Coproduction of Care in Living Well

A Qualitative Review

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Executive Summary

Coproduction lies at the heart of the Living Well programme. In Living Well the aim is to firmly position volunteers as integral to the coproduction of care for older people. In practice this is about volunteers having the power to: 1) shape how volunteers are trained and deployed; and, 2) be part of healthcare delivery through their involvement in the decision-making for their elderly clients. To achieve these twin aims the Volunteers in Communities (VIC) team have produced this qualitative review of the coproduction of care model in the Living Well programme. This paper examines coproduction from two perspectives. Firstly the paper reviews the current spaces for coproduction in Living Well. Secondly it reviews the challenges and opportunities for delivering alternative models of coproduction. The paper concludes by making recommendations about how coproduction can be better delivered through Living Well.

Key Recommendations

1. Living Well recruitment and training should emphasise the maxim 'medically aware, not medically trained'; emphasising the importance of risk identification, not necessarily action, and the process of how to escalate an issue.

2. Integration of volunteers into MDT should be trialled and reviewed and the lessons learnt embedded in the current Living Well areas before scaling up to a Cornwall-wide policy. The trials should happen at MDT where the GP chair is 'on board' with the coproduction model and, crucially, the meeting structure arranged to be accommodating for non-medical experts. If the trial is deemed successful an MDT protocol should be developed to guide MDT chairs in how to integrate volunteers without breaching confidentially.

3. Delivering the co-production model necessitates a change in approaches to volunteer management and deployment. The integration of volunteers into MDT will not suffice alone to deliver the co-production model. Lessons learned so far indicate the importance of: i) regular peer support opportunities for volunteers; ii) a system for non-medical referrals; iii) communication of 'success stories' back to volunteers.

4. Trial the attendance of medical staff to Living Well volunteer meetings; both formal and informal types. Review benefits of approach.

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Suggested citation:

Leyshon, C, Leyshon, M and Walker, T (2016) Coproduction of Care in Living Well – A Qualitative Review. University of Exeter

Please cite this report appropriately.

1.0: Introduction

This paper examines the coproduction of care model in the Living Well programme from two directions. Firstly it reviews the current spaces for coproduction in Living Well. Secondly it reviews the challenges and opportunities for delivering alternative models of coproduction; in particular focusing on the challenges and opportunities for volunteer integration into Multi-Disciplinary Team (MDT) meetings. The paper concludes by making recommendations about how coproduction can be better delivered through Living Well.

This paper builds on the work of the Volunteers in Communities (VIC) action research project, which evaluated how Living Well was operationalised in Cornwall. The VIC analysis is set out in 'How does change happen? A qualitative process evaluation' (Leyshon et al., 2015). A key observation was that "volunteers are not fully involved the in coproduction of care with healthcare practitioners" (Leyshon et al., 2015: 21). Funded by an Economic and Social Research Council (ESRC) Impact Acceleration Award (IAA) the VIC team have further evaluated the issue of coproduction. This review is underpinned by qualitative data collected from Living Well partners[1] through 2014-2015 and then supplemented with data from focused follow up interviews in autumn 2015. And then in the spirit of coproduction this report was presented to West Cornwall's Living Well Board in January (2016) (see Figure 1). Interactive feedback cards were developed and used employed to gather professional feedback on the report and its recommendations. For each model of coproduction reviewed in the report the Living Well board were asked: 1) "What opportunities for co-production does this approach create?"; 2) "What limitations does this approach have?". The feedback gained has been used to update and improve the first draft of this report.

Figure 1: Living Well Board completing report feedback cards

[1] Volunteer Cornwall, Age UK Cornwall, and the NHS, and independent consultant partners.

2.0: Coproduction and Living Well

Coproduction lies at the heart of the Living Well programme. Coproduction is a model by which public services can build mutual support systems to prevent social problems. Coproduction is achieved through catalysing community involvement and active citizenship. Indeed, at the heart of the coproduction model is the recognition that people are the greatest asset in any society (Boyle and Harris, 2009). In Living Well the aim is to firmly position volunteers as integral to the coproduction of care for older people. In practice this is about volunteers having the power to: 1) shape how volunteers are trained and deployed; 2) be part of healthcare delivery through involvement in decision making around their elderly clients. For this to be realised the Living Well partners need to create appropriate spaces for coproduction to happen. The paper begins by reviewing the current spaces where coproduction happens in Living Well and critically considers the pros and cons of each model.

3.0: Current Spaces of Coproduction

There are currently two spaces in Living Well where coproduction has been enabled: 1) Formal Meeting; 2) informal Coffee Morning.

Figure 2: Report feedback cards

3.1: Formal Meeting

In West and East Cornwall the space for coproduction has been created in the form of formal monthly work meetings between the volunteers and the Living Well Coordinator. This space is primarily used by volunteers to escalate issues and 'pass up' information about elderly clients to the Coordinator. According to the Living Well Services Manager (RP, 2015) these meetings are characterised by "a sense of function and work, where volunteers are carrying

out a role". The model of how these formal meetings work in practice is illustrated in Figure 3. The advantages and disadvantages of this model are then listed in Table 1.

Figure 3: Formal Meeting

Advantages	Disadvantages
Regular and formal space for volunteers to communicate risks to coordinator	Absence of time and space for peer support discussions between volunteers
No responsibility or pressure on volunteers to escalate risk themselves	Patients' situations change quickly and so time between monthly meetings could mean smaller risks are not reported
Coordinator can escalate issue to the correct support service	Risk of focusing on mechanism (i.e. meeting) rather than outcomes
Coordinator acts as the mediator between the volunteers and clinicians	May be intimidating and inhibit discussion
Protected time which gives a voice to the quieter volunteer	

Table 1: Advantages and Disadvantages of the Formal Meeting model

3.2: Coffee Morning

The Coffee Morning approach is employed in Central Cornwall (see Figure 4). This revolves around regular Living Well team meetings where volunteers, coordinators and team leads meet informally to discuss issues. Discussion focuses on the challenges and concerns of the volunteers. Essentially this space provides opportunity for peer support between volunteers. As Volunteer Cornwall's Team Manager (AB, 2015) said "we use this peer support approach in the Welcome Home programme too, we know it works and volunteers like it". The practical value of spaces for volunteer peer support was emphasised by a consultant for Age UK

Cornwall (JF, 2015); "the thing is that lots of the challenges volunteers have to navigate are local and client specific, so peer support opportunities are crucial as they offer a place to share knowledge". However, the central problem with this approach was highlighted by a member of the Kernow Clinical Commissioning Group "lacks a clear process for escalation of risks and issue follow-up" (GS, 2016). Rachel Murray (NHS Kernow) suggested that this could be addressed by the "provision of contact information, to the volunteer, about the name of who to call, their number, name of practice and what they could help with".

Figure 4: Informal Coffee Mornings

Advantages	Disadvantages
Opportunity for peer support between volunteers	Absence of formalised space and time to communicate issues may increase risks
Enjoyed by volunteers as creates sense of team work	Approach does not suit all volunteer personalities or their wishes for how they want to spend their volunteering hours
Discussions of risk are tailored according to need	Issues which arise may not all addressable by coordinators

Table 2: Advantages and Disadvantages of the Informal Meeting model

The current two approaches cumulate with the Coordinators and Team Leaders escalating health issues at MDT meetings. Other non-medical issues are escalated to other appropriate support services. There are two major advantages of these approaches. Firstly, because the responsibility for risk escalation lies with coordinator there is continuity in relationships between the voluntary sector and the medical or other support services. Secondly, having the coordinator as the conduit means risks are screened and escalated to the right expert, team or service. As is discussed below, the needs of the elderly are not always medical and therefore also require engagement with other types of services. The key observation from both these models is that there is not current mechanism for volunteers to receive 'good news' stories about the positive impact of their involvement, and risk communication, in

elderly healthcare. For volunteers to feel fulfilment and happiness as 'part of a team' requires an improved approach to communication. A key recommendation, which is salient for the alternative models, is that there needs to be better communication about the outcomes of risk observations back to the volunteers.

4.0: Alternative Models for Coproduction

There are two alternative models for coproduction which could be adopted in Living Well. Each of these models are illustrated, their advantages and disadvantages listed, and the practical barriers and opportunities are then critically considered. The two models are: 1) Team Leader Coordination; 2) Volunteers in MDT meetings.

Figure 5: Report feedback cards

4.1: Team Leader Coordination

The Team Leader Coordination model is used in the Welcome Home programme. The model is based on competent volunteers identifying and communicating risks, via a phone call, to the Living Well team leader who is then responsible for escalating the issue. The Team Leader Coordination model is illustrated in Figure 6.

Challenges and Solutions for Delivery

The key challenge for delivering this model for Living Well would be the necessary re-organisation of how volunteers are trained, managed and deployed. Volunteer Cornwall's Team Manager (AB, 2015) explained that the "Living Well coordinators are currently too busy to manage the programme like this, they are actually seeing clients". For this approach to work it would "require a shift in staff role, wherein staff are very much coordinating rather than doing on the ground" (AB, 2015). This re-organisation would also need to be accompanied with a shift in how volunteers are trained; because at the heart of this model is

a reliance on volunteers to identifying risks in the first instance. Volunteers would not necessarily need to act on risk identified risk, but would need to when to escalate an issue to the team leader. This considered we recommend that the Living Well recruitment should emphasise the maxim 'medically aware, not medically trained'. The Team Leader Coordination model would also require re-organisation in how volunteers are deployed: "which volunteers are going to be better at observing and dealing with different elderly people's problems? It's about deploying volunteers according to needs and this requires knowing your volunteers" (AB, 2015). Essentially, delivering this model would require reorganising Living Well so Team Leaders manage from above along with careful deployment of volunteers.

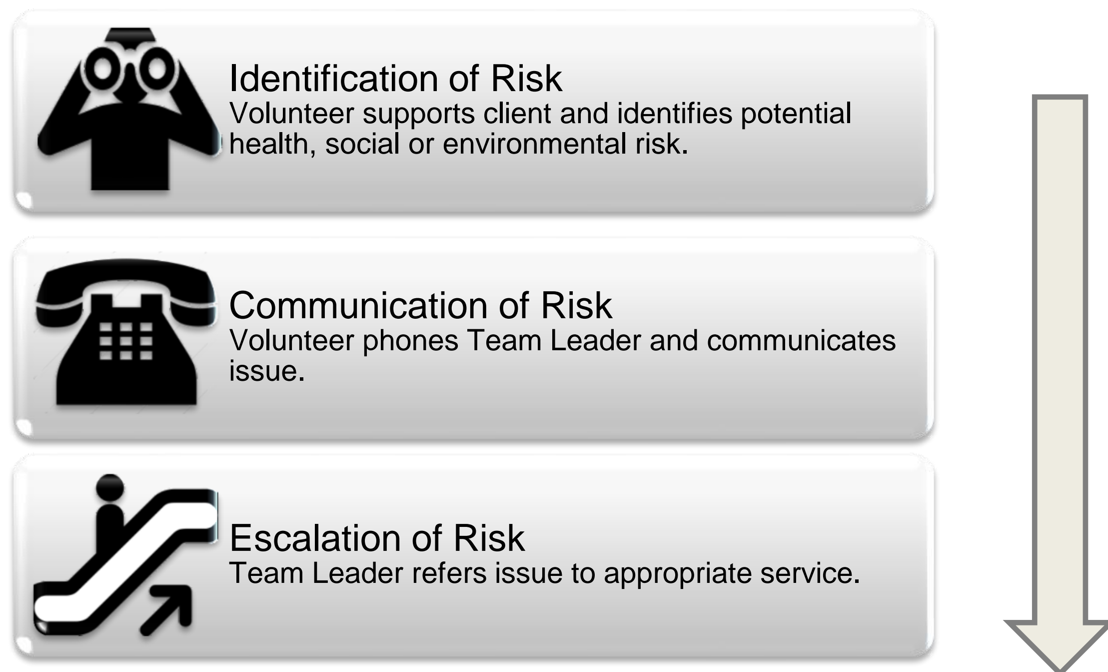

Figure 6: Team Leader Coordination

Advantages	Disadvantages
Expedient, responsive and time efficient	Reliant on competent volunteers to identify and communicate risks properly
Frees Team Leader to coordinate programme rather than 'hands on' care work	Absence of space for peer support discussions between volunteers
Enables more than just medical services to be contacted	Lack of team working benefits
Shows trust and gives responsibility	Requires commitment from the team leader to be instantly and always available as ease of communication is key
Referral is the responsibility of an expert who has connections, and capacity, to escalate issue to appropriate service	

Table 3: Advantages and Disadvantages of Team Leader Coordination model

4.2: Volunteers in MDT meetings

One much discussed opportunity for coproduction has been the integration of volunteers in Multi-Disciplinary Team (MDT) meetings. A MDT meeting "is an opportunity for a structured conversation about a person who has complex issues, potentially involving a range of practitioners" (Clement, 2014). Each practitioner brings their own knowledge about the client and disciplinary skills to the MDT meeting to jointly create an anticipatory care and action plan (Clement, 2014). This plan will then be delivered by the most appropriate key worker. The membership of MDT is listed in Table 4.

Core Membership:	GP's, Community Matron, District Nurse, Living Well Coordinator, mental health worker, social worker, Community Therapist, Practice Nurse, Community Pharmacist.
Additional Members:	Community Geriatrician, specialist nurses, Dementia Support worker and / or someone from the hospital discharge team, police

Table 4: Core and Addition members of MDT (Clement, 2014)

Our Living Well evaluation (2015) explains how volunteers' professional backgrounds, skills and passion represent an untapped resource for further co-production in care systems. The report goes on to explain how volunteers could do more than frontline caring. For example, volunteers have great potential to feedback useful observations to medical partners. In Figure 4 the potential model for volunteer integration is illustrated.

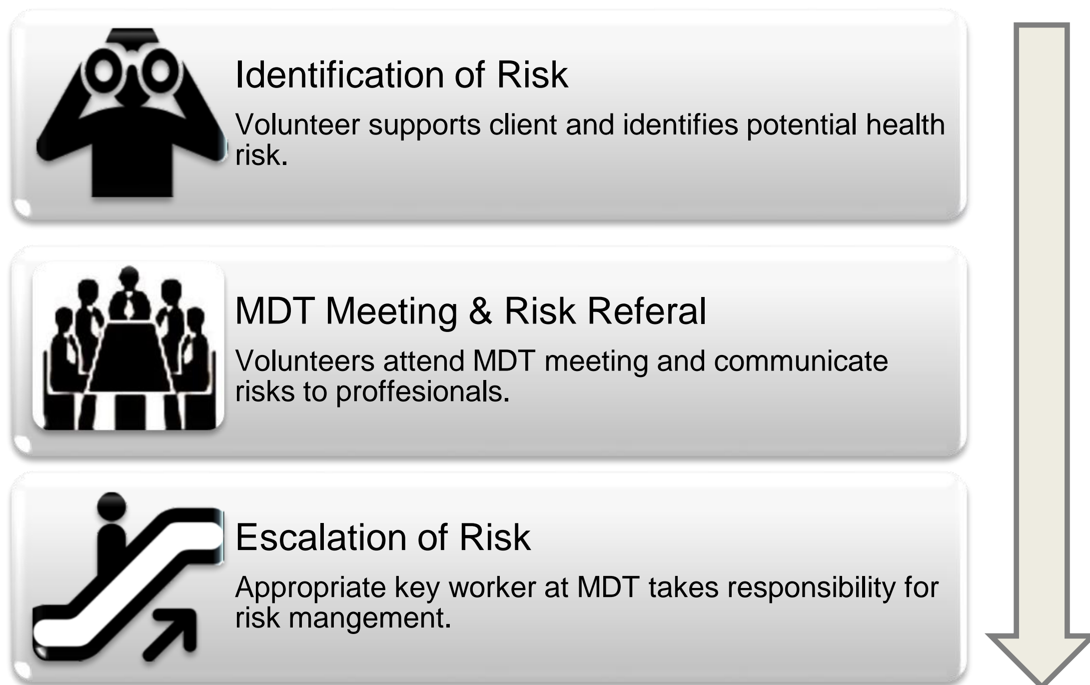

Figure 7: Volunteers in MDT Meetings

Advantages	Disadvantages
Volunteers have opportunity to gain professional healthcare experience	Absence of space for peer support discussions between volunteers
Volunteers look at elderly through a non-medical lens. Volunteers therefore 'ground' medicalised discussions of elderly needs and bring new insights	Continuity of relationship between GP's and voluntary sector is disrupted, with a potentially ever changing volunteer personnel attendance at MDT
Creating an open and wider conversation, across the whole locality, about current issues	Data protection issues of confidentiality and acquiring elderly consent for data sharing
Transition towards an organic evolution or services and practices	Practicality issues of high work load for volunteers
Enabling a culture of respect between volunteers and health practitioners around sharing information, understanding risk and identifying the barriers to delivery	

Table 5: Advantages and Disadvantages of Volunteers in MDT meetings model

Challenges and Solutions to for Delivery

The challenges and solutions are dependent on whose stand point you take but revolve around the following issues: 1) volunteer's desire and ability; 2) practicality; 3) language; 4) confidentiality; 5) recognition of benefits; 6) relationships.

1 - Volunteer's Desire and Ability: There is an assumption, from proponents of volunteer integration into MDT, that volunteers would want to integrate and secondly that they would have the professional ability to do so. As Volunteer Cornwall's Team Manager said "we need to stop looking at volunteers from an organisations perspective and start looking at volunteering from a volunteer's perspective; this MDT ambition is an organisational desire not necessarily the volunteers" (AB, 2015). Although the Team Manager continued, "some volunteers would revel in the opportunity as they might have had previous experience in such context or want to develop their professional CV. We should definitely develop the ability and opportunity to do so, but not force it. It can't be a policy for all" (AB, 2015).

With regard to the considering the volunteers' desires a specific concern was aired by the Director of Age UK Cornwall (NC, 2015): "what we have to protect volunteers from is the strategic wranglings which can go on in MDT, there is huge risk that such an experience would put a volunteer off". Alternatively a volunteer may have a strong desire to attend MDT because of their skill set and experience. However, this brings the potential challenge of "over confidence", as the Director of Age UK Cornwall explained (NC, 2015). For example, "while a volunteer might have been a nurse, per se, if they are not officially up to date on training and accreditation then they are not a nurse. This blurring of roles between past

professional experience and volunteering could be dangerous with a volunteer having an over confidence to contribute at moments in an MDT when it is not appropriate" (NC, 2015). It would therefore be sensible to explain the boundaries of the role to the volunteer in the first instance. In summary, as the Living Well Programme Manager (RP, 2015) noted, "some volunteers would love the challenge, others would hate; it comes down to the volunteer and their previous skills". The key point is that there are many different types of volunteers with different desires and abilities. Any initiative to integrate volunteers into MDT must put the volunteer first and organisational ambitions second.

2 - Practicality: There are number of practical considerations for the integration of volunteers into MDT. Firstly, not all elderly client needs are medical. As the Living Well manager pointed out: "what you have to remember is that transport, social issues and things like building access are often as important as medical type support". Integrating volunteers into MDT is only one way to achieve coproduction and thereby improve elderly healthcare. A second practical challenge, with regard to delivery, is that a volunteer may have to attend a number of MDT meetings in order to feedback on all their clients. For example, in Penwith there are nine GP practices and three of those practices are located next to each other. A volunteer may have to attend MDT meetings at all three practices. As a consultant for Age UK (JF, 2015) said "that's a lot of commitment for one volunteer, they are going to have to sit through a lot of cases which are not relevant to them". The key practical consideration here is for the workload of the volunteer. One solution might be for the Living Well Coordinator to allocate clients to volunteers who all are registered at the same GP practice.

3 - Language: As the Living Well Team Leader (CT, 2015) for West said "it's the medicalised, technical language, and abbreviations, so many abbreviations, that volunteers might struggle with. It takes a few meetings before you can work out what's going on". Essentially the MDT is the primary site for the medicalisation of elderly care and "they can be intimidating because they are do fast flowing and cold" (JF, 2015). The wider challenge referred to here is the "difficult process of integrating the voluntary sector with the expert health sector" as the Living Well Programme Manager (RP, 2015) explained. The language used and the fast paced ways of dealing with 'cases' in MDT is far different from the voluntary sector. This could create an insider-outsider challenge, as RP (2015) noted: "our staff get the 'outsider feel', let alone volunteers". The solution to the language challenge rests on "how well organised and structured [the meetings] are by the MDT chair if those coproduction benefits are going to be realised" (JF, 2015). A Living Well consultant explained that there are "a few examples of GP practices where the meetings are structured very well

such as Alverton practice". Therefore one solution, or step forward, would be to trial the integration of volunteers into meetings where the GP's are 'on board' with the Living Well coproduction philosophy.

4 - Confidentially: The most regularly cited barrier to the integration of volunteers into MDT is confidentiality and data protection. Within MDT confidential information is not simply mentioned in passing – sometimes "their whole medical history is put up on a slide" (SB, 2015). This of course is a huge concern for NHS practitioners who worry about volunteers being privy to personal medical data and breaking rules of conduct and ethics. As the Living Well Programme Manager emphasised: "there is a huge anxiety about volunteers in meetings by doctors for confidentiality reasons" (RP, 2015). The risk of breaching confidentiality rules is exacerbated by the potential for a volunteer to be a member of a GP practice where they are volunteering and as such know the other cases discussed at an MDT meeting. The GPs', and other practitioners', concern about confidentiality is heightened by the fact there are no national guidelines about how such issues should be handled in MDT. But as the Director of Age UK (NC, 2015) explained, "a national set of guidelines would not necessarily be the answer either. Because we all work in different contexts and with different stakeholders this might be more of a hindrance". The suggested solution was for a "locally developed MDT protocol" (NC, 2015) which would guide MDT chairs in how to integrate volunteers without breaching confidentially.

There was a fundamental criticism from the voluntary sector about the confidentiality issue in the first instance. Volunteer Cornwall's Team Manager noted that "there is a perception from medical officers that they are the only ones who can handle sensitive information. This stereotypes volunteers as untrustworthy. The reality is that those who would want this role are likely to retired lawyers or nurses and actually are most competent" (AB, 2015). The consensus among Living Well partners and consultants was that there were a number of solutions to overcome the challenge of confidentiality. Firstly, the most obvious and simple solution is for volunteers to sign the pre-existing NHS confidentiality agreement. Secondly, an agreement could be reached between the NHS and the elderly client if the client is 'ok' with their volunteer championing their needs at an MDT. Once an agreement is signed the volunteer is legally able to engage at MDT. The third solution would be to structure the MDT meeting agenda to allow volunteers to attend at the beginning of the meeting. By putting the volunteers' client's case at the beginning of the agenda the volunteers would not be privy to others, non-signed off, health data. How practical this would be in reality needs further research. The nub of the problem is the lack of guidelines about confidentiality and how

MDT's should be conducted. This has resulted in the different interpretations across the county about what is possible. Therefore what is needed, for the integration of volunteers, is a locally agreed protocol for involvement of non-NHS staff in MDT.

5 - Recognition of Benefits: The benefits of MDT meetings are well recognised, and are listed in Table 6 below (Clement, 2014). However, while there are a number of GP practices and MDT chairs that have endorsed the Living Well coproduction model there are many that have not yet realised the benefits of volunteer integration into MDT's.

Unrealised Benefits of Volunteer Integration into MDT
Improved communication and coordination, reducing duplication and preventing people falling between services
Better experience for people as it prevents ' ping pong' around the system
Provides more robust understanding about a person and their situation and therefore their support needs, matching the right person to the person.
Improved integration and trust
Identification of and use of a wider range of resources
Proactive approach to managing support

Table 6: Unrealised Benefits of Volunteer Integration into MDT (Clement, 2014)

The key benefit, of volunteer integration, was stated by a Living Well consultant "volunteers look at their elderly clients needs through a different lens, a much needed non-medical lens" (SB, 2015). In relation to the agreed benefits stated above, the integration of volunteers would thus bring a more 'robust understanding of the situation and the elderly's needs'. However, for the volunteer integration to be adopted by MDT across the county there needs to be a better evidence base for the benefits. This evidence then needs to be communicated in a holistic countywide campaign, and supported by NHS managers.

6 - Relationships: The final challenge, or barrier, is that of relationships. The current model works by the coordinator or team lead attending MTD and communicating risks. The relationship between the voluntary sector and the medical sector is built on more than just MDT meetings though. Enabled by co-location, the Living Well team are able to build a rapport with the medical team. This happens most effectively though 'corridor talk' where formal issues are discussed informally and action taken because of personal rapport. As a Living Well consultant explained, "this corridor chat is not just about creating trust with the doctors but it's actually where action happens, those relationships are key" (SB, 2015). Or as the Living Well Programme Manager (RP, 2015) said "the GP's like one point of contact with

the voluntary sector; their case loads are so busy". Introducing volunteers into MDT meetings potentially disrupts the continuity of that medical-voluntary sector relationship.

Widening the definition and practice of an MDT

A suggestion by the Living Well consultants was that the very definition and practice of an MDT should be widened: "I think that the focus should not necessarily be on volunteers in MDT's but about making volunteers more integrated as part of the healthcare team" (JF, 2015). The thing is that "people think of MDT as 4pm meetings on a Wednesday when everyone formally sits down. That definition needs expanding. MDT should be 24-7 and include informal conversations in the corridor as that's where we know the action happens. It's about a way of thinking and working" (SB, 2015). One practical suggestion we can draw from this alterative thinking around MDT is that it should not necessarily just be about volunteers integrating with the medical sector, but also the medical sector integrating with the volunteer sector. Our recommendation is that there should be trial in the attendance of medical staff to Living Well volunteer meetings; both formal and informal types.

5.0: Conclusion

This paper has examined the opportunities and challenges of current and potential models for the coproduction of care in Living Well. The paper has demonstrated that there is no 'one size fits all' model which would enable volunteers the power to: 1) shape how they are trained and deployed; and, 2) be part of healthcare delivery through involvement in the decision-making for their elderly clients. There is no 'right' model because of the plurality in volunteer's skills, personalities and ambitions. Thus the central conclusion is that a variety of different spaces and mechanisms for coproduction are required. This paper has shown that important spaces and mechanisms include: 1) regular peer support opportunities for volunteers; 2) an expedient system for non-medical referrals; 3) formal and informal spaces for healthcare professionals and volunteers to exchange information and learn together for the benefit of elderly clients. This considered it is recommended that new spaces, such as volunteers in MDT meetings, should be trialled as part of the transition towards a more successful and sustainable coproduced healthcare programme.

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Acknowledgements

Volunteers in Communities would like to acknowledge the ESRC for funding this project through an Impact Acceleration Award. Thanks to: Ian Jones (CEO Volunteer Cornwall) and Nigel Clark (Director of Care Age UK Cornwall and Isles of Scilly) for their input and guidance; Andy Brelsford (Support and Development Manager) Volunteer Cornwall and everyone who has provided information and advice.

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