People Powered Health & Wellbeing
Shifting the balance of power

How people with lived experience and people who work in services can have good conversations and build connections to co-produce wellbeing

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Introduction

A key area of public service reform in Scotland is for health and social care services to become person-centred, focussing on people, their family and carers so that:

- People have a positive experience of care and get the outcome they expect;
- Staff are valued and supported to work collaboratively, and
- People are empowered to be active partners in their care.

The Scottish Government's Person-Centred Health and Care Portfolio is central to the realisation of the NHS Scotland 2020 Vision and is one of the key priority areas for improvement within the Route Map to the 2020 Vision for Health and Social Care and the Healthcare Quality Strategy for NHS Scotland.

Co-production approaches are fundamental to achieving this vision of person-centred care through:

- a shift in power towards people who use support and services and unpaid carers
- improved understanding and relationships between all sectors involved in care and support (including public services and the third sector)
- recognition of the strengths, assets and skills of people (people who use services and the workforce) to improve health and wellbeing.

The human rights principles of participation, accountability, non-discrimination and empowerment also align closely with the aims of co-production.

As part of the Person Centred Portfolio, and funded by the Scottish Government 'People Powered Health and Wellbeing: shifting the balance of power' (PPHW) at the Health and Social Care Alliance Scotland (the ALLIANCE) has been working with third and public sector partners and health and social care teams across Scotland to develop the capacity and capability of both people who use, and people who provide, support and services to:

- have meaningful conversations about their outcomes,
- connect with assets that can support them, and
- become active collaborators in designing services and solutions to care delivery and in promoting their wellbeing.

People Powered Health and Wellbeing is co-produced with a reference group of people who use supports and services and unpaid carers.

This document describes a family of approaches to co-production characterised by their emphasis on values, relationships and the need to support a strengths-based approach to improving wellbeing. Whilst these approaches are synergistic we have divided them into three categories:

- Value – how what matters to the person can drive improvement (self management and personal outcomes)
- Connections – how stronger relationships can enhance capacity (peer working, asset mapping and community capacity building)
- Culture and systems – how change can be supported and sustained (values based reflective practice, co-design and House of Care).

Value – how what matters to the person can drive improvement

Co-production and person-centred approaches share a common principle that what matters is the value and meaning that a person gives to their life and experience. These statements guide the work of the PPHW programme in developing and supporting understanding of person-centred care and co-production.

- Lived experience is equal to other forms of knowledge, evidence and expertise and people are heard and listened to.
- To improve outcomes people (including clinicians and other health and social care practitioners) come together in equal relationships to share and exchange knowledge, skills and experience.
- People who use health and social care services and support can make a positive contribution to their own health and wellbeing.
- Health and social care staff feel valued and supported in their roles.
- Relationships between all parties are two-way and are built on a foundation of mutual respect.

A critical part of capacity building for co-production is ensuring that support is available to enable people to take charge of their own journeys to wellbeing and recovery. Services can contribute to this, as do informal, community resources, family and friends. The person, those close to them and practitioners need confidence and skills to enable

and support the person to take control. Brian Brown's story illustrates that this journey is fundamental to reclaim lives that have received a serious challenge. He says "I've learned that what I needed was to be listened to, to be treated as a person (and not just a diagnosis)".

Supported self management was at the heart of Brian's recovery journey. Self management enables people to live full lives while dealing with the reality of living with a long term condition by supporting and encouraging them to access information and to develop skills that will enable them to live their lives on their terms and stay well for longer. It supports people to make changes themselves, often alongside others.

Self management is not a replacement for services, nor does not mean having to manage alone without support. It enables people to make informed choices about how and when to draw on different kinds of support and to make changes, so that they can take control of their lives. The Self Management Network Scotland has been created to share learning and best practice and support people across Scotland to continue changing lives through self management.

Self Management Network Scotland

Personal outcomes – courageous conversations about what matters to the person. In Scotland the Personal Outcomes Approach has been developed as a way of asking people what matters to them. A Personal Outcomes Approach recognises the contribution of the person and their own resources to achieving their outcomes. At the heart of a Personal Outcomes Approach is a conversation that explores what matters to the person and elicits their strengths. It is then important that the personal outcome is recorded (with a narrative that explains it) and that this information is used to develop collaborative support in ways that are both meaningful and

measurable. Small steps towards achieving the outcome will be recorded and regularly reviewed. The Personal Outcomes approach:

- focuses on what matters to the person in their life and why
- builds on their strengths and capabilities
- supports people and practitioners to have good outcomes focused conversations that create meaningful engagement
- leads to enabling approaches to achieving outcomes and recovery in which the person, their family and support networks and all the professionals involved work together to achieve the outcomes
- involves a shift from service priorities to people's own priorities.

The Personal Outcomes Partnership has developed a series of training opportunities around the approach which draw heavily on the Joint Improvement Team's experience on delivering workshops on 'Talking Points', a Personal Outcomes Approach and the Thistle Foundation's experience in delivering training using outcomes approaches to support self management. Typical examples of the shift that occurs in practitioners include:

> "To listen and not to make assumptions that I know the answer. Involve patient and carers and the right people in conversations"
>
> "Self-awareness is very important, we need to know what matters to ourselves to enable people we work with to identify what matters to them"
>
> "Will make me look at people differently – in a more positive light".

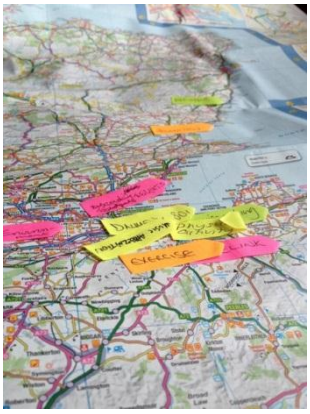
A short film, 'Inspiring Better Outcomes' explains how the InS:PIRE project team at Glasgow Royal Infirmary adopted a Personal Outcomes approach to support people who had previously had a prolonged stay in intensive care to gain greater control over their health and wellbeing, and to link better to community resources with the support of the third sector.

Connections – how stronger relationships can enhance capacity

Relationships are at the heart of person centred care and co-production. Services can be enhanced by stronger connections with people with lived experience, the third sector and local communities. Equally people who use supports and services and unpaid carers can also derive hope and support from others with similar experiences, while strong communities provide the environment for people to flourish.

The Route Map to the 2020 Vision reiterates the Scottish Government's "commitment to shift the balance of power to, and build up and on the assets of, individuals and communities".

Community capacity building describes a particular way of working with and supporting communities – to build people's skills and experience, increase opportunities, and enhance involvement in the decisions that affect them. Building community capacity is at the heart of community development and community empowerment. When communities are well organised, inclusive, influential and cohesive they create a positive environment for people to enjoy a good quality of life.



Asset mapping – how to build powerful connections

Assets are the resources, including the skills, knowledge and networks which people and communities have to offer. Asset-mapping is a co-production approach which identifies, and collects and shares information about

resources within communities to assist people and communities to achieve positive change using their own resources. Resources can be made findable through ALISS (a Local Information System for Scotland.) ALISS is a search and collaboration tool for health and wellbeing resources in Scotland and provides a means of communities working together to gather, maintain and share information.

The Highland Third Sector Interface, Let's Get On With It Together (LGOWIT), has been working with local groups to bring information together and to learn what the mapping process can offer across an extensive and largely remote and rural area.

> "When we were going around talking to people about self management and promoting the idea, the common theme …was that people were interested in people self managing but didn't know where to point them …to support them to find activities that were relevant to them."

Early experiences indicate the importance of working alongside community representatives and workers to ensure the process draws upon and enhances relationships. The LGOWIT example shows how assets to support health and wellbeing can be identified using approaches rooted in the community. It also illustrates how systematic work is needed to co-ordinate, build capacity and make meaningful use of these resources.

Peer Working. Peer Support harnesses the experience and expertise of people with lived experience to support people in similar circumstances. It can bring hope to those at an earlier stage of their journey, provide social support to increase resilience and is an opportunity for people to make a contribution to others through the skills and experience they have gained. People in recovery from mental health problems have always shared their experience of recovery and mental health to offer mutual support and learning and peer support. Peer support workers are

trained and employed to support other people in recovery. To be a peer support worker you must have your own recovery experience. The Scottish Recovery Network has produced a values framework for peer working and there is now a Personal Development Award for Mental Health Peer Working.

Culture and systems – how change can be supported and sustained

Change at the frontline needs to be supported by cultures and systems that enable people to innovate. In this section three approaches at different levels are presented:

- values based reflective practice to support resilience of practitioners and teams,
- engagement of people with lived experience in service improvement
- the House of Care, as a whole system approach.

Values based reflective practice – courageous conversations in the team. If practitioners are to take an enabling role, to do 'with', rather than 'to', and not to get in the way of people using their own strengths, then it follows that they need to be confident with working in this way and to feel supported themselves. For practitioners themselves, the skills, tools and habit of reflective practice provide a means of integrating new learning in order to improve outcomes for the person they support.

Values based reflective practice (vbrp) developed by NHS Scotland provides a framework in which teams can consider their day to day experiences of practice in the light of the values that drew them to that work in the first place. It supports them to be resilient and it helps equip them to be able to do the best they can for the people they support. Vbrp encourages practitioners to pay attention to the perceptions and needs of others and recognise whose voice is being heard or ignored.

People power and co-design. People's personal strengths can also be brought to bear collectively to improve services and influence change, using the power of lived experience to change hearts and minds and also make a practical contribution to making services fit for purpose. The PPHW Reference Group of people who use supports and services and unpaid carers is one model of facilitating the inclusion of people as influential and experienced partners at national and local level. Members pursue their own passions, for example through action research as well as contributing to wider policy and service developments.

The Keeping it Personal project, facilitated by the Institute for Research and Innovation in the Social Services (IRISS) is an example of co-produced person centred improvement work which will require shared understandings of person centred care and opportunities to work together to shape services. In North West Glasgow and North Lanarkshire IRISS brought together people accessing services, their carers and practitioners from health and social care across public and third sectors. Through regular meetings and facilitated support from IRISS participants engaged with others as equals to develop person-centered improvements to supports and services.

In North West Glasgow the group has set up a dementia café and in North Lanarkshire the group has collated information to help GPs, health workers

and the general public to recognise symptoms of early onset heart failure. This is information that the group felt was not currently readily available.

House of Care is an evolution of the Chronic Care Model and represents a tangible and proven improvement framework focused on care and support planning to support the self management of people living with multiple conditions. The House of Care model also provides a framework and checklist by which healthcare and social care can absorb the pressing challenges of multiple conditions, health and social integration and health inequalities. The challenge of "building" a House of Care lends itself to collaborative locality working and, if supported by investment, is likely to inspire grass roots leadership and local champions.

Conclusion

For co-production to become 'just the way we do things' in Scotland there is a need to develop confidence in working in equal partnerships across public services and with people and communities. This will mean letting go of habits of control that stifle personal and local initiative. It will involve recognising the common ground in approaches developed in different sectors and evidenced in different ways.

Time spent in building trusting relationships, reflecting on practice and sharing learning will prove an investment to improve outcomes. Above all it will entail believing in the strengths of people, including frontline staff, and community groups to take control of their lives.