

East Midlands PCT Development Programme
Building a Strong PCT – Community Dialogue

Proposal from the Centre for Innovation in Health
Management

University of Leeds

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Contents

Introduction	p 3
Our Approach	p 4
Our Offer	p 6
Co-production Projects	p 6
The patient and clinician voice	p 9
Organisational Sustainability	p 10
The Network	p 13
Methodologies	p 14
Evaluation Tool	p 16
Outputs	p 19
Our Experience	p 21
The Evidence	p 24
Our Team	p 25
Project Management	p 27
Timelines	p 28
Costs	p 29
Appendices	
Appendix 1: Example Toolkit	p 30
Appendix 2: CVs for the Team	p 38

Introduction

Defining Co-production

Co-producing health is at the heart of system's redesign at the:

- Individual level - co-producing treatment and care between clinician and client.
- Service level - co-producing services between health service staff and communities of patients/users in relation usually to specific health challenges e.g. chronic disease.
- Organisational level – developing fit for purpose management capacities and organisational forms which can support co-production co-producing (and possible co-creating) new organisations with local communities (mutuals/social enterprise).

Our Service

We offer a unique service to support co-production of service redesign particularly for people living with long-term conditions.

Our service has three distinct strands:

- (a) Co-production Projects: User-centred design process and communities of practice
- (b) Organisational Development (OD) and Learning for Sustainability – supporting innovation spread and Trust-wide learning about co-production.
- (c) Developing Health Professionals capability in co-production – developing skills to enable health professionals to work in service redesign with patients/users/carers.

We believe co-production – the ability of participants to actively work together to shape their own services over time – will deliver radical and effective solutions.

What does a Co-production look like?

We start with some emerging definitions.

Co-design – a collaborative process to generate both problem definitions and solutions that have the full participation of as many stakeholders as possible but crucially that of the final recipients of the solution.

Co-production – the follow-on process by which the final recipients (users) work with the people (including staff and carers) who will deliver the design to shape, refine and contribute to outcomes.

Our Approach

The process

Our co-production approach is often based on user-led design. Design is good at motivating people to do things: no-one needs an iPod, they are costly and complicated but people have bought them in their millions. Our design process examines the motivations of people in their own context, and tries to fit a solution into a natural space in their lives. The process does this through a series of facilitated interventions that are simple, fun, immersive and tangible; this makes them accessible to all. They are carried out locally, in context, to understand 'what works around here',.

At its heart the process gets under the skin of the patient/ user, carer, and health professionals to see what it is that leads them to behave the way they do – what motivates them, what is their lived experience.

How we do co-production

There are several models for co-production projects – the PDSA (plan, do study, act) cycle of the NHS “Collaboratives” <http://www.improvementfoundation.org> and the “double diamond” process described by the UK Design Council – they are broadly similar project processes and typically form the basis of our project designs. For more on our methodologies please see the methodologies section.

These models do not tell you how to do projects of this type, but they do form the structure within which the co-production team together chose methods and approaches and solve the problems they have identified.

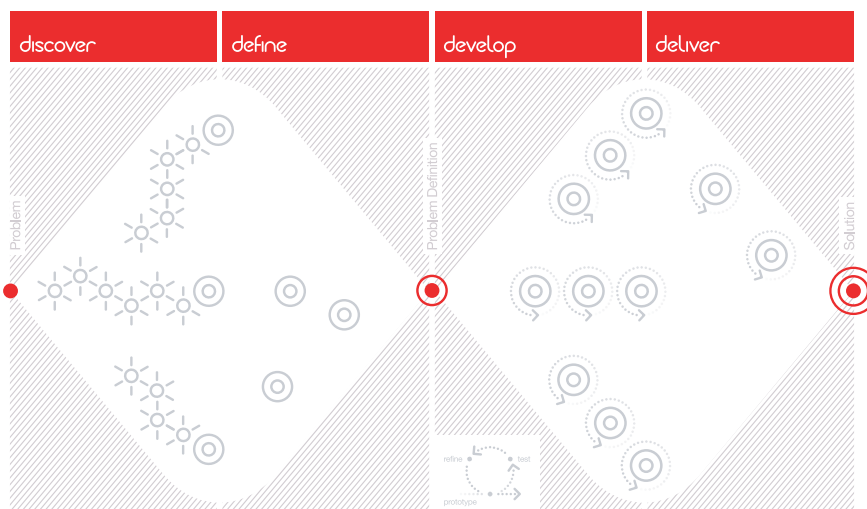


Figure – the UK Design Council's double diamond design project model

What's the issue we are going to work on?

We start with a question or problem statement; in Kent (one of the Design Council's RED projects) it was "how can we get people over 45 to be more active?" or in Grimsby "how can we provide services to hard-to-reach people?" The community (i.e. people living in the community; the PCT; strategic and operational managers professionals; other stakeholders) works out the problem it wants to work on that we believe requires us to work together to find a solution that makes the most of all our talents and skills, and requires all to change behaviour. PCTs / commissioning Trust often lead this stage, based on their needs assessment work.

Design Teams

We are fully committed to the co-production process. We therefore work with you to co-produce your own capacity to lead this work after we leave. We will work with a small number of dedicated staff from the PCT who co-design the whole project with us (called the 'engagement team for this work'), and learn the processes in real-time from us. We will be working together on all aspects of the process, and reflecting together on 'what's working'. This will include the development of metrics to measure the success of the projects, and taking part in the events for wider participation from the rest of the PCT and your colleague PCTs within West Midlands.

Our Offer

How we work

The first task is to clarify the problem statement with the participating PCTs. We work with you to identify the 'core' of your issue. We suggest that you bring a range of people into this early discussion. We also then scope your ambition for the work – in this case developing internal capacity to do this work in other areas in the Trust and across other Trusts in the SHA.

We then scope with you the organisational climate for this work, so that we can work through a project design that generates organisational support over the long term.

Overview of the proposal

We are offering collaborative organisational development support to the 4 PCTs in three ways:

- (a) Co-production projects –based on user-centred design and collaborative organisational development processes.
- (b) Working with the patient/person and clinician voice.
- (c) Organisational Sustainability – using designed conversations to sustain change and innovation for the lifetime of the project and beyond, and develop organisational capability in co-producing services.
- (d) Network meetings – 2 meetings of the participating PCTs along with the other Trusts in the SHA interested in learning about this work.

(a) Co-Production Projects

One of our project team has recent experience of a project with very similar aims to this – with Kent County Council. Martin Bontoft has been working with project teams, facilitating their exploration of engagement techniques, whilst helping them to develop a project methodology and codifying that in a process document and toolkit – in this way embedding co-production within service development.

Experience of the KCC project has shown that:

1. As soon as possible we need to identify and begin working with the 4 members of the PCTs who will form the caucus of this discipline; we'll call them the "engagement team" for now.
2. They will need protected time and effective, high-level managerial support; clearly they will also be members of a larger team who will be personally motivated to explore deep engagement and co-production.
3. The engagement team need some time to get to know each other and they will be tutored by us in co-production and experience-based design.
4. Co-production takes time and resources; the project budget provides scope for only one or two co-production projects, whereas we need many opportunities to allow the team time to develop skill in identifying specific issues and exploring the right responses.

5. Significant time and resources are required to develop, write, refine and communicate the methodology and toolkit; otherwise it risks not being sensitive enough to the ways in which different people, and different PCTs, conduct this type of work, in which case it risks being a waste of effort.

[Sophia Parker, the lead within KCC for this project has agreed to be a reference point for this work, she can be reached on 07939 229125 or at Sophia.Parker@kent.gov.uk]

Project strategy

With this background in mind, we propose that we facilitate the engagement team working on several projects that are already underway (where possible), as well as working with new areas as necessary within the target PCTs and city districts. We will support the engagement team fully as they offer support and practical assistance to these projects (existing ones, and ones that the PCT instigates), helping them to become more reflective of the communities' interests and aspirations. In this way we get numerous opportunities to intervene; real-life issues to deal with; we spread knowledge of this new discipline and we embed it properly within the host organisations.

The range and diversity of the inputs we make, and techniques we explore, will improve the quality of the methodology and toolkit. We will use appropriate designers at this stage to ensure the quality and usability of the final product.

The project in action

- One or two days (dependent on current capability in the team) spent with the engagement team (in addition to Organisation Sustainability workshop 1) where we exchange views and skills, explore in detail co-production, experience based design and examine case studies of engagement and co-production projects.
- We create a process whereby we connect with and list the project teams that we could work with, the type of input they are likely to need, and the areas we want to practice and develop skills within. We schedule our engagement in these projects. At this stage it is hard to assess how many, but our intention is to create enough learning opportunities for the team, which probably means between 8-12 projects. Clearly then the scale of our involvement is limited to those activities that allow the host team to better consult, engage or co-design with their communities.
- Members of the CIHM team will work with and accompany the engagement team as they work with their host projects, we will guide their input to ensure they offer real value to the projects, we will then work off-line with them to ensure they deliver on those promises. We will do whatever is required but at all times push the engagement team to do the thinking and practical work, to develop those skills and become self-sufficient.

- We will also facilitate learning sessions where the engagement team come back together, shares their learnings and we extract and collate whatever deserves to be repeated and documented.
- We will support the engagement team as they write the first draft of the methodology by which they work (we say “first draft” as we foresee this document being constantly developed and revised).
- We will offer techniques and approaches that we have used, discovered or developed to create the toolkit; in addition we will offer support to design a high-quality document or on-line resource.

Example of a Project Process using the Design Council Model

Getting the picture

The project begins with a number of **discovery** activities that examine the problem area from diverse perspectives: anthropological, technical, organisational. An intense phase of contextual work then follows – on the ground, in the clinic, home and shops – talking to people and engaging them in the issue, one to one, in their groups or at public meetings we organise. We capture the here and now visually through photographs and film, to make the patients/ users lived experience and issues visible.

Scoping the issue

These discovery activities generate information for a series of open dialogue meetings where participants **define** the issue/problem – those aspects to be supported by the co-designed solution.

Designing solutions together

The teams then **develop** a series of potential solutions; they do this by engaging locally and with expertise from diverse but related areas to provide innovative solutions. We facilitate workshops at which people and health professionals together develop ideas that form the basis of a design solution to the problem statement.

In developing solutions and in the spirit of co-production, the on-site team will both generate the ideas and decide on the ideas we take forward; we will offer guidance to ensure they can be achieved within the resources available and do all we can to make them successful. The two main criteria for the ideas will be their likelihood of implementation success, and how innovative they are for the local problems. We are looking to support ideas that come from the local situation, that are co-produced in context. These may be large or small changes. These changes are more likely to be sustainable because they are well thought through with maximum local ownership across all parties involved.

Prototyping

We lead the patients and health professionals through the development of simple prototypes that will be used to assess the idea quickly and iteratively. These prototype evaluations become progressively more realistic until they approximate to the final mode of delivery. Throughout, we will provide the support and facilitation to ensure that everyone’s contribution is positive and

equivalent, so that the participants in the design would become its users and advocates. The final prototype becomes the **delivered**, implemented service. This will reduce the long-list of ideas, to a few primary changes for each PCT.

Situated Learning

As we do this design work, we will evaluate the support we are giving and feed this knowledge back to the organisation through the Organisational Sustainability Workshops (see below) so they can develop the organisational changes and support needed to ensure this process continues, widens and gains momentum.

(b) Working with the patient/person and clinician voice

As we work in this project we can offer support to enable clinicians to listen too, and work with patients / carers/ community's ideas, experiences, wishes. At the core of our work is the idea is that patients and communities have gifts, assets and capacities to be recognised and built on, rather than merely deficits to be remedied by professionals. The learning theory we use is similarly asset -focussed and aims to strengthen the voice of the person within the patient and the professional.

The success of this approach has entailed working to strengthen the voice of the patient/carer/community member as that of an expert by experience who understands how to speak out, so that professionals will listen. At the same time, training for professionals helps shift their perceptions of the capacity of patients and carers to be their equal partners.

This part of the offer is based on our work in the Think Tank on Co-production, where organisations from across the UK have been sharing their learning and experience, and where we have heard the need for more development particularly for doctors.

Workshops for clinicians

Two-day workshop events (for up to 27 people per workshop) can be delivered for each PCT. The workshop is aimed at consultants, junior doctors, specialist nurses, GPs, AHPs and Practice Nurses. The workshops will aim to enhance the reflexive and practical skills of clinicians in order to enable them to support co-production, and will be underpinned by a proven approach that will develop their interpersonal and facilitation skills. The workshop will build the confidence of clinicians, to provide a constructive challenge to traditional approaches and assumptions, and to develop techniques supporting patients to self-manage. We can train your own staff to deliver this workshop so that by the third iteration they will not need input from us. We find that working with clinicians to prepare them for co-production, is a valuable intervention, that increases their capability within the projects.

The workshop includes coaching skills, feedback skills, listening skills; co-consulting; and also includes a simulation.

We will coach your Engagement Team to deliver this with other OD people from within the Trusts. Therefore we will provide the first 2 of these workshops (one for each PCT) and then partner with the Engagement Team for the next 2; then supervise a subsequent workshop,

Workshop for clinicians, patient/users, community workers, managers leading the co-production work together

This is an afternoon where we bring together all the clinicians and patients who are going to co-lead local co-production projects, to develop a feedback relationship that builds their relationship to do this work. This includes a skills development; modelling feedback; and working through with the partners their key requirements from each other. Each Trust will require 1 per project – say 8 in total.

(c) Organisational Sustainability

Collaborative Organisational Development – the organisational level

At the organisational level there is a special responsibility to act as a steward of public resources, particularly financial resources. In this context an organisation operates within a zero sum game, yet must promote service innovation in order to thrive. A key question therefore is how to manage current resources in order to encourage innovation and release resourcefulness? The options are to manage this through greater

- efficiency and/or
- effectiveness and/or
- user sensitivity.

Many health service organisations have experience of service improvement projects. These may arise from external factors such as policy directives, targeted investment, technical aid or internal conditions such as clinical champions. Few could claim that they have been able to capitalise on these projects to make continuous service improvement to change 'the way we do things around here'.

Modern Service Organisations are being encouraged to engage in interactive strategy making which implies a shift from the traditional 'relieving to enabling strategies'. (Normann R and Ramirez R Designing Interactive Strategy Wiley 1994). The concept of co-production is helpful here. Our working hypothesis is that if organisations use co-production as a lens through which to examine their way of doing business, it could provide new insights into overcoming familiar blocks to service development.

Making the work mainstream

You wish to mainstream the approach taken by their demonstration project into service provision for other long-term conditions.

You are seeking providers who will design their interventions for this local sustainability from the outset. This will require not just local development of

skills and expertise in service design, but organisational readiness to support this.

Throughout the project we will work with a local project team (which includes executive leaders) who will sponsor wider engagement across the health economy to ensure that an organisational perspective supports the co-production pilot¹.

We identify four groups with whom we would wish to work in each PCT :

1. Corporate/top group
2. The Engagement Team
3. Specific service design group (made up of patients/ users/ carers, clinicians, managers)
4. Other service groups

We understand there will be overlapping membership and that, as a design principle, service users will participate in all the activities we design. With an over-arching aim of releasing local resourcefulness and uncovering new possibilities for action we will explore what shapes three key areas of organisational work:

- Spending decisions
- Production efforts (keeping the show on the road and performance management)
- Possibilities for change.

We are offering 3 days. This will begin with an exploration of examples of times when training initiatives, projects and good local practice have been taken up, acted on to improve services for patients, and sustained into the future within the PCT. It will also explore local experience of barriers to developments of this sort.

We give an example below of an outline programme for this work. In each case we will develop programmes in detail with local people, as one contribution to building local capacity, but we anticipate that within any collaborative cycle attention will be given to things that:

- (i) Individuals can do themselves (professionals and patients)
- (ii) Groups of practitioners and managers can do together
- (iii) Groups of practitioners and managers can do with strategic support.

¹ Pratt J Gordon P & Plamping D (1999 / 2005 2nd edition) *Working Whole Systems: putting theory into practice in organisations*. Oxford, Radcliffe Publishing

Workshop 1

Participants: Top group and Local project team (20-30 people)

Purpose: to share ideas of 'what works here' based on real local experiences; to share understanding of co-production in improving services; to identify criteria for success; to begin action planning

Possible shape of the day: Four interactive sessions, each with small group work and whole group dialogue

- | | |
|-----------|---|
| Session 1 | Audit of past experience of service improvement |
| Session 2 | The role of co-production in service improvement. |
| Session 3 | Identifying criteria for success of this programme. |
| Session 4 | Action planning-what do we have to begin to do now. |

Workshop 2

Participants: All four groups in the award site (50 – 150 people)

Purpose: to shape expectations of this development programme

Possible shape of the day: A three part programme building on workshop 1

- | | |
|--------|--|
| Part 1 | What supports innovation around here |
| Part 2 | Conversational conference with two cycles of inquiry
Cycle 1: Presentation 'What we have learnt works around here'
Small group discussion 'what would we add, alter, amplify'
Whole group dialogue.
Cycle 2: Presentation 'Case studies of co-production in action'
Small group work 'what do we like/what needs more attention'
Whole group dialogue. |
| Part 3 | Action planning – what does this mean for us. |

Workshop 3

Participants: All four groups (50 – 150 people)

Purpose: to review progress and decide what next

Possible shape of the day: A collaborative PDSA cycle (plan, do, study, adapt)

(d) Network meetings

The purpose of the network meetings is to provide the opportunity for shared learning for patients, clinicians and managers involved in the pilots across the sites, and with the wider network of PCTs sponsoring this work.

The network will support the development of network-based communities of practice in service re-design. The participants in the network are resourceful and bring experience of the local pilot projects and the organisational context. We will design and facilitate the network meetings in a way that enables all to teach and all to learn. This is most effectively achieved by providing participants with opportunities for focused small and large group dialogue. The small group dialogue requires attention to the make-up of each group – often these will be mixed groups but there may be discussion questions that are more productive for groups that are focusing on the same long term condition; or for groups comprising managers or clinicians or patients. These small group discussions are often most fruitful when they are preceded by a

focused input from one of the participants. We can also design the network meetings so that they provide opportunities for people to raise current issues and to work together on a shared task – which might include influencing others not directly involved in the projects.

The network enables people to contribute to the evaluation, through the generation of evidence about their experience of the project and the making of evaluative judgements based on this shared evidence about the whole project.

Our experience is that in an ever pressured NHS, clinicians and patients find it hard to offer considerable days to cross- organisational events. We suggest that 2 network events are offered. These are 2-day events, requiring 2 consultants.

Methodologies

Co-production and collaborative organisational development – the methodology

We propose applying collaborative principles to the processes of service development. In so doing we work on the assumption that any organisational change which is co-produced with frontline staff and service users is more likely to change working practices in the short and long-term, because it is both well-informed and those who 'do the implementing' have had their say.

'Collaboratives' (www.ihl.org www.modern.nhs.uk) as a specific model of action learning, have been successfully applied to service development within operational teams. The model brings together the actual 'producers' (sometimes including patients, carers and operational managers) who can redesign a service through deciding to change their **own** behaviour. They adopt a 'pdsa' cycle (plan, do, study, adapt).

These collaborative processes embody assumptions about how people learn and change their work practices. They begin with exploration of how things *really* work around here. They assume multiple perspectives. No one player has the whole picture and both problem and solution finding are seen as collaborative processes (all learn, all teach). The action learning cycles promote learning through doing. These actions are based on 'grounded aspirations' (Cooperrider D 1997 *Appreciative Inquiry: a constructive approach to organisational development and change* Case Western Reserve University) and generate a virtuous cycle (Charles Hampden-Turner *Corporate culture*: 1990 Hutchison). One definition of collaborate is to '*make together*', so collaborative methods are congruent with the concept of co-production.

The collaborative model shares some characteristics with inquiry methods in which the cycle is described as the 4 Ds (Discover, Dialogue, Decide and Deliver). It differs from protocol development in which the design responsibility is delegated to a representative expert group, whose 'product' is then cascaded through the rest of the system. There is an extensive literature on the application of these approaches.

Collaborative Organisational Development is designed to support honest and grounded conversations, between people with different beliefs and aspirations about the possibilities for improving services for patients and their carers.

Possible changes as a result of the co-production process are likely to span investment to strengthen existing practices, and investment in new practices, and changes in practice which don't need new investment but need new ways of working.

We propose using Collaborative Organisational Development in each of the PCTs. It enables people to create a shared understanding of the conditions which are necessary to support 'fair trade' between the parts of a health care system. It enables a range of agents to ask 'What do we want of each other?' It requires every participant to consider their own actions and the consequences, intended or unintended, on other parts of the system. It requires every participant to contribute to service redesign. It requires both operational and strategic groups to work separately and together in ways which produce possibilities for action i.e. service improvement.

Designed conversations

We work with the originators of some of the most effective community dialogue processes and engagement and systems learning processes including Juanita Brown (The World Café); conversational conferences (Julian Pratt); Communities of Practice (Etienne Wenger and Myron Rogers); design teams (Myron Rogers). We will bring all these processes into the work as needed, and teach the facilitation of these processes to colleagues in the PCT.

Evaluation Tool

A key part of our work is to enable the system (in this case the PCTs) to articulate what they would consider 'success' to look like, and as part of their own interventions to support the co-production process to develop metrics that give them feedback on their trajectory to this picture of success. For instance in our pilot work in Bolton PCT, where we are evaluating the co-production work, we worked with a group of patients, clinicians, managers, and stakeholders to determine what they saw as success, and how they would know if the project was successful – what impact would they like to see. This led to a number of metrics.

Metrics

In our Organisational Development work, we work with the client to help them develop their own metrics, and to explore the relationship between these 'outcomes' and the processes we are engaged with. The essence is that 'you get more of what you pay attention too' so that metrics as part of systems feedback are a powerful intervention, and keep the organisation focused on the co-production project.

These metrics can be shared across sites using shared web-based space for benchmarking and to support learning across the sites.

Alongside this we have learning reviews on-site (as part of the organisational sustainability work) to 'make sense' of what is coming out from these measures, in relation to the co-production process.

As an example of metrics – these are what we co-produced with the Bolton project on diabetes. Any measures must make sense locally and be 'doable' i.e. must be metrics against which you can gather data.. The measures in Bolton are:

1. Effective Self-Management

- (a) The number of patients moving from 'knowing struggler' to 'able knower' – using the Design Council definitions.
- (b) Patient Activation Measure – Activation appears to involve four stages: (1) believing the patient role is important, (2) having the confidence and knowledge necessary to take action, (3) actually taking action to maintain and improve one's health, and (4) staying the course even under stress. The measure has good psychometric properties indicating that it can be used at the individual patient level to tailor intervention and assess changes.
- (c) Quality of Life
- (d) Changes to professionals behaviour
- (e) The patient's learning journey

2. User Outcomes

- (a) Patient satisfaction and voice
- (b) Social capital and social networks

3. Clinical Outcomes (disease specific)
4. Service Outcomes
 - (a) Cost
 - (b) Uptake of innovation
 - (c) Impact on core NHS deliverables
5. Diffusion to other service areas
 - (a) Rate of adoption
6. Impact on Health Delivery System Intervention
 - (a) Leaders attitudes

However with all these metrics we still have to make a link between improvement in that which is measured and the organisational change we are implementing.

Relationship to Evaluation

A research framework is usually designed to investigate research question in which there was little debate about what is valued nor consideration of multiple perspectives. The product of such research would be the 'truth': the one 'right' answer (Assessing quality in qualitative Research Nick Mays and Catherine Pope BMJ vol 320 2000 p50-52).

An alternative perspective is to adopt an approach that assumes different people will value different things i.e. multiple perspectives and that these may change over time. We expect to work along side the evaluators and award sites to co-produce an evaluation framework which can embrace these inquiry question(s).

This project is predicated on two propositions which are to be tested. The first is that co-production is a key element of service innovation. One of the evaluation challenges is to question:

- How are service changes valued and by whom? – criteria for success

The second proposition is that interventions on several levels will effect a change in the way people in local health care systems/award sites see 'the necessary conditions for sustainable service improvement'. This is effectively a culture change.

We are working with you to identify the best possible interventions on the basis of evidence and experience in this field of OD practice. The evaluation challenges are to question;

- How is the technical support linked to changes in behaviour?
- In what ways does the experience of working with the co-production project influence how people in the local system manage service innovation and delivery out with the project?

The Patient Learning Journey

In addition we have experience in capturing patient's learning journey which we can offer to the evaluators and/or to the sites to help ongoing feedback about the impact of this work on patients' self-management.

Outputs

Framework for Co-creating solutions

The Design Team will be designing a framework for the PCTs, with our guidance, support and supervision. This framework will be captured in the processes described below. It will incorporate and **Evaluation Tool**, that has been co-designed as part of the whole process (see section on Evaluation Tool).

The Story of the Process

You asked for a document describing the process developed in the 4 sites. Whilst we are happy to provide this, we also suggest you augment this with audio and visual capturing of the process and learning. Our process for the document will be to capture the story of the whole process, in a way that reflects the way we have worked with you and your communities.

Video

Here at the CIHM, we video our work, and make it into short (usually 3 minute clips) to go with our written materials. This means that people who have taken part in events and processes, can use the clips to show others they meet or work with, what happened and what they learnt. A good example of this is on You Tube at:

http://uk.youtube.com/profile_videos?user=bottomsmiddlestopsc

This was a 2-day workshop on Power in Organisations – people who were at that workshop can find the bits they were involved in; show a flavour of the event; and access the outcomes.

The costs of this are just the consultancy, as you can post the materials for free on You Tube, and then link it to your own website. An example where we have done that is:

http://www.cihm.leeds.ac.uk/themes/sust_health/case_studies/view_case_study?case_study_id=13

Audio

In addition we also undertake audio interviews so that these can be posted as podcasts for downloading and listening too at leisure. These would be useful for others to hear individuals' stories of being involved in the process.

Digital Storytelling

Finally we have a process for capturing stories that combines the above and produces a longer version of stories.

Toolkit

We are able to produce a very accessible toolkit for this work, that combines well with the document explaining the journey and learning and the audio and visual materials above. You can see an example of one of our toolkits at Appendix 1 from a project we undertook on the productive relationship between doctors and managers. This is designed for doctors and managers,

and is produced simply as that was the requirement. We can produce the toolkit in a user-friendly design for using with communities, leaders, managers, professionals. You can see an example of how the toolkit works with other materials on our site at:

<http://www.cihm.leeds.ac.uk/themes/managers/downloads>

Embedding the work in PCT priorities and practice.

The organisational sustainability design within our offer, and the work with the design team to be clear about boundaries in the 'designing solutions together' phase ensures that the PCT priorities are a critical part of the design of solutions that work. In addition the whole process for the projects incorporates the embedding of practices and the development of capabilities in the PCT design team members.

Our Experience

Here we offer some examples of our work on co-production.

Grimsby Open Door

Co-producing a new primary care service for groups that seldom use primary care in an area of Grimsby with multiple deprivations.

Grimsby is a smallish town in a forgotten area of Lincolnshire. It has the dubious distinction of being one of the most deprived areas in the country. Consequently it has high levels of obesity, substance abuse and chronic ill-health. Making matters worse, it has many groups who do not go to their doctors until they are literally falling apart. The Primary Care Trust (PCT) wanted to develop a new service to give better access to healthcare to these vulnerable groups - problematic drug users, sex workers, offenders, economic migrants and asylum seekers.

The project was to co-design and help co-produce the primary care service they need.

Clearly there is some reason why these people are not getting health care right now - it's available and accessible, so what is going on? The team felt we needed to get them on-side in some way, so we decided to co-design and co-produce the service with them.

The PCT were happy to explore this new approach; though the evidence is still being gathered, it is intuitively the right thing to do. Throughout the whole of the project, people were involved in doing the design research and in helping us to understand what we'd found out. They helped us to see, for example, that there are key aspects of the NHS that simply distance people from the services they need, and their needs are really simple, deceptively so.

The co-produced service that emerged from this work is built around a place of safety - somewhere warm, safe and non-judgmental - that they can spend all day in if they wish. Almost like an after-thought, there just happens to be a nurse or doctor there too. We developed this service as a social enterprise; the Department of Health is looking for good examples to promote their support of the social enterprise movement. They judged this project, out of several hundred applicants, worthy of "Pathfinder" status. This provides extra funding and expertise as the project moves into its implementation phase.

Renal Services

Working with the people on dialysis in Salford Foundation Trust's Renal Unit to co-produce service changes. We were directed to focus on their diet and management of phosphate, which is inefficiently removed by dialysis and can cause bone problems. We've been concentrating on developing ways of sharing good practice amongst people on dialysis, on empowering them to say or ask things they want but feel uncomfortable about, and allowing them to discover more about their food and its effect on their bodies.

One of the things we co-developed with the Wigan people was a "patient held care plan", a document that is kept by the person, that records all the information they feel is valuable to them and to their care team, and which is given to clinicians at the appropriate time - it helps transfer some of the authority for care to the "patient". In the New Year we'll extend the work we've done on this and try to encompass the whole pathway - from kidney disease to end-of-life care.

Governance

Co-designing Bradford Care Trust's Governance Model, with the local community and other stakeholders. This process is leading to a fully engaged membership model.

Kent County Council

We worked with Kent County Council to develop a methodology for the co-production of new services, specifically focusing on helping people to do user research, to develop an understanding of the needs for new services, and then to frame the specification for procurement or in-house design.

This was done by supporting two projects: one sought to develop new services for "families at risk", and the other redeveloped the online directory for adult care services. We lead a workshop for the "families" project that brought together a number of services with a specialist team of ethnographers who had been commissioned to help us tell the story of 'families at risk'.

Treatment Centre

One of our team has just started a project to develop a consultation process for a new £10m treatment centre in a deprived area of South Liverpool.

Sexual Health

We worked with a local multi-agency group who wanted to explore possible new models of sexual health services. We designed and led a series of workshops to bring together young people, professionals and managers from the statutory, voluntary and commercial sectors.

Simulated Patients

Finally we have a number of projects that have enabled collaboration with a wide range of patient, carer and community groups, extending the well-recognised, long-established approach of work with simulated patients, by a systematic involvement with the patient voice.

We are leaders in the development of patients as teachers, a key recommendation for effective work of the Picker Institute report on Education for Partnership. One of the cornerstones of this work is the development of the 'Spanner' model of simulated patients: this is a learning model where people roleplaying patients contribute a patient perspective as co-teachers, in an environment where learners are enabled to address feelings, attitudes and behaviours. Patients now co-design these roles and related assessments and, increasingly, are training as simulated patients and co-teachers.

Older People

Over 220 people took part in 5 workshops for those working and living in the 5 districts served by a PCT, to improve services for older people. The aim was to strengthen day-to-day working relationships, as well as contribute to strategic planning both for the PCT and the city. The participants agreed that they had developed a much better understanding of each other's roles. Some were able to make immediate changes to their practice. The PCT was able to identify a dozen key strategic themes, each with suggestions for very practical action to improve services.

Patients as Teachers Projects (delivered by the Faculty of Medicine and Health) including the contract for developing patients as teachers across the four West Yorkshire Universities (ongoing started June 2006 to finish July 2006); widening participation project funded by West Yorkshire Workforce Development Confederation; and a number of mini-projects e.g. delivery of a simulate surgery for EU doctors for North West postgraduate GP Deanery and supporting a local Acute Trust to enable people with long term neurological conditions to participate in service redesign (June 2006-Oct 2006). These have enabled collaboration with a wide range of patient, carer and community groups, extending the well-recognised, long-established approach of work with simulated patients, by a systematic involvement with the patient voice. Paper attached. Demonstrates our expertise in developing patients and clinician-patient dialogue.

The Evidence

We have been exploring the current evidence to support effective co-production at our own National Think and Do Tank. You can see the full range of our work on

http://www.cihm.leeds.ac.uk/themes/building_local_solutions/downloads

Our approach to the patient/user/person and clinician voice

The approach for the work with both professional and patient groups is informed by a long-established and tested model of experiential learning (the 'Spanner' model), developed to enable new conversations about healthcare, both clinical and organisational, that include patient engagement (Morris and Trafford 2004). This has been extended with a validated patient voice. Linked to this has been the development of the 'Patient Learning Journey' model for supporting the patient voice in professional learning and service development (O'Neill et al 2006).

These models are rooted in practice development and workplace learning. Currently, the partnership provides the patient voice focus for the National Centre of Excellence for the Assessment of Learning in Practice Settings and the National Practice Accreditation Scheme run by Leeds University.

Based originally in community development philosophy, these approaches continue to be informed by established and lasting collaborations with community groups, such as the Westside Health Authority, an African-American community health coalition in Chicago (www.healthauthority.org).

Our Team

The co-production design work is lead by Martin Bontoft working with Joe Heapy and Aviv Katz.

The Organisational Sustainability and network components will be lead by Diane Plamping The delivery team to include Pat Gordon, Julian Pratt, Martin Fischer, and Peter Whittingham.

The Workshops for Clinicians and for users/patients will be lead by Penny Morris, Fiona O'Neill, and Diane Plamping

The Capturing Learning and the e-based materials will be undertaken by Martin Wells.

The overall project will be lead by Martin Bontoft

Biography for Martin Bontoft

Martin Bontoft is one of the UK's top experts in user research within product development. His key contribution is in understanding human needs and communicating them to design teams in a way that informs and inspires.

Over the last few years he has been working with groups and communities helping them to co-design or co-produce services for themselves. Using many of the attitudes and techniques of experience-based design he is helping...

- Liverpool PCT to develop a consultation process for the future of a new £10m treatment centre in the south of the city.
- Bradford Care Trust as they seek Foundation Trust status: he is helping them to design a governance structure that allows good representation and user involvement at all levels of the organisation.
- Kent County Council's Social Innovation Lab: guiding two co-design projects as they develop solutions with and for the people of Kent.
- Wigan Renal Unit, where he is helping the people on dialysis to design service and environment changes for themselves.

He has just completed projects with the NHS, DePuy and Smith & Nephew in which he conducted ethnographic and design research to develop innovative product and service solutions.

In 2006 he worked with North East Lincs Primary Care Trust, leading a research and co-design project developing new services to reach vulnerable communities. He worked with a start-up to develop a new service using semantic web technologies He also created a new understanding for Gillette on why men skip shaving so readily. Over the summer of 2005 he worked with the Design Council, providing strategic input to the Health and Learning Environments project teams. He worked with their Directors to develop a plan for a 3 year programme of co-design projects aimed at establishing the role of design in health.

Previously he was Head of Human Factors and a member of the leadership team of IDEO in London – the worlds most award-winning design consultancy. Martin has

won 6 major design awards, written on inclusive design and lectures on design and user research methods.

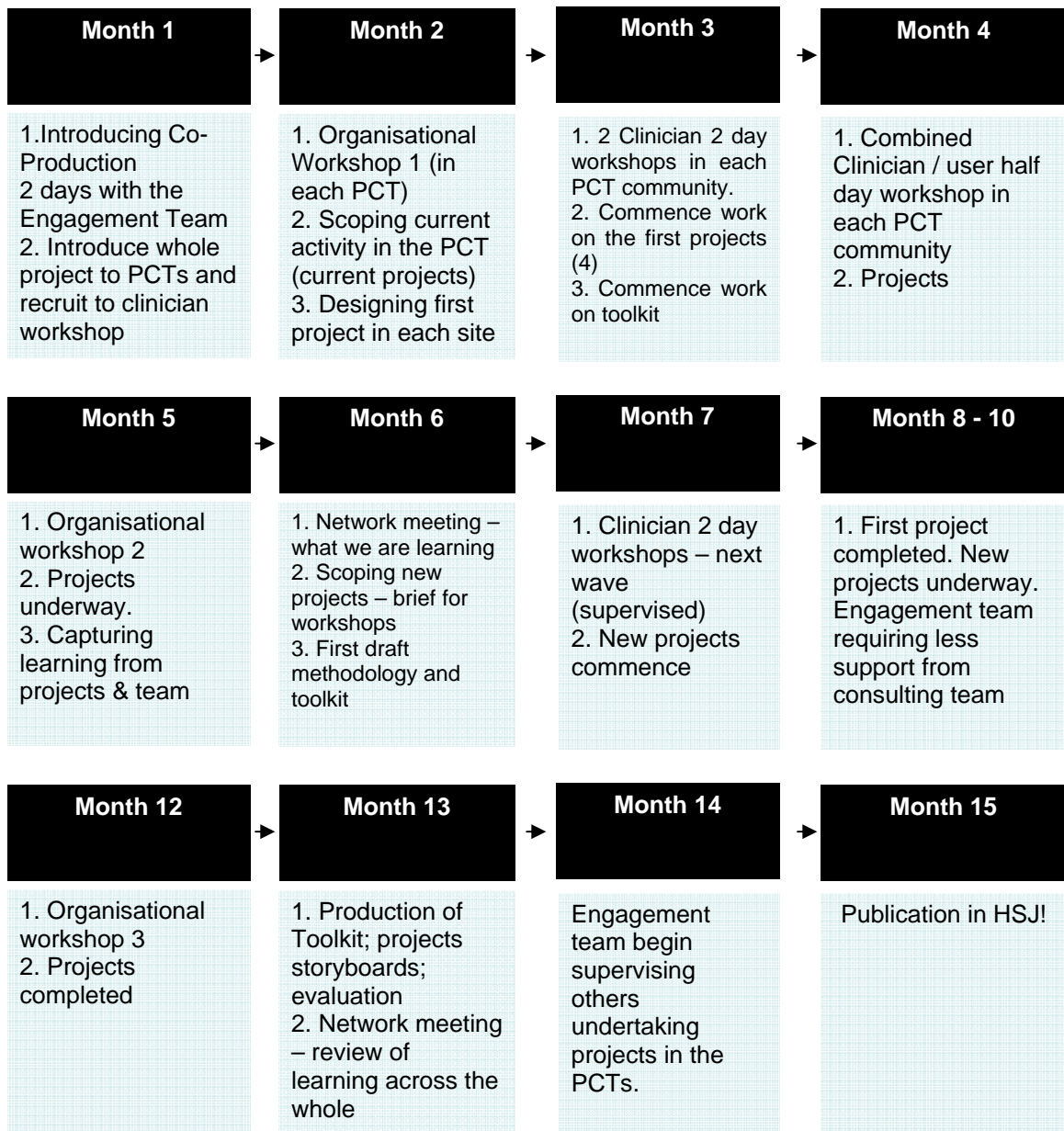
For CVs for our team please see Appendix 2

Project Management

The CIHM will provide a project manager for the whole programme of work. This project manager will provide:

- (a) The focal point of contact for the whole contract.
- (b) Client management and liaison – including site co-ordination; relationships with the commissioners.
- (c) Distribution of staff over the programme of work - ensuring appropriate staffing to reflect local requirements (Site specific needs).
- (d) Co-ordination of the CIHM's contractual obligations – ensuring all activities are delivered to schedule.
- (e) Quality control of the CIHM activity – including liaison with the commissioners; Performance review with the entire CIHM team; Learning review with the entire CIHM team. This will include attending some of the delivery on each of the sites.
- (f) Bringing in intelligence from other CIHM co-production activity that will inform the design and delivery of this programme of work.
- (g) Ensuring administration takes place smoothly.
- (h) Dissemination of learning from this programme of work into the CIHM network and other activities with the PCTs as opportunities present.
- (i) Coordination of products as required (e.g. toolkit)

Timelines



Costs

Our rates are as follows:

Consultancy for co-production and project management £1300 per day.

Consultancy for the e-based capturing of learning £1000 per day.

Note	West Midlands Co-Production	Cost	Faculty Days	
			Per PCT	Total
	Intro 2 days	5200	2	4
Note 1	Supporting projects + deliverables per community (x 2 per PCT)	54600	21	42
	Organisational Sustainability			
Note 2	3 days per PCT	20800	8	16
	Voice			
Note 3	Clinicians 2 day workshop	28600	11	22
Note 4	Workshop for clin and patients	15600		12
Note 5	Network meetings	7800		6
Note 6	Capturing learning video/audio/web			
	Capturing team learning	2000		2
	4 events	12000		12
	interviews participants x 20	8000		8
Note 7	Evaluation	10400	4	8
Note 8	Travel & subsistence	17000		
Note 9	Project Management	5200		4
	Total	187200		136
	Without travel & subsistence	170200		

- Note 1 21 days per PCT to cover up to 6 projects per PCT (i.e 3 per community) + toolkit
- Note 2 2 Faculty per workshop includes preparation time
To support 4 workshops per PCT for up to 27 staff - with decreasing involvement from our team, and increasingly delivered by PCT team.
- Note 3
- Note 4 2 workshops per PCT with 3 of our faculty.
- Note 5 2 x 1 day meetings. 2 faculty + preparation time.
- Note 6 To produce audio and video capturing for wider access to learning
Additional support for evaluation - supervision of data capture/ analysis/and making sense
- Note 7
- Note 8 An estimate for train fares; transport to meetings; hotel costs if required.
- Note 9 4 additional days for the whole for meetings to assess progress with the lead Directors.

Appendix 1 – An Example Toolkit

Developing Productive Relationships between Management and Medicine

The Inquiry Toolkit

2007

Introduction

This toolkit offers a way of improving productive working between doctors and managers in your Trust. There are a number of basic assumptions behind the set of questions you will be using to help you improve these relationships. These are:

- (a) Your intent in how you currently work together is to improve services
- (b) There is room for you to improve the management medicine relationship in your trust
- (c) You have a partial view.
- (d) Working with peers from other Trusts will offer you new perspectives

We start this work with a set of generative questions – questions that are useful to stimulate knowledge and creative thinking. These questions will uncover the assumptions you hold (as individuals, as professionals, as a Trust), about why you want to develop these relationships; what makes the relationship between medicine and management productive, and how to develop that productivity. They will then lead you into conversations about what we found in the Inquiry, and a process of reviewing your own potential as a Trust.

Your Intent

Questions for each Individual

- (a) What is important to you about developing productive relations between management and medicine? Why do you care?
- (b) What draws you to this Inquiry?

Questions for each Trust Group

- (c) What opportunities can we see for us in working on management and medicine?
- (d) What is it that we don't understand about the current situation (in our Trust, nationally)?
- (e) What is our intention here?

Questions for the managers and doctors separately

- (f) What do you most appreciate about (doctors / managers)?
- (g) What have we each got to offer?
- (h) What more can we do if we do it together?

What We Know

The Inquiry used doctors and managers stories of times when the working relationship was productive, and from these elicited the conditions that support these relationships in the workplace. It is much easier to understand these categories if you start with your own stories. We used Appreciative Interviewing to find out 'what worked'.

Appreciative Interviewing is described as part of a wider process called Appreciative Inquiry (AI). Essentially AI is based on the premise that all systems work to some degree. Our approach is to uncover where and how the relationship between management and medicine is working; focus energy and attention on understanding why and how it works; and uncover the conditions that are enabling it to work well.

We use the term Appreciate here in the affective. It does not mean 'like' or focusing on positive scenarios – it literally means appreciating the conditions that support things working round here (which could be how conflict is handled for instance).

Working in fours, you take the role in turns of Storyteller, Interviewer, and Observer (twice).

The Interviews

So, to start the interviews the Interviewer needs to introduce the process of the Interview, saying that the interview will focus on the times in the interviewees work when the relationship between management and medicine has been at its best. Explain that this is to help learn about what it takes to make this relationship work well.

You ask the interviewee to tell their story of a productive relationship between management and medicine in their own workplace, that they have been part of. You ask the interviewee to take their time, telling the story as richly as possible

The Interviewer will be listening and looking during the interview for the instances when the person being interviewed 'comes alive' to gain a better understanding between you of what gives the interviewee vitality and a feeling of success.

In interviewing the storyteller, ask for their story and then when you have given them time to tell the story out, probe deeply and intently to get to what they did and thought and felt.

Use open ended questions such as:

- 'Why do you think that?'
- 'Who else is involved?'
- 'What do you think he/she would say, if they were here?'
- 'What is the most important thing?'
- 'Have you been in this sort of situation before?'
- 'What did you do then?'
- 'How were the outcomes different?'

Then ask about the conditions that supported the times when the interviewee felt like this. Use questions like:

- 'How do you know that?'
- 'How is this different? (from other work and the ways things are done round here).'
- 'What about the relationships (in the team, across the organisation, with partners, with the community).'
- 'What about information did you use?'
- 'What are your hypotheses/ ideas about what was going on?'

Some of the interviews may move into analysis/ hypothesising. The Interviewer needs to keep them on the evidence rather than their interpretations/assumptions/ opinions, for as long as they can to get the full story, then let the interviewee move onto their views as to 'why'. Guide them back to the work of the interview.

Observer

During the interview, the Observer has the invaluable job of listening. You will all hear the story slightly differently, and it is this difference that will help you analyse all the information. The role of the observers is to listen for the conditions of the productive relationship, that underpins the interviewee's story, and make notes of these. The conditions need to be specific (saying good communication is not enough – what made it good, who was involved).

At the end of the Interviewers session, the observer can ask questions relating to the conditions.

Together

At the end of the storytelling session, gather your own views on the few things that enable productive relationships to flourish. See how these relate to the Inquiry findings and categories.

How Are You Enabling and Supporting Productive Relationships Between Management and Medicine? – Your Diagnosis of ‘What Is’.

These questions are for you to answer collectively, as a Trust. Answering the questions should in itself help you develop a better understanding between professional groups.

1. Do You Have the Features of Productive Relationships in Your Trust?

Do you:

(a) Negotiate a shared identity?

Evidenced by: shared language (‘we’ not ‘them and us’); describing Trust ambition in a way that demonstrated shared responsibility; stories that show both doctors and managers ‘manage’; stories of having ‘done it together’.

(b) Have open, participative, inclusive communication?

Everyone free to voice their views; time and space for discussion and exploration; conflict seen as productive and useful; mutually agreed ways of talking about sensitive issues; clear about what counts as acceptable behaviour; able to give and receive feedback; make the most of conflict, seeing it as a useful way of getting to new solutions.

(c) Have a collaborative leadership style?

See yourselves as partners; managers enable doctors to manage themselves; influence rather than control; mutual challenge; making the best of each other’s strengths; leading together.

(d) Make decisions at all levels with greater clinical input?

Managers value clinical decision making and let go, willing to delegate responsibility; Doctors see the value of management; making more decisions together; a structure that puts doctors and managers together at the heart of the organisation; a performance management system that offers services feedback that is useful for developing practice.

(e) Care about the same thing? (Our Business is Health)

The management agenda is a clinical agenda – the patients and the clinical service is the purpose of the Trust; you make sense together of the context in which you are managing services, including the political and policy environment; the first conversation in any decision is the impact on the clinical service.

2. Do You Have the Conditions in Place that Enable Productive Relationships?

Do you

(a) Work strategically?

Ensure you meet national targets to give you 'air cover'; play the 'long game' – leaders who stick around to see things through; have a long-term vision; avoid complacency – seek challenge to stimulate development.

(b) Use the current situation to stimulate engagement?

Link change to things doctors and managers care about; offer incentives for improved performance; share the 'diagnosis' of the current situation – own it together; be energetic about change; genuinely listen to and understand all perspectives.

(c) Invest in the Trust to support productive relationships?

Organisational development – to embed behaviours and culture; Human resources – offering joint management training, and leadership development to all interested and involved in managing; Performance Management – developed at service level, owned by doctors and managers, negotiated across the Trust, with agreed metrics, supported by information systems.

In Summary

We found doctors and managers work best together when the following conditions exist.

- A clear focus on the clinical business
- space is created for local innovation by managing upwards
- decisions are devolved to the right level
- there is continuity over time
- complacency is avoided by seeking internal and external challenge
- interests are aligned through rewards, information, and performance management.
- doctors and managers make sense of the external environment together
- there is frequent dialogue to build a shared purpose
- differences are seen as an asset – conflict is used positively
- managers and doctors understand each other
- there is investment in organisational change, doctors and managers learn together, and locally relevant performance management systems are developed.

How would you summarise your performance against this list?

And Now

Thinking about the questions you have answered so far, for you personally:

What surprised you?

What challenged you?

What hasn't been said?

What has real meaning for you from this conversation?

What has been your major insight, learning, discovery so far?

What Next?

Answer these questions together....

What's possible for us in our Trust and who cares?

If success was guaranteed, what bold steps would we take?

What needs our attention going forward now?

How can we each contribute?

What challenges might we face and how might we meet them?

What are we going to do tomorrow?

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Appendix 2

Curriculum Vitae for our Team

Name	Mr	Martin	Bontoft
Degree subject/ Professional Qualification (s)	BSc Hons Ergonomics		
Present and Previous Positions Held	<p><i>Independent design consultant, May 2005 to date</i> Providing strategic advice on user research and design strategy.</p> <p><i>Head of Human Factors, IDEO London, 1996 to April 2005</i> I managed two teams – an office team of 12 people and the Human Factors team of 5. I deputised for the Head of Office, with responsibility for 45 people.</p> <p><i>Human Factors Consultant, self-employed, 1984 to 1996</i></p>		
Examples of previous training, development and organisational change work relevant to this work on supporting co- production	<p>Retained by the Design Council to advise the directors on plans for the Health campaign.</p> <p>Worked with the RED team during their Health project – research planning and analysis of findings.</p> <p>Developed plans for Surrey & Sussex PCT Alliance project on proactive telephone health advice service.</p> <p>I lead the development and presentation of participative courses in the IDEO design process.</p> <p>For Eli Lilly, I lead a project to look at the needs that people express at first diagnosis of diabetes and then created a map of opportunities to satisfy those needs.</p> <p>I conducted user research to assist the design of a new brachytherapy device for Varian.</p> <p>I helped develop a new wound treatment service for Smith & Nephew, taking the technology from the lab to the clinic and market place.</p>		

Relevant Publications

Design awards

2004 IDEA Gold award for Vodafone Lisbon Interactive Cube
2004 Red Dot award for Lufthansa Technik Wireless Handheld Remote
2002 IDEA Gold award for SpyFish User Interface
2002 IDEA Silver award for SpyFish Vehicle
2001 IDEA Gold award for Amtrack Acela

Publications & Invited Lectures

Lectures and tutorials at Royal College of Art, University College London and Loughborough University
Chapters 12 & 30, Bontoft M & Pullin G; "Inclusive Design – design for the whole population"; Clarkson, P.J., Coleman, R., Keates, S., Lebbon, C., 2002, SpringerVerlag
"18 Brownies came to visit", paper delivered at Include Conference 2001, Helen Hamlyn Research Centre, Royal College of Art, London
Master class for Danish Architects Association, 2000
CRAMP – The Development of a Graphical User Interface; Bontoft M & Dillon J; 1993; Contemporary Ergonomics, Taylor & Francis, London
A Quality Standard for Maintenance Manuals; Bontoft M & Whitton R; 1993; Proceedings of the 1st European Meeting on Postal Technologies, Nantes, France
Graphical User Interface Development; Bontoft M & Dillon J; 1992; Proceedings of the USPS 5th Advanced Technology Conference, Washington DC

Name	Mr	Martin	Fischer
Degree subject/ Professional Qualification (s)	1977 - 1980 B Sc Joint Honours Mathematics and Economics (Manchester) 1980 - 1981 MSc Economics (LSE)		
Present and Previous Positions Held	2007 – present: Director Sg2 1990 – 2007: Senior Fellow Kings Fund & Associate of the Centre for Innovation in Health Management. 1987 - 1990: Commissioning Editor Open College 1982 - 1987: Head of Resource Centre. World ORT Union		
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	<p>Working with North London Standing Group on HIV/AIDS... reaching hard to reach groups (e.g. Male Zimbabweans)</p> <p>Working with Homeless People in East London. Enabling them to decide what they wanted from services, and how to engage with the health & local authority sectors.</p> <p>Mental health Foundation: Strategy for Learning Disability - design plus working with the client group so they could participate in and shape the strategy.</p> <p>Work with Doctors, nurses users and carers on how they want to reorganise service and behaviours - Kings Paediatric Liver unit.</p> <p>Management for Specialist Registrars. A programme that I have been directing for 13 years at the Kings Fund.</p>		

Name	Ms	Pat	Gordon										
Degree subject/ Professional Qualification (s)	<p>MSc London School of Economics MA Glasgow University</p>												
Present and Previous Positions Held	<p>Current Appointments Research Associate, LSE Health and Social Care Partner, PPG Partnership Non-Executive Director, Whittington Hospital NHS Trust Chair of Governors, Acland Burghley School</p> <p>Previous positions held</p> <table border="0"> <tr> <td>1999-2005</td> <td>Research Associate, Urban Partnerships Group, Operational Research London School of Economics</td> </tr> <tr> <td>1994–1999</td> <td>Co-director, London & Northern Health Partnerships</td> </tr> <tr> <td>1988 – 1994</td> <td>Director, Primary Health Care Development, King's Fund</td> </tr> <tr> <td>1980–1988</td> <td>Programme manager, Inner City Initiative, King's Fund</td> </tr> <tr> <td>1974–1978</td> <td>Secretary, City & Hackney Community Health Council. Special Adviser, Parliamentary Select Committee on the Ombudsman</td> </tr> </table>			1999-2005	Research Associate, Urban Partnerships Group, Operational Research London School of Economics	1994–1999	Co-director, London & Northern Health Partnerships	1988 – 1994	Director, Primary Health Care Development, King's Fund	1980–1988	Programme manager, Inner City Initiative, King's Fund	1974–1978	Secretary, City & Hackney Community Health Council. Special Adviser, Parliamentary Select Committee on the Ombudsman
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1988 – 1994	Director, Primary Health Care Development, King's Fund												
1980–1988	Programme manager, Inner City Initiative, King's Fund												
1974–1978	Secretary, City & Hackney Community Health Council. Special Adviser, Parliamentary Select Committee on the Ombudsman												
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	<p>National learning networks of clinicians and managers</p> <p>We were engaged to design and facilitate a national network that brought together the leads from the 34 local cancer networks every 2 months for a year to learn from and support each other. We have also run chief executive networks for the NHS and an urban primary care network at the King's Fund.</p> <p>Engaging clinicians in service improvement</p> <p>We have carried out a wide range of work with local systems of health and social care, including clinicians, to improve local services. This has included city-wide strategies for urgent & emergency care and for hospital discharge, and the provision of crisis care for people with mental health problems.</p> <p>Working collaboratively as part of a multi-organisational team</p> <p>We have brought together consortia of organisations to carry out large development tasks. These have included working with modellers and programmers to deliver on time a computer simulation of flows and costs in the criminal justice system for the 2004 spending review; and with specialists in workforce planning to develop new models of care and a strategy for future health services in the Milton Keynes sub-region of rapid population growth</p>												
Relevant Publications	<p>Pratt J Gordon P & Plamping D (1999 / 2005 2nd edition) <i>Working Whole Systems: putting theory into practice in organisations</i>. Oxford, Radcliffe Publishing</p> <p>Gordon P, Plamping D & Pratt J (1999) <i>Partnership: fit for purpose - testing a theory in practice</i> in Schrujijer S Multi-organisational partnerships and co-operative strategy, Dutch University Press</p> <p>Gordon P & Hadley J (1996) <i>Extending Primary Care</i> in <i>Primary Care Development Series</i> (eds Gordon & Plamping) Radcliffe Medical Press: Oxford</p> <p>Hughes J & Gordon P (1992) <i>Hospitals and primary care: breaking the boundaries</i>. King's Fund: London</p>												

Name	Ms	Penny	Morris
Degree subject/ Professional Qualification (s)	BA Hons Eng/Phil, University of York		
Present and Previous Positions Held	<p>2001- present: Senior Lecturer in Communication Skills, Medical Education Unit, Faculty of Medicine and Health, University of Leeds; Associate Adviser, London Postgraduate General Practice Education for doctors in difficulty</p> <p>99 -01 Associate Director, SE Thames Postgraduate General Practice Education</p> <p>97-99 Associate Dean, Clinical School, University of Cambridge</p> <p>97-99 GP Tutor, NE Thames Postgraduate General Practice Education</p> <p>95-97 Senior Research Associate, University of Cambridge</p> <p>92-95 Research Associate, Curriculum Facilitator, University of Cambridge</p> <p>90-91 Harkness Fellow, <i>investigating patient voice in healthcare</i>, Northwestern University, USA</p> <p>86-91 Research Fellow, Clinical School, University of Cambridge</p> <p>72-86 Founder, director Inroads and NW Spanner community drama cos.</p>		
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	<p><i>Community of practice building:</i> Co-convenor of meeting, 'Patient and Community Voices in Professional Learning: Building a Platform for Change', 2006. Member of the Taskforce for the 'Where's the Patient Voice in Healthcare Education?' Conference, Vancouver, 2005. Founder of UK Network for Communication in Healthcare (COMNET), now established as a Royal Society of Medicine Section.</p> <p><i>Learning model development:</i> Co-originated and developed the 'Spanner' learning model, working with simulated patients as co-teachers, a model disseminated nationally and internationally.</p> <p>Implemented controlled trial of intervention to improve medical students' abilities to involve patients in management during consultations. Results, including the 'Oxbridge' rating scale, applied in medical schools and NHS Trusts nationwide.</p> <p>Leading developer of patients as teachers models in UK and USA</p>		

Relevant Publications	<p>Thistlethwaite J and Morris P. (2006) <i>The patient-doctor consultation in primary care: theory and practice</i>. RCGP publications, London, <i>in press</i></p> <p>O'Neill F and Morris P (2006). <i>The Informed/Empowered Patient: A literature review</i>. European Health Care Management Association, <i>in press</i>.</p> <p>Armitage A, O'Neill F, Morris P, Roberts T. (2006) The Patient Voice in Medical Education. <i>Clinical Teacher</i>, <i>in press</i></p> <p>Morris P, O'Neill F. (2006) Preparing for patient-centred practice: developing the patient voice in health professional learning. Paper presented at Beyond Reflective Practice conference, 3 July. Available at www.leeds.ac.uk/educol/documents</p> <p>Morris P and Trafford P (2004). Learning from Patients. In: Burton J, Jackson N (eds). <i>Work Based Learning in Primary Care</i>. Oxford: Radcliffe, pp 87-102</p> <p>Kilminster S, Hale C, Lascelles M, Morris P, Roberts T, Stark P, Sowter J, Thistlethwaite J (2004). Learning from real life: patient-focussed interprofessional workshops offer added value. <i>Medical Education</i>, 2004; 38: 717-726</p>
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Name	Dr	Fiona	O'Neill
Degree subject/ Professional Qualification (s)	PhD (Politics, Birmingham University, 2000) B.A. (Hons) Social Science RGN, RMN		
Present and Previous Positions Held	<p>Programme Associate and Evaluation Lead, Centre for the Development of Health Care Policy and Practice, School of Healthcare, University of Leeds (2004 to present)</p> <p>1999-2004, Lecture Applied Health Studies and Researcher, School of Healthcare, University of Leeds.</p> <p>1993-1999, Research Assistant and ESRC funded doctoral student, University of Strathclyde and University of Birmingham</p> <p>1977-1989, Number of nursing posts mainly in acute and community based psychiatry</p>		
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	<ul style="list-style-type: none"> • <i>Development and Training to Enhance the Patient and Public Voice in Professional Education</i> (Funded by the West Yorkshire Workforce Development Confederation, July 2006-2007) <p>This extends a successful approach to supporting and enabling people to get involved in professional learning. The model complements self-management approaches by providing opportunities for people who have long term health conditions to reflect on their journey and through guided discussion and small group work, identify what they as individuals might have done differently. These insights allow individuals to make very positive and potentially transformative contributions to professional learning.</p> <ul style="list-style-type: none"> • <i>Long Term Neurological Conditions; Making a Difference</i> (June 2006-ongoing, Bradford Foundation Hospital NHS Trust) <p>Our team have been commissioned by this local Trust to provide a tailored programme for people who have a long term neurological conditions. The aim is for people to feel prepared and supported to get involved in service improvement activities linked to the long term conditions NSF.</p> <p>Evaluation of our training model indicates that individuals value our approach. People have found the training to be a springboard for taking more control over their illness and changing their approaches to interacting with health professionals. The training for service users is linked in with professional learning approaches. Scenarios developed from issues discussed during training inform simulated patient sessions and a number of people who have gone through the training now work as simulated patients.</p> <ul style="list-style-type: none"> • Practice Development Unit (PDU) Programme facilitator and coach <p>This accredited Programme provided by CDHPP supports multi-professional health and social care teams make intentional, evidence-based and patient centred changes. I am the coach to a number of community and hospital based Units and have supported teams to make changes in their approach so that self management becomes a more integrated and supported element of health care. A number of people who have long term health conditions are supporting the Programme and are able to give advise and challenges to the Units.</p>		

Relevant Publications	<p>O'Neill F.H. and Morris P (2006). <i>The Informed/Empowered Patient: A literature review</i> . European Health Care Management Association,</p> <p>O'Neill, F.H., Morris, P and Symons J (2006) Bridging the gap: Learning with Patient Teachers in Health Professional Education. <i>Practice Development in Healthcare</i>, 5 (1) 26-29.</p> <p>O'Neill, F.H. (2004) Beyond the Tick Box: Developing a Strategic Approach to Patient Involvement in Education. In: McAndrew and Warne (eds) <i>Using Patient Experience in Nurse Education</i>, Palgrave, Macmillan</p> <p>O'Neill, F.H, (2002) Service User and Carer Involvement in Nursing and Midwifery Education, Leeds University.</p>
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Name	Dr	Diane	Plamping
Degree subject/ Professional Qualification (s)	1983 1969 1972	PhD London University BSc Hons Genetics and Human Immunology, London University BDS London University	
Present and Previous Positions Held	1999 – present 2006 – present 1999 – 2006 1994-2001 1994-1998 1987-1994 1982-1989 1972-1982	Partner in PPG Partnership Research Associate PSSRU London School of Economics Research Associate Dept of Operational Research & Decision Science, London School of Economics Chair of Tower Hamlets Health Care NHS Trust (THHT) Director of the London Health Partnership (LHP), Kings Fund Fellow in Organisation Development Kings fund Senior Lecturer, London University Clinical/professional experience	
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.		<p>National learning networks of clinicians and managers</p> <p>We were engaged to design and facilitate a national network that brought together the leads from the 34 local cancer networks every 2 months for a year to learn from and support each other. We have also run chief executive networks for the NHS and an urban primary care network at the King's Fund.</p> <p>Engaging clinicians in service improvement</p> <p>We have carried out a wide range of work with local systems of health and social care, including clinicians, to improve local services. This has included city-wide strategies for urgent & emergency care and for hospital discharge, and the provision of crisis care for people with mental health problems.</p> <p>Promoting co-production in service re-design</p> <p>We were instrumental at the King's Fund in sponsoring the first visit to the UK by Edgar Cahn to explore the development of Time banking as a mechanism for promoting co-production in service re-design</p>	

Relevant Publications	<p>Plamping D (1994) <i>Community-Oriented Primary Care; A resource for developers</i>. London, King's Fund</p> <p>Pratt, J., Gordon, P. & Plamping, D (1999 / 2nd end 2005) <i>Working Whole Systems: putting theory into practice in organizations</i> Oxford, Radcliffe Publishing</p> <p>Plamping D, Gordon P & Pratt J (1998) <i>Action Zones and large numbers</i> London, King's Fund</p> <p>Plamping D (1998) <i>What organises the NHS – organisational structures or guiding principles?</i> British Medical Journal 317 July</p> <p>Pratt J, Plamping D, Ombler-Spain S, Harries J, Gordon P, Fischer M & Evans K (1998) <i>The NHS - Order for free?</i> Proceedings from the Organisations as Complex Evolving Systems conference, (Warwick, BPRC)</p>
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Name	Dr	Julian	Pratt										
Degree subject/ Professional Qualification (s)	BA in Animal Physiology, Oxford University MA (Oxon) B.M, B.CH Oxford University and University College London MRCP (UK) Membership of the Royal College of Physicians MRCPGP (UK) Membership of the Royal College of General Practitioners												
Present and Previous Positions Held	<table border="0"> <tr> <td style="vertical-align: top;">1999-Present</td> <td style="vertical-align: top;">Partner, PPG Partnership</td> </tr> <tr> <td style="vertical-align: top;">2006-Present</td> <td style="vertical-align: top;">Research Associate, LSE Health and Social Care London School of Economics</td> </tr> <tr> <td style="vertical-align: top;">1995-2005</td> <td style="vertical-align: top;">Research Associate, Urban Partnerships Groups, Department of Operational Research and Decision Science, London School of Economics</td> </tr> <tr> <td style="vertical-align: top;">1993-1999</td> <td style="vertical-align: top;">Visiting Fellow, King's Fund, London</td> </tr> <tr> <td style="vertical-align: top;">1974-1992</td> <td style="vertical-align: top;">Clinical and Professional Experience in health care provision and development</td> </tr> </table>			1999-Present	Partner, PPG Partnership	2006-Present	Research Associate, LSE Health and Social Care London School of Economics	1995-2005	Research Associate, Urban Partnerships Groups, Department of Operational Research and Decision Science, London School of Economics	1993-1999	Visiting Fellow, King's Fund, London	1974-1992	Clinical and Professional Experience in health care provision and development
1999-Present	Partner, PPG Partnership												
2006-Present	Research Associate, LSE Health and Social Care London School of Economics												
1995-2005	Research Associate, Urban Partnerships Groups, Department of Operational Research and Decision Science, London School of Economics												
1993-1999	Visiting Fellow, King's Fund, London												
1974-1992	Clinical and Professional Experience in health care provision and development												
Examples of previous training, development and organisational change work relevant to this work on supporting self-management.	<p>National learning networks of clinicians and managers</p> <p>We were engaged to design and facilitate a national network that brought together the leads from the 34 local cancer networks every 2 months for a year to learn from and support each other. We have also run chief executive networks for the NHS and an urban primary care network at the King's Fund.</p> <p>Engaging clinicians in service improvement</p> <p>We have carried out a wide range of work with local systems of health and social care, including clinicians, to improve local services. This has included city-wide strategies for urgent & emergency care and for hospital discharge, and the provision of crisis care for people with mental health problems.</p> <p>Working collaboratively as part of a multi-organisational team</p> <p>We have brought together consortia of organisations to carry out large development tasks. These have included working with modellers and programmers to deliver on time a computer simulation of flows and costs in the criminal justice system for the 2004 spending review; and with specialists in workforce planning to develop new models of care and a strategy for future health services in the Milton Keynes sub-region of rapid population growth.</p>												

Relevant Publications	<p>Pratt J Gordon P & Plamping D (1999 / 2005 2nd edition) <i>Working Whole Systems: putting theory into practice in organisations</i>. Oxford, Radcliffe Publishing</p> <p>Pratt J, Plamping D & Gordon P (2003) <i>Conversational Conferences: from ideas to action</i>, British Journal of Health Care Management, 9, 98-103</p> <p>Pratt J, Plamping D & Gordon P (1998) <i>Partnership: fit for purpose?</i> London, King's Fund</p> <p>Pratt J & Kitt I (1998) <i>Going home from hospital - a new approach to developing strategy</i>, British Journal of Health Care Management, 4, 391 – 395</p> <p>Freeman R, Gillam S, Shearing C & Pratt J (1997) <i>Community Development & Involvement in Primary Care</i>. London King's Fund</p>
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Name	Mr	Peter	Whittingham
Degree subject/ Professional Qualification (s)	<p>First Class Honours Degree, Chemistry, London University 1970</p> <p>Diploma in Sociology and Anthropology, Kent University, 1971</p>		
Present and Previous Positions Held	<p>Owner Strategic Possibilities Consulting Ltd, trading as Peter Whittingham Consulting: 1997 to date, associate with the Centre for Innovation in Health Management and with a range of consulting firms including PwC, IBM and Hedra.</p> <p>Visiting Fellow, Nuffield Institute for Health: 1997 to date</p> <p>Community Care Director, Moores Rowland Consulting: 1995 - 1997</p> <p>Head of Community Care consulting in the health group with KPMG Consulting: 1991 – 1995</p> <p>Assistant Director of Social Services, North Yorkshire County Council: 1987 - 1990</p>		
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	<p>Annual facilitation of Southwark PCT and Council Leadership Group in the search for new ways of designing, delivering and reviewing services which has included focus on user empowerment and realisation.</p> <p>Transforming Services for Older People in Leeds: a four year change programme which focussed on the establishment of integrated commissioning teams and worked with a range of user and community groups in designing access to services that were more relevant and meaningful for them as they managed their lives and problems rather than fitting in with existing orthodox service patterns. Included the use of drama and play scripted and filmed by service users to explain needs to professionals and politicians.</p> <p>Developing New for Old in Croydon, a five year change programme, culminating in new resource centres for older people, with active citizen participation in the development and design of the services and the incorporation of engagement and self management as part of a Wanless approach to service functionality.</p>		

Name	Mr	Martin	Wells
Degree subject/ Professional Qualification (s)	Bsc Physics, University of Surrey AUS Nuclear Physics, Germany MSc Radiation and Environmental Protection, University of Surrey PGCE Further Education and IT, University of Huddersfield		
Present and Previous Positions Held	2001 – present Owner and Managing Director and facilitator HeadandHeart Ltd 1995-2001 Solutions for Business: Owner and facilitator 1987 – 1995 Consulting Project Analyst. P&Pplc 1986 – 1995 Project manager : BICC Cables		
Examples of previous training, development and organisational change work relevant to this work on supporting self- management.	Facilitator committed to quality results through analysis, creative thinking and craftsmanship. An inventive communicator with an open style who achieves results through investigative listening, the production of engaging learning experiences, their effective planning and control, and clear direction and engagement of the learner. Clients include: ALENIA MARCONI SYSTEMS, ATTACHMATE LIMITED, AXA INSURANCE UK, BACKHOUSE INSURANCE GROUP, BAE SYSTEMS, BNFL, BURNLEY COLLEGE, CETAD UNIVERSITY OF LANCASTER, CUMBRIA CONSTABULARY, DEPARTMENT OF WORK AND PENSIONS, FOCUS EXPERIENTIAL TRAINING LIMITED, FUSION RADIO, HBOS, ICELAND.CO.UK, LANCASTER UNIVERSITY, LEICESTER HOSPITAL PATIENT SIMULATION UNIT, MANCHESTER CITY COUNCIL, MANCHESTER MUSEUM, NATIONAL RAILWAY MUSEUM, NEWS INTERNATIONAL, NHS, NORTH AINLEY HALLIWELL SOLICITORS, NOSWA, NTS LIMITED, O2, QUEST INTERNATIONAL LIMITED, ROYAL & SUNALLIANCE, THE COMMONWEALTH GAMES MANCHESTER 2002, THE HOLT - AMERICAN STANDARD, UK MUSEUMS, UNIVERSITY OF LANCASTER, UNIVERSITY OF WARWICK, VIRGIN MEDIA, WARBURTONS LIMITED, ZETEX SEMICONDUCTORS..		