, there needs to be greater illustration of how patients and public could help co-design future services and treatment environments using 'experts by experience' (formerly 'expert patients').

End to End Pathway

R1. Better use of the excellent primary care support and engagement could be made within the narrative, highlighting the total end to end pathway focus. The narrative could also be strengthened particularly with reference to broadening the team engagement.

R2. A more detailed audit of the users is required to fully understand demand, and how it would best be provided.

R3. Clearer information about what the proposed changes mean to patients, their families and carers would be helpful. This needs to be presented on a very personal level, addressing how the change will affect their lives and how it will make a difference.

Clinical Model

R1. The PCBC needs to detail further evidence for how the public and patients have been involved with the co-design of the proposed new clinical model and pathways to date. Opportunities for model and pathway co-design both as pre-engagement and in later consultation should be sought, capitalised upon and reflected within the PCBC and consultation document. The current narrative within the PCBC suggests that engagement to date with the wider public regarding proposed changes has been limited.

R2. Describing the disadvantages for patients would help provide a balanced assessment of the service. Such disadvantages include the potential for lack of continuity of care (one-off single-issue appointments not with their regular GP), and the disconnect from other primary care services that their own surgery is set up to coordinate. In principle it is much better to steer patients to their own primary care system first time.

R3. The proposals as currently presented focus more on the perceived requirement to close the service, and the potential financial savings. The reconfiguration of town centre primary care should be seen as delivering more integrated, patient centred care with streamlined signposting to other services, continuity of care, and improved access. This would be enhanced by providing examples of specific patient pathways (and vignettes) for the common types of presentations to Walk In Centres (WICs), and how such patients would receive their care in the new configuration. This would make the new pathways much clearer, and thereby potentially more acceptable.

R4. Co-creation of proposed changes needs to be given a higher priority. Healthwatch and the Stroke Association were not included in the initial workshop regarding the longlist of options. Both have however been involved in helping the programme access patients, carers, family and the public and although this has provided valuable insight it is not that same as patients and families being partners in the decision making. The PCBC would benefit from clearly demonstrating co-production with patients and the public through the use of patient stories highlighting patient need and choice.

R5. Brief patient stories, capturing the service population catchment area, summarising critical service issues identified through pre-engagement will provide confidence in terms of breadth and depth of engagement, demonstrating a thorough and inclusive approach.

R6. There should be greater emphasis on showing how newly designed integrated care will improve patient experience, access, and quality of care, with less focus on the need for closure and potential financial savings.

The following case studies showcase how systems are utilising co-production with people and communities to put people at the heart of service change.

Case Study One
Surrey Heartlands[65] **Background and aim** Surrey Heartlands has been working with Gypsy, Roma, and Traveller (GRT) families: It is known that Surrey has the fourth largest GRT population of any UK country, with the population estimated at between 10-12,000. Research continues to show that this group continues to experience poorer health outcomes and inequalities. **Approach** In 2019, a project was initiated across Surrey Heartlands with the focus of improving the health of GRT families by improving access to routine healthcare with objectives including development of a culturally competent workforce and reduction in infant mortality, including still births. **Outcome** Co-production was supported by joint work with the Maternity Voice Partners in Surrey to improve the GRT patient experience of childbirth and pre and postnatal care, by consulting with GRT clients and feeding back to maternity services, to achieve system changes. The GRT team works closely with the Surrey Community Gypsy and Traveller Forum and consults with community leaders within this group, at every stage of the project's development and delivery. Learning is informed by listening to the concerns and priorities of the GRT population.
Case Study Two
Medway and Swale Health and Care Partnership[66] **Background and aim** Medway and Swale have been working to narrow health inequalities for children and young people by co-producing lifestyle education with young people and delivering support, including a mobile children's asthma service, through a local foodbank bus.[67] **Approach** With 620 children living in poverty and high levels of children's admission to hospital, Medway and Swale Health and Care Partnership, a place-based organisation, has used population health management to identify high need populations and help address the wider determinants of health. This has been supported by a ground-breaking Voluntary Sector Framework between health, local authorities**,** and the area's 1,500 voluntary sector groups. **Outcomes**

[65] Co-production-good-practice-examples-from-LMNS-perinatal-equity-strategy-submissions.pdf (southeastclinicalnetworks.nhs.uk)
[66] Medway and Swale :: NHS Kent and Medway (icb.nhs.uk)
[67] Improving population health by reducing health inequalities with the community and voluntary sector - YouTube

Focussing on asthma, the partnership has worked with the local school to co-design healthy lifestyle intervention programmes within the school.

By actively showing children the issues and involving the children in discussions around their health, the children know which organisations can facilitate them to achieve better health outcomes.

Case Study Three

Croydon Service User Network (SUN) Service[68]

Background and aim There is evidence that co-production, by leveraging wider community networks, can directly reduce demand on acute services. The SUN, a mental health support service, was co-designed by psychiatrists and service users.

Approach People using the service were involved in running the network, peer-support, providing feedback, and the SUN steering group.

Outcomes

After six months of members being part of the network, the SUN programme showed a 30 per cent reduction in use of A&E services.

Case Study Four

Hampshire and Isle of Wight ICB[69]

Coproducing training to develop Self-Advocacy and Leadership skills for people who are autistic, have a learning disability, or both.

Background and aim Hampshire and Isle of Wight ICB has a mission to increase the number of people who are autistic, have a learning disability, or both, to speak up and have their voices listened to within health, social care and education environments. Using NHS funding, the ICB commissioned Koala Community Hub, a third sector organisation that specialises in autism and learning disability to deliver a self-advocacy training package that will provide people who are autistic, have a learning disability, or both, with training in self-advocacy. The training is intended to support recruitment of experts by experience and people with lived experience for a growing portfolio of co-production work within the Learning Disability and Autism Programme.

Approach Koala Community Hub is led by autistic people and this enhanced the focus of the project. With the recruitment of seven experts by experience they collectively designed, created and produced the training package in self-advocacy, starting from a blank page. Working together they initially highlighted the diversity of needs and options for self-advocacy and agreed key themes which resulted in five self-advocacy modules being built:

- **What is self-advocacy?**
- **Understanding what I need**
- **Understanding my rights**
- **Communicating my needs**
- **What do I need to continue my journey.**

Outcomes

Key learning

[68] Service Detail - South London and Maudsley (slam.nhs.uk)
[69] Self-advocacy-and-leadership-skills-for-people-who-are-autistic-or-have-a-learning-disability-ICB.pdf (ndti.org.uk)

• Coproduction with autistic people, have a learning disability, or both, is very time consuming and requires an intensity of effort and preparation to ensure everyone gets the individual support they need to be truly involved.

• Creating a safe space for the group and establishing an environment in which they are freely able to offer their experiences and suggestions is key to coproduction taking place.

• The outcomes of experts by experience working closely together have added benefits, such as building lasting friendships and developing personal skills.

Koala Community Hub spent time at the beginning of the project building trust and generating a safe space with and for the group, which was essential for the project to succeed through supporting the group to also build bonds, connections and trust with each other. The dedication of Koala Community Hub ensured each individual expert had their individual needs acknowledged and supported. This also quickly built the groups commitment to attend sessions and their energy, articulation, critique, and contributions to the development of the training packages. It also enabled the group to share personal experiences, personal challenge and actively contribute to the design and development of the training package, and in doing so they have developed a deeper understanding of what self-advocacy is for them.

6. Conclusion

People are the biggest champions of the NHS. They are the ones who, day-to-day, are the recipients and the reason for the services that the NHS delivers. Service change therefore invariably affects peoples' healthcare pathways and their health and well-being – and by extension their personal lives and their working lives and relationships.

Putting people at the heart of service change is about commissioners and providers making choices about what's right for the NHS, taking due account of the needs and choices of patients and their families and carers. The earlier that people are involved in service change and the more transparent and open we are, the more likely people will feel engaged in the process. Insufficient engagement and involvement is likely to result in resentment and resistance and knowing when and in what ways to put people at the heart of service change, dramatically increases the likelihood of success. NHS England's Director of Personalised Care reminds us that "Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters to them' and their individual strengths, needs and preferences. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities to deliver better health and wellbeing outcomes and experiences."

Community power and co-production are not the most accessible tools in the box, however if systems want to crack the intractable, complex wicked problem that service transformation often becomes they would be wise to use these tools as the assets they will find within the local people and communities will nicely oil the wheels to a solution that works for everyone, but most importantly the people most affected by the service transformation.

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8. Further Information, resources, and tools

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Resources

Co-Production: Stories from the patient community Co-production: stories from the patient community - YouTube

Cormac Russell and John Knight – The Connected Community. Discovering the Health, Wealth, and Power of Neighbourhoods. ISBN 97815523002528

Gill Phillips – Whose Shoes Podcast (47. The power of storytelling - it's liberating! (buzzsprout.com))

ImROC - Welcome - ImROC - Implementing Recovery through Organisational Change

Involve, the UK's public participation charity - About | involve.org.uk

The King's Fund explanation of the Health and Care Act 2022 - Health and Care Act 2022 | The King's Fund (kingsfund.org.uk)

The King's Fund Guest Blog, 18/10/22 - Can Deaf and disabled people's organisations help shape health and care services in the UK? | The King's Fund (kingsfund.org.uk)

'Our Future Leaders' course, a course for people with learning/intellectual disabilities to develop practical leadership skills. Core components of the course are taught by past participants - Our Future Leaders Course - Inspiring Scotland

South East Maternity and Neonatal Co-Production Resource Pack - CS54385-Co-production-resource-pack-v05-FINAL.pdf (southeastclinicalnetworks.nhs.uk)

Working with people and communities online course: Working with People and Communities to Improve Health Outcomes - FutureLearn

Tools

Coalition for Personalised Care Payment Policy - Our co-produced Payment Policy is finally here! | Co-Production Collective (coproductioncollective.co.uk)

Hyper Island prepares individuals and organisations to anticipate and adapt to the changes of tomorrow, today. Hyper Island Toolbox - Hyper Island Toolbox

Tameside and Glossop Integrated Care NHS Foundation Trust Co-Production Guide and Toolkit - Co-Production Resources & Information - Wakelet

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