Changing together: brokering constructive conversations
Summary

Wicked issues – complex problems that cannot be solved in a traditional fashion – are endemic in the NHS. They are nothing new. But the current challenges the NHS social care and others are facing are arguably the most ‘wicked’ yet. There is a danger that the new models of care discussed in the Five Year Forward View will be implemented in ways which fail to recognise their inherent complexity. This is because the issues surrounding integration involve a number of different organisations and people with competing interests, who disagree about what exactly needs to change, and how. There is also a growing recognition that attempts to transform systems of care purely from the top-down are neither effective nor sustainable in actually delivering better outcomes on the ground.

In his 2016 speech to the NHS Confederation, Simon Stevens, the Chief Executive of NHS England, said that times were going to be tough for the NHS. He spoke about there being difficult finances, the lack of progress being made on scaling up innovative practice, and the difficulty in recruiting enough good staff. Referring to Sustainability and Transformation Plans (STPs) – the sub-regional plans that set out how services will be reshaped – he told the audience that it is, ‘going to be bloody tough; let’s just be frank about that too. But that is what the nature of the leadership challenge is in front of us right now’.

Developing these plans will partly be so tough, he said, because of how difficult it will be to win the backing of local citizens for radical change. Formulating a vision for new models of care is one thing, agreeing how it will be delivered in practice will be much harder. What happens to a vision that isn’t followed by a widely owned and agreed plan? In these instances, it very often gets stuck, opposed by the very people who are most expected to benefit from it: patients, people who use services and the wider public. Service user, patient and carer involvement in service design, commissioning, and delivery is critical to building visions and plans that are more likely to be sustained.

This report presents the findings from a research study which sought to explore how we can better broker constructive conversations with citizens to tackle wicked issues associated with the implementation of new models of care. The research was undertaken by the Social Care Institute for Excellence, working in partnership with PPL and the Institute for Government and funded by the Health Foundation’s Policy Challenge Fund.

Case studies

The case study sites were selected to draw learning from vanguard sites and innovative early adopters of new models of care who had demonstrated a commitment to co-production:

- **Mid-Nottinghamshire Better Together**: this primary and acute care system vanguard supports people with complex needs to get back home and stay safely after hospital care. Its wicked issue covers a range of stakeholders from patients and carers to leaders, managers and frontline staff in the acute, primary and community
sectors, requiring a complex change process to align incentives across all services to deliver a better patient and system approach to transfers of care.

- **Dudley Multispecialty Community Provider**: this multispecialty community provider vanguard is working to transform end of life care, aiming to develop a network of integrated, GP-led providers across health and social care. Its wicked issue covers the complexity of care required and the multitude of organisations/professionals involved in a person’s end of life care, with the team working to transform both the patient, carer and professional experience of the system.

- **Camden and Islington NHS Foundation Trust**: in an area with significant demand for mental health services, the local NHS Foundation Trust has embarked on a programme to transform the service offer available. The Trust believes that too many people who use services needlessly end up in specialist, acute care and often for unnecessarily long periods of time. As part of the proposed solution, the Trust is moving towards an integrated-practice based model of mental health service provision, and has rigorously adopted co-production as a way to engage the patients and public.

**Findings**

As others embark on developing and implementing new models of care or the plans set out in their STP, there is much learning to be drawn from the significant body of literature reviewed as part of this research [1] and our case study sites about how we can better broker constructive conversations. In summary our research suggests:

**Brokering constructive conversations at a whole system or service level**

- There is no one-size-fits-all methodology.
- Genuine co-production, deliberation and negotiation take time and resources.
- The best results are achieved when the engagement process begins at an early stage of planning service change and is maintained during implementation.
- Building public understanding of the choices and trade-offs to be made is a strong foundation for constructive conversations. Nonetheless, there is also value in demonstrating a clinically led case for change.
- Citizen Boards or other forums that foster a culture of leadership amongst the community can act as ‘translators’ between patients and professionals.
- There is a need to continually look for innovative ways to engage more seldom-heard groups.
- Being clear about the remit and purpose of the conversation, what professionals want from people who use services, and managing expectations about how views will feed into the decision-making process, are all important ways of building relationships and trust.
• Positive steps need to be taken to address the imbalance between health, social care and mental health professionals, in enabling constructive conversations with citizens.
• A shared language should be agreed and adhered to and, as much as possible, be jargon-free.

**Brokering constructive conversations at an individual, care-planning level**

• Whilst not wishing to lose sight of the many actors involved in service transformation, to make the implementation of new models of care a success there is a need for constructive conversations with citizens not only at a system or service level but also at an individual, care-planning level.
• Constructive conversations are critical to good, proactive care planning and good care planning is essential for tackling wicked issues such as the transfer of care or end of life care.
• There is a need to further support and develop frontline health and care staff to have these challenging conversations and articulate the benefits of new ways of delivering care in the community.
• Constructive conversations between and across frontline professionals and managers are essential to constructive conversations with patients and families.
• The health and care system needs a workforce that is reflective creative, empathetic, and comfortable with uncertainty and committed to learning.

**Conclusion**

Change on the scale required within the health and care system cannot be dictated through old-fashioned linear planning that is ‘done to’ communities. Rather, we need creative approaches to problem solving – which include a fair degree of trial and error and experimentation – to arrive at solutions. Constructive conversations between service providers and people who use services and communities can help broker these solutions, enabling hard-pressed service leaders to use the expertise, assets and experience of citizens to help guide their decision-making.
1. Introduction

Wicked issues – complex problems that cannot be solved in a traditional fashion – are endemic in the NHS. They are nothing new. But the current challenges the NHS, social care and others are facing are arguably the most ‘wicked’ yet. Rising demand due to an ageing population, the rise of chronic and long-term conditions and growing expectations from citizens have placed an enormous amount of pressure on local health economies and if left unaddressed will lead to a £30 billion funding gap by 2020/21 [2]. Spending reductions have also led to many local authorities increasing the threshold for receiving adult social care, with £941 million worth of savings in adult social care planned for 2016/17 [3]. Shifting resources from acute treatment towards prevention and self-care, developing new models of care and integrating health and social care are now widely seen as a key part of the answer to these pressing challenges.

NHS England’s Five Year Forward View [4] sets out a vision for the future, calling for fundamental changes to the way health services are commissioned, organised and delivered. It includes five new models of care being developed in 50 vanguard sites, which aim to ‘forge a new relationship with patients and communities’. Building on this, the 2015 Spending Review announced a commitment to health and social care integration by 2020 and NHS England is also pressing forward with large-scale reforms which require local areas to produce Sustainability and Transformation Plans (STPs) [2] for the health and care needs of whole populations.

Wicked issues and new models of care

The literature describes [1] wicked issues as being multi-causal with connections to many other issues; difficult to define; socially complex and that require a whole-system, multi-agency response. What makes wicked issues ‘wicked’ is that they cannot be solved using traditional linear problem-solving techniques and evidence-based solutions. These approaches fail because often a number of different organisations and people with competing priorities are involved and disagree about what exactly needs to change and how. Both the process of health system transformation and many of its current goals (e.g. achieving health and social care integration, shifting resources from the acute sector into prevention) are classic examples of wicked issues [5-15]. The challenge for health and social care leaders and planners is to recognise which problems are ‘wicked’ and to approach them accordingly – a concept highlighted in the case studies identified through this research project.

In addition to recognising the complexity of the challenges faced, policy and literature increasingly regards citizen involvement – in the design, commissioning and delivery of services, as essential for building local solutions and buy-in. Building on recent commitments in the Five Year Forward View [4] and in the Care Act [16] to enhance citizen involvement, Next Steps on the Five Year Forward View states:

Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities.
Nationally, we will continue to work with our partners, including
patient groups and the voluntary sector, to make further progress on our key priorities.

So what does this mean in the context of the Five Year Forward View? Building on the characteristics outlined in the literature, we have identified a host of wicked issues which fall into three different (but overlapping) categories:

- **Why change is needed**: the drivers for change are longstanding, deep-rooted and highly complex issues, which commonly involve different groups of stakeholders with competing interests, who disagree about problem causes and how to intervene.

- **What change will look like**: changes required to bring about new models of care, cut across organisational boundaries, and for which clear definitions and solutions may be elusive.

- **How change will happen**: elements needed to support the change process that are socially complex and may be politically contested, where evidence may be necessary to make progress but is by no means sufficient to achieve lasting success.

Figure 1 provides specific examples of wicked issues in the Five Year Forward View, mapped against each of these categories.

**Figure 1: Examples of wicked issues currently facing the health and care system**

- **Why change is needed**
  - Closing the funding gap
  - Improving prevention and public health
  - Tackling health inequalities
  - Mental health problems
  - Supporting carers
  - Delivering services for people with multiple, complex needs
  - Personalisation of care
  - Improving dementia care
  - Managing demand

- **What change will look like**
  - Health and social care integration
  - Care closer to home
  - Multi-professional team working
  - Technology embedded in the organisation and delivery of care
  - People having greater control of their health and care
  - Appreciation and use of community assets
  - 7 day services
  - Integrated personal commissioning

- **How change will happen**
  - Service and system reconfiguration
  - Reforming how services are commissioned and paid for
  - System wide leadership
  - Co-designing local services
  - Workforce redesign
  - Aligning incentives across the system
Brokering constructive conversations

There is growing recognition that attempts to transform systems of care purely from the top-down are neither effective nor sustainable in actually delivering better outcomes on the ground. For example, on the critical issue of health and social care integration, Shaw and Rosen note that:

A number of integration initiatives have focused on reducing fragmentation but have failed to appreciate the complex nature of fragmentation; lacked clarity about what they are addressing and why; and rarely appreciated the way in which the context of such initiatives shapes integration. Services remain fragmented and ill-equipped for patients with complex needs.[17]

This is because the issues surrounding integration involve a number of different organisations and people with competing interests, who can at times disagree about what exactly needs to change, and how. Progress crucially depends on ‘constructive conversations’ between health and social care services, as well as with the communities they serve.

What is a constructive conversation?

The term ‘constructive conversations’ was coined by Marshall Marinker in relation to the policy-making process in health [18], but appears to be rarely used in either literature or practice. There is strong resonance between Marinker and the wicked issues evidence [1], with both emphasising that decision-making is a social process involving different (and potentially clashing) interests and the negotiation of conflicting values. On this issue, Marinker observes that:

‘In recent years the aspiration has been that health policy be ‘evidence-based’. However policy is not the product of the data alone. It emerges from group interaction. In this, the light of evidence and reason is inevitably deflected through the prism of the values, preferences, emotions, intellect and personality of the individuals who take part. The term conversation implies far more than ‘speaking together’.[18]

When we tested this concept out with both national stakeholders and the local areas participating in the action research, there was a common view that ‘constructive conversations’ imply in-depth dialogues between people who commission and provide services and patients, people who use services and the public. This dialogue, it was felt, would involve elements of co-production¹ and be sustained over a period of time. People also felt that a constructive conversation was one that is trusting and inclusive, treating people as equals.

¹ SCIE defines Co-production as being ‘about developing more equal partnerships between people who use services, carers and professionals.’[21]
Indeed, concerns have been raised about the lack of citizen involvement in STPs [19], prompting NHS England to issue guidance about engaging local people for local areas developing STPs [20]. The guidance recognises that ‘Involving people, communities and stakeholders meaningfully is essential to effective service improvement and system transformation, from collectively identifying problems and designing solutions to influencing delivery and review. Effective communication and involvement throughout the process will help to build ownership and support for proposals to transform health and care and will also help identify potential areas of concern.’

‘STPs are not a bidding process; they are a problem solving process. They are a way of having a focused, honest, trusted conversation about some of the ‘elephants in the room’, some of the ‘big ticket items’, the difficult choices, that need to be resolved. How they are resolved will look different in different parts of the country.’

(Simon Stevens, Chief Executive, NHS England speech to NHS Confederation Conference 2016)

Hence, involving citizens in this dialogue is viewed by many as not just desirable but essential. National Voices, a coalition of health and social care charities in England, states that ‘The evidence is increasingly clear that better engagement – by which we mean involvement and co-production – is not a nice-to-have, it is core business’ [22]. Citizens offer a unique perspective, are willing to think differently about some of the issues they are most passionate about, and want to get involved in finding solutions to the challenges of spending cuts, service reconfigurations and infrastructure change when given the opportunity to engage more deeply. Citizens need to be part of developing a shared understanding of what successful change looks like, and the trade-offs required. This involves making value judgements and addressing competing priorities.

‘Properly embraced, the insight, experience and expertise of citizens can make services better tailored, more sustainable, and ensure that service changes command legitimacy. Services should engage with, involve, and empower patients, carers and the public’ [22]

(National Voices, June 2016)

However, co-producing solutions with citizens and communities is neither easy nor straightforward. The well-documented challenges include: lack of time, resources and capacity; public concerns about whether it makes a difference; the difficulty of trying to engage seldom heard groups, and; difficulties in preventing certain perspectives from dominating. We know it is particularly difficult in relation to health and social care integration because of individual, organisation and system-level barriers to public involvement in health and care policy.

**About this report**

Within this context, this report presents the findings from a research study which sought to explore how we can better broker constructive conversations to tackle wicked issues associated with the implementation of new models of care.
This report draws on the following work streams:

1. An evidence scan, undertaken by ICF, focusing on what ‘wicked issues’ the Five Year Forward View presents for local health and care economies; what is meant by a ‘constructive conversation’; what attempts have been made to involve the public in constructive conversations in health and other sectors; and what are the barriers and enablers to constructive conversations.

2. A workshop, chaired by Lord Michael Bichard, Chair of SCIE, bringing together experts in health and care policy, people who use services and health and care practitioners to discuss the importance of having better conversations about the wicked issues of the health and care changes in England today.

3. Conversations with senior leaders at the Department of Health, NHS England, the National Audit Office and the Local Government Association about what supports or hinders constructive conversations at a local level and the role their organisation plays in creating the conditions for successful conversations taking place.

4. Action research with three case study sites (Mid-Nottinghamshire, Dudley and Camden and Islington) to help us generate rich and varied insights and learning about how local places are having constructive conversations with citizens, to tackle the ‘wicked issues’ surrounding the implementation of new models of care.

A more detailed overview of the methodology can be found in Appendix 1.

This report will be of particular interest to commissioners and providers of health and care services about to embark on service or system redesign and the implementation of new models of care; STP leads; NHS England nationally, regionally and at area team level; voluntary sector groups and organisations with an interest in patient and public participation; and health and wellbeing boards.
2. Brokering constructive conversations to tackle ‘wicked issues’

One of the main objectives of this research was to gather insights and learning about how constructive conversations with the public about health and social care transformation can be enabled and supported.

How localities are brokering constructive conversations with citizens

We sought to explore in-depth how localities are brokering constructive conversations with citizens, to develop sustainable solutions to tackle the ‘wicked issues’ surrounding the implementation of new models of care. Building on the evidence base [1] and using an action-research approach we worked with three sites – Mid-Nottinghamshire, Dudley and Camden and Islington. The case study sites were selected in order to draw learning from vanguard sites and innovative early adopters of new models of care who demonstrated a commitment to co-production.

The case studies below describe how citizens are being involved in developing new models of care. The case study narrative describes and reflects the views and perceptions of the many actors directly involved in the action research.

Case study 1: Improving relationships between staff and patients

Mid-Nottinghamshire Better Together: Supporting people with complex needs to get back home and stay at home, after hospital care.

Context

The Mid-Nottinghamshire integrated primary and acute care system (PACS) vanguard - Better Together – is a programme created to develop a joined-up way of working for health and social care across the districts of Mansfield, Ashfield and Newark and Sherwood. This area of Nottinghamshire, north of Nottingham city has a population of approximately 347,000. The deprivation indices for Mid-Nottinghamshire vary considerably, with particular levels of deprivation in Mansfield and Ashfield. The demand for health and social care is increasing, there is a growing number of patients who need more complex care and the costs are rising. It is estimated that this could lead to a funding gap of £140 million in this area of Nottinghamshire alone in 10 years’ time. [23]

This PACS aims to deliver a whole-system integration of hospital, community, social and primary care within a single outcomes-based capitated budget contract, with social care funding via personal budgets running alongside. This will be enabled through moving from a predominantly reactive hospital-based system of urgent care, to one of home-based proactive care. Specific service interventions include:
• a single front door which will ensure that people entering the emergency department, regardless of where they have been referred from are dealt with quickly;
• locality based integrated care teams (LICTS) who work in partnership with general practice to deliver proactive integrated physical, mental health and social care in the community;
• a specialist intermediate care team who will provide intensive home support, to patients with a higher level of need and delivering discharge to assess and rapid response to support people to remain at home.

This will all be underpinned by improved data sharing between primary and secondary care providers, and improved data sharing between the emergency department and out-of-hours GP services.

Mid-Nottinghamshire’s wicked issue

Reducing length of stays in hospital, supporting effective reablement and enabling people to stay independent at home are all key priorities for Better Together. Staff and managers from different organisations across Mid-Nottinghamshire are already involved in working groups and discussions about how to support people with complex needs to get back and stay safely at home, after hospital care. However, achieving better outcomes in this area involves changing hearts and minds as well as organisational practices and processes and Mid-Nottinghamshire is still facing challenges around achieving more integrated transfers of care. These include:

• A number of cultural barriers and frustrations between the different partners involved – there is a view held by some that the medical model dominates rather than a model that reflects both health and social care and is person-centred.
• Pressure (and targets) to achieve quick discharge from hospital resulting in insufficient discharge planning which can sometimes lead to key issues for people not being addressed.
• Negotiations at the system level have not translated into changes at an operational level, even after a significant amount of time has been spent by leaders on this issue.
• There is a risk that the high use of agency staff leads to a lack of understanding of individuals’ ongoing needs.
• A lack of agreement between different stakeholders about how advanced and proactively discharge planning should be approached.
• The lack of a consistent or efficient approach to engaging patients and their carers in the process of transfer of care.
• Health staff promising social care solutions to family prior to assessment which subsequently cannot be met when the patient is discharged.
• Health and social care partners do not yet ‘speak with one voice’ and need to clarify process and protocol.

Many of the issues identified above point to the need for greater collaboration and consensus between professionals. This is particularly true of frontline professionals who are at the forefront of trying to deliver both new models of care and also constructive conversations with people who use services and their families.

**Brokering constructive conversations**

The Better Together programme has undertaken an extensive programme of engagement with a wide range of stakeholders, including partner organisations, the voluntary sector, staff, patients and the public. The engagement programme heard from a wide cross-section of the public and patient community and took place via several routes and approaches. These included three interactive public events; meetings with seldom-heard groups, coordinated by Newark and Sherwood CVS and Voluntary Action Ashfield; ‘outreach’ engagement at four public venues at Kings Mill and Newark hospitals, and two local Asda stores; meetings with Patient Participation Groups and social media routes.

The Programme Board also established a Citizens Board made up of eight lay members from the Mansfield and Ashfield and Newark and Sherwood Citizens Groups, alongside officers from the CCGs and County Council. Its function is to enable active consultation of citizens and patients before, during and after the reforms to deliver the new model of care. It is also responsible for testing possible options and desired outcomes with patients ahead of any formal public consultations. In this way, it acts as an engaged partner to confirm and challenge the transformation options and intervention approaches from the perspective of citizens.

As part of our action research with the site, health and care leaders expressed a desire for an independently facilitated constructive conversation between staff and managers from across the local health economy alongside local people from the Citizens Board, to discuss ways to improve how people are helped back home safely after hospital care. The event, which SCIE helped to set up and facilitate, was very popular and well attended by over 70 frontline staff, managers, leaders and members of the Citizens Board.

A commitment to find solutions was evident and the opportunity to take time out to have an open and honest conversations about the issue was appreciated by those who attended. It was a highly participative event which sought to achieve consensus about the actions and objectives required to progress this issue. The event helped to identify a number of challenges that needed to be addressed collectively, including lack of communication, accountability and risk-taking, discharge planning delays, lack of capacity in parts of the system, and a lack of health and social care integration. Once these issues were identified, the event also enabled groups of staff to work together to develop possible solutions to overcome these barriers.

One of the key findings from our action research was the need for more proactive, advanced discharge planning. Frontline staff are responsible for making this happen and it requires good engagement not only with the patient but also with their families and carers so that they can discuss the different care options available in the
community and record their preferences and decisions about their future care. This is not always an easy task especially when there is often a view amongst the public that hospital care is superior and preferable to other options. There is a need to support and develop frontline health and care staff to have these sometimes difficult conversations and articulate the benefits of care based in the community, such as good quality home care.

What is evident is that good constructive conversations between and across frontline professionals and managers are essential if good constructive conversations with patients and families are to take place. Before engaging citizens it is critical that partners speak with one voice and have a shared understanding about the objectives of the transformation programme as well as the different services available in the community. In one hospital – Kings Mill – there is a multi-disciplinary team in the emergency department, the Frailty Intervention Team (FIT), which brings together clinicians, social workers, nurses, occupational therapists and physiotherapists who are responsible for assessing people’s needs and getting them home as quickly as possible. The team is co-located and this has helped facilitate more regular constructive conversations about a patient’s care and fostered effective working relationships, which helps in turn to ensure that both nurses and social workers give the same messages to families. Better relationships at the frontline are further supported by a daily discharge hub meeting during which a multi-agency, multi-disciplinary team reviews each patient who requires a supported discharge ward by ward and discusses their discharge progress and plan.

In Nottinghamshire we found that how professionals use language both when they are working with other professionals and in their communications with the public is crucial. Each profession uses different terminology and jargon. For instance in social care people are often referred to as service users or people who use services, whereas in health they are most often called patients; and getting the terminology wrong can sometimes lead to breakdowns of trusts or misunderstandings. In constructive conversations with professionals and the public, it is important that a shared language is agreed and adhered to and, as much as possible, is jargon-free.[24]

The Citizens Board in Mid-Nottinghamshire came together voluntarily to guide the work of the vanguard and ensure that there is a good dialogue between staff and patients and people who use services. Further to this, Citizen Boards or other forums that foster a culture of leadership amongst the community can act as ‘translators’ between patients and professionals, helping to create and sustain the conditions that promote positive relationships and constructive conversations over time and across different issues.

They perform a two-way process of educating professionals about patient needs and building a shared understanding of patient and operational needs. This can help to flag when language is unhelpful, for example where terms such as ‘discharge’ or ‘end of life’ can make patients and families feel nervous, which can undermine the trust and relationships required for having successful constructive conversations about their care.

**Looking to the future**

The Better Together health and social care partners have recently signed up to a set of principles and behaviours which they hope will help them to work together more
effectively and help with addressing some of the cultural challenges and professional barriers around discharge arrangements. The principles and behaviours focus on the need for greater collaboration and consensus and include, for example:

- Encouraging cooperative behaviour between partners and engendering a no blame culture
- Learn, develop and seek to achieve full potential by sharing appropriate information, experience and knowledge to learn from each other and to develop effective working practices
- Work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost.

Following the participatory event, the Better Together health and social care partners have agreed to undertake an integrated review of discharge arrangements using the findings of this constructive conversation between staff and managers from across the local health economy and local people from the Citizens Board as a starting point. A steering group of senior managers has been convened to drive the review forward. This has included a further workshop for frontline staff and the Citizens Board. Encouragingly this most recent event was also attended by a wider group of stakeholders from the voluntary and community sector who were deemed to have had a really positive impact on the conversation.

Case study 2: Engaging the public on a sensitive issue – Dudley Multispecialty Community Provider: Transforming end of life care.

Context [25]

Dudley is a metropolitan borough located approximately nine miles west of the city of Birmingham. It has a population of 318,000 and in two decades time there will be 25,100 more people aged 65 and over and 9,900 more aged 85 and over. While Dudley is relatively affluent, there is disparity in levels of deprivation across the borough with 23.9 per cent of the population living in areas that are in the 20 per cent most deprived in England.

One in five people in Dudley have a long-term illness and a quarter of early deaths (40–59 age band) are due to smoking, obesity, cardiovascular disease and lack of physical activity.

The Dudley Multispecialty Community Provider (MCP) vanguard – All Together Better – is a new partnership between local NHS and care organisations, general practitioners and the voluntary sector in the borough. The MCP model in Dudley aims to develop a network of integrated, GP-led providers across health and social care, each working at a level of 60,000 people. This system will see the frontline of care working as ‘teams without walls’ for the benefit of patients, taking mutual responsibility for delivering shared outcomes. Under the new provider system, people who use services will have care overseen by a multi-disciplinary team in the community including specialist nurses, social workers, mental health services and voluntary sector link workers. This will ensure holistic care that better meets an individual’s medical and social needs at one
time, in one place, to help them to live more independently for longer. One of the key areas that will be transformed through the development of a multi-specialty community provider model is end of life care.

**Dudley's wicked issue**

When an individual gets to the end stages of life the complexity of care required increases significantly, and therefore the potential for multiple organisations to be involved also increases. Coupled with this is the problem that many staff and patients struggle to have conversations about death, making it more difficult to plan for this. Significant costs are incurred in the last two years of an individual’s life, further compounded by the fact that the numbers dying in acute hospitals remains high, despite this often not being a person’s preferred place of death. Dudley has identified a number of areas that require improvement including:

- patients nearing the end of life not being identified early enough
- increasing referrals to end of life care services
- multiple entry points to services with variance in response times
- fragmented community care and a lack of integration
- a need for improved support for patients and carers, which meets their expectations.

The Dudley Group NHS Foundation Trust, Dudley Clinical Commissioning Group, Dudley Council and Mary Stevens Hospice are working in partnership to transform the way they care for dying patients and families or carers.

They are supporting local services to work more effectively together and enhance the quality of care and treatment they provide for people at the end of their lives to ensure people are treated with dignity and respect, and receive compassionate care in accordance with their wishes and in the place of their choice. To facilitate these improvements, All Together Better is currently developing a new End of Life Care Strategy to support its service transformation.

**Brokering constructive conversations**

Dudley recognises that communication, involvement and engagement need to be at the heart of the service transformation it is trying to achieve to make it sustainable for the future and responsive to the needs of the Dudley population.

It has embarked on a significant programme of communication and engagement regarding the development and implementation of the MCP, involving multiple events with the public, research and online engagement.

Building on five years of work by Dudley Council for Voluntary Service (CVS) in experimenting with new approaches to active citizenship in the borough, the partnership has been testing out innovative ways of involving people in co-producing new ideas for how health and care can be better provided locally. In doing this, it has sought to promote an asset-based approach, which is an approach to service development that seeks to build on people’s natural skills, knowledge and assets, rather than seeing them as people with problems to fix.
The health and social care partners in Dudley have well-resourced engagement functions that have access to a wide network of established voluntary organisations, community forums and patient participation groups which are helping to build a leadership culture in the community which enables the local population to participate in constructive conversations on an equal footing. Nonetheless, there is always a danger that people who have been involved in decision-making for a while lose some of their objectivity, and so All Together Better and its partners need to continually look for ways to engage more seldom-heard groups.

Building on this, Dudley has been taking a proactive approach to involving people in constructive conversations about end of life care. As it can be sensitive to talk to people when they are at the point of accessing end of life care, Dudley is trying to have more proactive conversations with the public who may need these services in, say, 20 years’ time. The aim here is to ensure that communities are more engaged in thinking about their healthcare needs and the services they may require, encouraging people to plan for their care – especially end of life care – well in advance. This began during Dying Matters week in 2014 when Dudley convened a Public Healthcare Forum meeting, attended by around 70 members of the public to have a conversation about how Dudley could help ensure that at the end of life, patients die in the way they want to, where they want to and with the right support and help to make important decisions. This public meeting was followed up in 2015 with an initiative Dudley call ‘feet on the street’ which is where they approach individuals on the street and try to engage them in a videoed conversation about a range of different health and care issues – this one in particular was about end of life planning. What struck the team in Dudley was the fact that only 20 per cent of those they approached actually wanted to engage in a conversation about end of life care.

The CCG has most recently (June 2016) made efforts to engage the public in the development of the new End of Life Care Strategy by holding a workshop to understand peoples’ experiences and perceptions around end of life care in terms of what works well and what could be improved; to help All Together Better take stock of how current services are delivered and to explore how things could be improved. The workshop was attended by members of the public and patient participation groups, staff from the local authority, charitable organisations and housing providers.

Participants were shown a short film of the results of the ‘feet on the street’ exercise and the lead commissioner for end of life care from the CCG then talked about those areas of end of life care that needed to improve and what needed to be done to achieve this. Participants were then asked to discuss their perceptions and experiences in small groups and explore solutions together to inform the strategy and future end of life care.

Some of the key findings from the workshop included the need for more recognition of cultural beliefs; families having more of an awareness of what support is available; improved communication between all relevant teams and a person’s family and friends; talking positively to one another; and respecting patients’ end of life wishes and their rights. These point to the importance of having constructive conversations with individuals and their carer and families about advanced care planning.

Dudley has undertaken a programme of work around advance care planning and giving individuals the choice to discuss and record their preferences and decisions about their
future care. The new ‘Advance Statement’ document is a bespoke Dudley tool launched in 2015 to capture the preferences of patients about all aspect of their future treatment and care. The palliative care team has been providing education across the region to hospital teams, GPs, district nurses, community specialist nurses and others about how to have constructive conversations with patients about their wishes and support them with advance care planning. Dudley currently has c.1,600 advanced care plans in place and the next step is to implement an Electronic Palliative Care Coordination System (EPaCCS) to enable the recording of people’s care preferences and allow rapid access to care plans across boundaries, including for paramedics.

Looking to the future

The findings from the workshop were fed back by the lead commissioner to the End of Life Strategy Group to inform the emerging strategy. A group discussion based on the findings from the workshop followed and it was agreed that additional areas to be included in the implementation plan should include organ donation; paediatric end of life; supporting people to die in a care home if that was their preference and normal place of residence; engaging seldom-heard groups. There are plans to hold further conversations with the public as the strategy and implementation plan develops.

Dudley says it is already starting to see the impact of its efforts to transform end of life care. It is reporting an 8 per cent drop in the number of people who die in hospital as opposed to their preferred place of care.

As part of this, one of the key outcomes it hopes to achieve through its continued engagement efforts is supporting health and care leaders and teams to develop the skills, knowledge and confidence to facilitate the co-production of health and care services.

Case study 3: Co-producing a clinical strategy with service users – Camden and Islington NHS Foundation Trust: Transforming mental health services.

Context

Camden and Islington Mental Health and Social Care Trust was established in 2002. In March 2008, it became the first care trust to achieve foundation trust status.

The Trust provides mental health and substance misuse services to adults living in Camden and Islington and has two inpatient facilities, at Highgate Mental Health Centre and St Pancras Hospital, as well as community-based services throughout Camden and Islington.

Camden and Islington covers an area with a rich mix of ethnic and social backgrounds. The area has some of the highest needs for mental health services within the United Kingdom, with a high prevalence of mental health problems and substance misuse. Islington has the highest prevalence of psychotic disorders in England, nearly double the national average, and the highest prevalence of depression in London. It serves seldom heard groups and a transient population of young adults, particularly students and young professionals moving into London, who are highly mobile. As a
consequence, at least 38 per cent of inpatients are new to them, each year, which makes special demands and has a direct impact on the services provided.

**Camden and Islington’s wicked issue**

Camden and Islington is in the process of transforming its mental health services. Despite a number of mental health initiatives from central government in recent years, challenges with system-wide implementation coupled with an increase in people using mental health services has led to real pressures on services. Many feel that mental health has not had the priority awarded to physical health, with a lack of funding and staff shortages.

The independent Mental Health Taskforce formed in 2015 brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England. This was published in February 2016 and signifies a strategic approach to improving mental health outcomes across the health and care system. The strategy was the product of wide-ranging engagement with people with personal experience of mental health issues, families, carers and professionals. Improvements in access to high-quality services, choice of interventions, integrated physical and mental health care, prevention initiatives, funding and challenging stigma were people’s top priorities as to how the system needs to change by 2020.

Like much of the NHS, the Camden and Islington Mental Health and Social Care Trust is facing multiple challenges including severe financial constraints, increasing demand and higher expectations of quality. Staff at the Trust believe that too many people who use services, needlessly end up in specialist, acute care or end up staying there for unnecessarily prolonged periods. In addition, too many people with mental health problems die years earlier than average. Staff at the Trust said that as a group, they have a higher prevalence of smoking, alcohol misuse, poor diet, and fewer social networks. Self-management may also be a challenge for some. [26]

To address these challenges, in line with the Five Year Forward View for Mental Health, the Trust is looking to fundamentally change the types of services it offers over the next five-year period. As part of this, it is moving towards an integrated practice model, basing mental health practitioners in primary care, and moving away from hospital-based services for those who would be better supported within the community. This will allow people who use services to access person-centred support in one location, and staff will be trained in dealing with mental health as well as physical health issues.

This innovative pathway is using value-based commissioning principles and includes moving funding from the acute sector into the Trust so that it ultimately becomes commissioner for its population.

**Brokering constructive conversations**

There is a rich tradition of service user involvement at the Trust (going back as far as the late 1990s) and people who use services are involved in the business of the Trust in a number of ways including attending Board meetings; the recruitment of mental health staff and ward inspections.
Most recently however, the Trust has started to host monthly workshops called ‘evolution groups’ which bring together people who use services, partners, staff and other stakeholders in order to influence the development and implementation of its new clinical strategy. The ambition is to genuinely co-produce the clinical strategy and the way services are delivered.

Indeed, within the strategy itself, the co-production of care is the first overarching theme for all its services. ‘Instead of services ‘doing for’ they will ‘do with’ service users. Through helping and supporting them, service users can become participants in their community rather than dependent on services.’ (Clinical Strategy 2016–2021) [26]

The evolution groups are helping to build trust from what was a difficult starting point because despite a rich tradition of service user involvement, there was a feeling that past reorganisations had not been communicated effectively and left some service users marginalised. This trust is in part being fostered by a group of passionate and committed staff who are building two-way relationships with service users based on transparency, honesty and integrity.

To foster a culture of co-production, staff talked about the need to give up the authority they are used to having in their day-to-day job as mental health practitioners and instead make themselves more open, vulnerable and comfortable with uncertainty.

The monthly evolution groups involve partners, staff and other stakeholders, including mental health charities, the Clinical Commissioning Group (CCG) and GPs on an ongoing rather than a one-off basis, which provides the foundation for meaningful involvement. This ongoing dialogue builds an active community of people who use services, which makes it easier to develop a shared understanding between service users and other stakeholders.

People who use services are paid for attending, which recognises their time and expertise, and places them on the same footing as paid staff. Further to this, the facilitators ensure that the discussion groups include a mix of service users, staff and other stakeholders and that all contributions are reported anonymously so that all feedback and ideas are treated equally.

Each evolution group meeting starts by recapping what was discussed at past meetings, which provides an opportunity to update people who use services on previous discussions so that everyone understands how their views have been taken on board. In addition, being clear about the remit and purpose of the group, what they want from people who use services, and managing expectations about how views feed into the decision-making process, are other important ways of building relationships and trust. Nonetheless, the Trust is aware that this does need to be carefully managed because for some service users change is not happening quickly enough. They want to see real change to services on the ground based on their feedback. The perceived absence of change on the ground makes some service users sceptical about the influence their input is having and there is a risk that this will start to erode trust.

**Looking to the future**

The Trust admits it still has room for improvement in its approach. For example, the organisers would also like to involve service users in the actual planning of the evolution groups which they are not currently doing. Further to this, despite the evolution groups
being open to everyone there is a tendency for the same people to attend and those people are often involved in other user forums. So they are currently thinking about how they reach seldom-heard groups, for example through social media.

Nonetheless, staff reflected that the process has taught them how to be flexible – ‘if things aren’t working, change it’.

Ultimately the Trust’s ambition would be to have the freedom to give service user groups their own funding, agenda and accountability to go away and design services that will advance the aims of the organisation and empower service users to be public servants.
3. Discussion: Changing together: How can we better broker constructive conversations to make service transformation more sustainable and responsive to needs?

It is evident that the local areas we worked with recognise that communication, involvement and engagement need to be at the heart of the service transformation they are trying to achieve in order to make it sustainable for the future and responsive to the needs of their population. As others embark on developing and implementing new models of care or the plans set out in their STP, there is much learning to be drawn from the significant body of literature [1] and our case study sites about how we can better broker constructive conversations. Figure 2 provides an overview of the main lessons, which we then discuss in more detail below.
Figure 2: Brokering constructive conversations to tackle the wicked issues associated with the implementation of new models of care.

System Level:
- Clinically led case for change
- Resources
- Power
- Build leadership through VCS and citizen boards to deliver change at pace
- Shared and jargon-free language

Individual Level:
- New models of care
- Solutions emerge from experimentation
- Constructive conversations
- Reflective, creative and empathetic workforce
- Individual care planning
- Care managers
- Frontline professionals
- Patients and families
- Service providers
- People who commission services
- The public
- Seldom heard groups
- People who use services

Need for change
Our work with the case study sites suggests that **to make the implementation of new models of care a success there is a need for constructive conversations with citizens not only at a system or service level but also at an individual, care-planning level.** All of the case study sites reported that in general when engaged in thinking about new models of care their communities agree in principle with the outcomes being sought by the transformation e.g. multi-disciplinary teams providing care closer to home, having greater control of their health and care and being supported to live independently at home for longer. However, when it comes to wicked issues such as the transfer of care or end of life care, constructive conversations with the individual and their families and carers will be critical to ensuring that more people avoid unnecessary hospital care and feel comfortable with the idea of care in the community. We discuss these both in more detail below.

### Brokering constructive conversations at a system or service level

#### Planning the approach

We found **there is no one-size-fits-all methodology at the system level** with different approaches used to broker constructive conversations. For example in Mid-Nottinhamshire where they are trying to develop a PACS model which will deliver a whole-system integration of hospital, community, social and primary care within a single outcomes-based capitation contract, they have used a range of methods to work with the public to identify the outcomes that future services should deliver which will directly inform service design. And in Dudley, where they are implementing an MCP to ensure holistic care that better meets an individual’s medical and social needs they have focused their efforts on exploring how community assets and people’s organising and project skills can be used to co-produce ideas on new models of care.

Our research found that **genuine co-production, deliberation and negotiation take time and resources**, as does the kind of relationship building that is needed for a genuinely whole-system response. But so often there is pressure for actions and results, and this may be particularly the case in the current climate where financial pressures are driving a focus on immediate cost savings. Where involvement is rushed, it is far more likely to be tokenistic. Where plans and change are required at pace, such as the STP process, it is potentially more effective to work with existing networks such as, Citizen Boards or panels, CCG lay members and voluntary and community networks.

#### The timing and positioning of conversations

The timing and positioning of conversations with the public about health and care transformation and new models of care are key to building relationships and trust. The evidence and our research suggest that the best results are achieved when **the engagement process begins at an early stage of planning service change and setting the strategic context.** [27-30] Co-production often doesn't happen because involvement is too late, and in these cases consultation may only begin once decisions have effectively been made. Indeed, a number of the service users we spoke to during our research were keen to point out that they don’t like engagement exercises that basically involve rubber-stamping decisions already made, but prefer to be involved.
early. Good engagement in shaping plans for new models of care have taken place in some parts of the country and have provided a strong bedrock of insight on which to develop more detailed plans. Unfortunately this appears to have not always not been the case with the development of the Sustainability and Transformations Plans [2].

Our research indicates that **building public understanding of the choices and trade-offs involved in service change is a strong foundation for constructive conversations** – being open and honest about the need for, and implications of, change. There is a tendency not to talk about finances in transformation projects, which can foster public mistrust (especially in the current financial climate). Techniques used in participatory budgeting, whereby you engage citizens in complex decisions about how money is spent, could prove useful as part of constructive conversations.[31]

Nonetheless, we found **there is also value in demonstrating a clinically led case for change**, with a focus on service improvement and what changes mean for the individual rather than cost savings. This may mean that the process is best led and supported by clinicians involved in delivering the relevant services.[27] Indeed, although Camden and Islington acknowledges the financial pressures on its service, which it says service users are well aware of because they have experience of these pressures, it has focused very much on the clinical case for change, that is, creating a service which is much more focused on prevention and recovery-orientated treatment and support rather than acute treatment and dependency. In Islington, for instance, people who use services have found it helpful to have clinical involvement in the evolution groups as it has enabled a better understanding of the clinical issues that need to be considered to develop a sustainable clinical strategy.

**Promoting positive relationships and building trust**

Further, our research suggests that **Citizen Boards or other forums that foster a culture of leadership within the community can act as ‘translators’ between patients and professionals**, helping to create and sustain the conditions that promote positive relationships and constructive conversations over time and across different issues. The Citizens Board in Mid-Nottinghamshire came together voluntarily and acts as a translator between patients and professionals to help explore how to have constructive conversations. It performs a two-way process of educating professionals about patient needs and building a shared understanding of patient and operational needs.

Nonetheless, our research also shows **there is a need to continually look for innovative ways to engage more seldom-heard groups**. The establishment of, and access to, a wide network of established voluntary organisations, community forums and patient participation groups are helping local areas to build a leadership from within the community, which enables the local population to participate in constructive conversations about the future of health and social care on an equal footing. Nonetheless, there is a danger that as these people become more familiar with health and care processes, they cease to be lay participants. Some of the people who use services we spoke to talked about the predominance of ‘retired, middle class people’ being involved in their community forums and patient participation groups. Dudley is trying to engage more seldom-heard groups via its ‘feet on the street’ method; Mid-Nottinghamshire has tried to reach out to people in areas such as supermarkets or
access people via community groups; and Camden and Islington is exploring how social media can be used to engage a more diverse user group.

Our research found that **being clear about the remit and purpose of a group, what it wants from people who use services, and managing expectations about how views feed into the decision-making process, is an important way of building relationships and trust.** Further to this, those leading constructive conversations should demonstrate where and how public views, concerns and priorities have shaped decisions, in order to sustain interest and participation. For example, in Camden and Islington each evolution group meeting starts by recapping what was discussed at past meetings and how different views have been taken on board.

Our research also shows that it is important that local areas **take positive steps to address the imbalance between health, social care and mental health professionals, in enabling constructive conversations with citizens.** New models of care involve multi-disciplinary working. This requires establishing clear objectives and a strong narrative for change, which then forms the foundation of having constructive conversations with citizens. However, cultural differences between health and social care professionals, social care partners feeling that their input is less recognised than healthcare partners, and mental health partners not always being involved, can mean there are tensions as well as differing views on what, and who, to prioritise. All of this can make it difficult to communicate a clear shared purpose to, and have constructive conversations with, citizens.

Further, our case study work indicates the importance of **a shared language that is agreed and adhered to and, as much as possible, is jargon-free [31].** In Nottinghamshire we found that how professionals use language both when they are working with other professionals and in their communications with the public is crucial. Each profession uses different terminology and jargon. For instance in social care, people are often referred to as service users or people who use services, whereas in health they are most often called patients; and getting the terminology wrong can sometimes lead to breakdowns of trust or misunderstandings.

**Brokering constructive conversations at an individual, care-planning level**

As discussed, having constructive conversations with citizens about the overall design and commissioning of new models of care is one thing but, whilst not wishing to lose sight of the many actors involved in service transformation, when it comes to actually delivering the new care pathways presented and making them a success our research suggests constructive conversations with the individual and their families and carers become essential.

We would suggest that **constructive conversations are critical to good, proactive care planning and that good care planning is essential for tackling wicked issues such as the transfer of care or end of life care.** Frontline staff are more often than not responsible for making this happen and it requires good engagement not only with the patient but also with their families and carers so that they can discuss the different care options available in the community and record their preferences and decisions about
their future care. This is not always an easy task especially when there is a culture which avoids having difficult conversations with citizens or a view that hospital care is superior and preferable to other options. We would argue that there is a need to support and develop frontline health and care staff to have these sometimes difficult conversations and articulate the benefits of care in the community.

Further to this, our research indicates that constructive conversations between and across frontline professionals and managers are essential to constructive conversations with patients and families. Our research found that before engaging citizens it is important that partners speak with one voice and have a shared understanding about the objectives of the transformation programme as well as the different services available in the community. This was exemplified in Mid-Nottinghamshire where despite significant work on implementing integrated discharge arrangements, there were still significant challenges in making it work. Negotiations at the strategic level (and meeting after meeting) have not translated into changes at an operational level and there are still a number of cultural barriers and frustrations between the different partners involved which has led to different staff giving conflicting information to patients.

Overall, whether we are talking about constructive conversations at a system-wide level or an individual level, in reality it is frontline staff who will bear the brunt of the responsibility for brokering these conversations. Likewise it is frontline staff who in reality will bear the brunt of the responsibility for operationalising the new model of care and ways of working. We would argue that the health and care system needs a workforce that is reflective, creative, empathetic, and comfortable with uncertainty and committed to learning.

Developing people’s skills

This research has found that enabling constructive conversations is not an easy task. It takes people leading this to have a specific set of skills in community engagement, holding difficult conversations, participation and coproduction. We also need to consider what support people who use services and members of the public most require if they are to successfully engage in constructive conversations. The kinds of skills that need to be developed in staff and in people who use services include [21, 32]:

- listening skills
- holding difficult conversations
- understanding and working with diverse communities
- facilitation skills
- presentation skills
- shared decision-making
- asset-based community development
- experience-based co-design.
Changing together: brokering constructive conversations

Achieving this will require a more assertive approach to developing these skills through existing training, education and leadership programmes.

Conclusion

Recent surveys and analysis of the funding situation for the NHS and local government are disheartening to read.[33] The NHS and local government face enormous challenges just to manage current demand, never mind meeting fast-rising future demand. The new models of care could provide an important way to overcome these challenges by providing delivery models that enable more people to be treated and cared for within their homes and communities rather than in expensive acute care settings. But change on this scale cannot be done to local communities – it needs to be negotiated with their close involvement through co-production. And change also cannot be dictated through old-fashioned linear planning. We need to creative approaches to problem solving — which include a fair degree of trial and error and experimentation — to arrive at solutions. Constructive conversations between service providers and people who use services and communities can help broker these solutions, enabling hard-pressed service leaders to use the expertise, assets and experience of citizens to help guide their decision-making.
Appendix 1: Methodology

There were four strands of work that contributed to this report and its conclusions:

1. **A rapid evidence scan**, undertaken by ICF. Key research questions included:
   - What ‘wicked issues’ does the Five Year Forward View present for local health and care economies?
   - What is meant by a ‘constructive conversation’, how might it be defined?
   - What attempts have been made to involve the public in constructive conversations in health and other sectors?
   - Why have health economy transformation projects failed to facilitate constructive conversations in the past? Where have they been successful and why?

   The review looked at published evidence and literature, including readily accessible grey literature; quantitative and qualitative empirical studies; systematic reviews and meta-analyses; and evidence-based reviews/commentaries and a brief survey of theoretical and conceptual literature was undertaken to help address the first two research questions.

   The databases used were MEDLINE, PsychINFO, CINAHL, Health Management Information Consortium (HMIC), Social Sciences Citation Index, Social Care Online, and Cochrane Database of Systematic Reviews. In addition hand searches of reference lists of key articles/reports; a structured internet review to expand the search for grey literature and consultation with SCIE, project partners and project advisory board members were also used to source evidence.

   The review Included studies/literature:
   - Published and readily available
   - Published from 1990 to present
   - Available in abstract or full text
   - Published in English
   - Reporting empirical evidence which answers one or more of the key research questions OR
   - Conceptual or commentary pieces addressing research questions 1 and 2

   The review excluded studies which report on:
   - Public conversations around ‘tame’ issues (e.g. service improvement)
   - Wicked issues not directly related to the themes of the Five Year Forward View (e.g. rationing, tackling obesity, health behaviour change)
   - Public involvement which is one-way, not dialogic (i.e. limited to giving information)
   - Conversations concerning ‘wicked’ issues which do not include the public (e.g. limited to staff consultation and involvement)
   - Examples of general public involvement – e.g. PALS, complaints, PPI structures
2. A workshop, chaired by Lord Michael Bichard, Chair of SCIE, bringing together experts in health and care policy, people who use services and health and care practitioners to discuss the importance of having better conversations about the wicked issues of the health and care changes in England today. Attendees were:

- Clenton Farquarson, Chair, Co-Production Network
- Michael Bichard, Chair, Social Care Institute for Excellence
- Paul Corrigan, Senior Adviser, Independent
- Felicity Dormon, Senior Policy Fellow, Health Foundation
- Emma Norris, Programme Director, Institute for Government
- Joanna Ellins, Senior Managing Consultant, ICF International
- Natasha Porter, Senior Consultant, PPL
- Helen Codd, Community Engagement Manager, Dudley Clinical Commissioning Group
- Stephanie Cartwright, Head of Organisational Development, Dudley Clinical Commissioning Group
- Laura Broster, Head of Communications and Public Insight, Dudley Clinical Commissioning Group
- Chris Wajzer, Senior Researcher, Institute for Government
- Lisa Larsen, Chief Operating Officer, PPL
- Greg Wilson, Consultant, PPL
- Dawn Talbot, Co-Production Advisor, Co-Production Network
- Larry Gardiner, Co-Production Advisor, Co-Production Network
- Laura Able, Co-Production Advisor, Co-Production Network
- Ewan King, Director, Social Care Institute for Excellence
- Rich Watts, Integrated Personal Commissioning (IPC) Advisor, Think Local, Act Personal
- Claire Kennedy, Managing Director, PPL

3. Conversations with senior leaders at DH, NHS England, NAO and the LGA about what supports or hinders constructive conversations at a local level and the role their organisation plays in creating the conditions for successful conversations taking place.

4. Action research with three case study sites (Mid-Nottinghamshire, Dudley and Camden and Islington) to help us generate rich and varied insights and learning about how local places are having constructive conversations with citizens, to tackle the ‘wicked issues’ surrounding the implementation of new models of care.

The case study sites were selected in order to draw learning from vanguard sites and innovative early adopters of new models of care and who demonstrated a commitment to co-production. Working with the nominated lead for each site we agreed an approach to the research involving sites in three ‘cycles’ of action research – the approach taken in each site is detailed below:
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<td><strong>Mid-Nottinghamshire</strong>&lt;br&gt;(Lead contact: Wendy Lippman, Transformation Manager, Adult Social Care, Health and Public Protection, Nottinghamshire County Council)</td>
<td>A one day site visit (7 April 2016) to Kingsmill Hospital, Mansfield to observe discharge processes and structures and face-to-face interviews with key stakeholders from across health and care involved in supporting people to get back home and stay home after a hospital stay and the Citizens Board</td>
<td>Health and care leaders expressed a desire for an independently facilitated constructive conversation between staff and managers from across the local health economy alongside local people from the Citizens Board to discuss ways to improve how people are helped back home safely after hospital care. The event (23 June 2016), which SCIE helped to set up and facilitate, was attended by over 70 frontline staff, managers, leaders and members of the Citizens Board.</td>
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<td><strong>Dudley</strong>&lt;br&gt;(Lead contact: Helen Codd, Engagement Manager, Dudley Clinical Commissioning Group)</td>
<td>Telephone interviews with key stakeholders from across health and care involved in transforming end of life care in Dudley</td>
<td>The CCG held a workshop (30 June 2016) to inform the development of the End of Life Care Strategy to understand peoples’ experiences and perceptions around end of life care in terms of what works well and what might be missing; to help All Together Better take stock of how current services are delivered and to explore how things could be improved. The workshop was attended by members the public and patient participation groups, staff from the local authority, charitable organisations and housing providers.</td>
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<td><strong>Camden and Islington</strong>&lt;br&gt;(Lead contact: Emily van de Pol, Divisional Director-Community Mental Health &amp; Primary Care, Camden and Islington NHS Foundation Trust)</td>
<td>A face-to-face meeting and telephone interviews with stakeholders from across health and care involved in transforming mental health services in Camden and Islington</td>
<td>The Trust has started to host monthly workshops called ‘evolution’ groups which bring together service users, partners, staff and other stakeholders in order to influence the development and implementation of their new clinical strategy. Researchers attended the group in May and June.</td>
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Appendix 2: References


21. SCIE, Co-production in social care: What it is and how to do it. 2015.


32. Foot, C., Kings Fund Implementing the NHS five year forward view: let’s not forget engaging patients and communities. 18 February 2015.

Changing together: brokering constructive conversations

The findings in this report are based on a synthesis of the existing literature, the research undertaken as part of this project and SCIE’s experience and knowledge of co-production. This information was collated, and synthesised/organised through iterative discussions within the project team. Our lessons and conclusions were developed through careful consideration of what those embarking on developing and implementing new models of care or the plans set out in their STP could learn from the significant body of literature and our case study sites about how we can better broker constructive conversation.