In Practice

Quality improvement, co-production, health inequalities and art

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INTRODUCTION

In this article, I briefly describe aspects of my 2019–2020 Darzi Fellowship in system leadership in the UK, and its extension as a National Health Service (NHS) England national pilot site in 2020–2021. My Darzi Fellowship was based in a quality improvement (QI) team in London. The lack of co-production in QI was a fundamental gap locally and nationally. My project was a pioneering integration of co-production and QI methodologies. The purpose of the project was '*The redistribution of power whereby patients and communities have stronger voices in strategic decision making and reshaping services*'. Co-production with communities enables targeted initiatives of real issues emerging from local communities.[1] This project aimed to fundamentally challenge power relationships between providers and receivers of services, within the largest general practitioner (GP) practice in Tower Hamlets, London. The project adopted an emergent co-produced approach, with the diverse community in Tower Hamlets, rather than for them.

The project was designed in two phases: phase 1 was for citizens to identify five primary care service improvement areas and phase 2 aimed to train community members in QI, and create a new QI co-coaching model, whereby a community member provided coaching alongside a professional QI coach, to implement one community-identified QI project with the GP practice.

A RELATIONAL FOCUS

QI initiatives often focus on unwarranted variation and a '*product dominant logic*', that is, processes and outputs, potentially neglecting relationships, individual patient preferences and warranted variation.[2] My ambition was turning QI on its head via community-led QI themes, and to use a '*service dominant*' and relational mind-set.[3]

The project was fast-paced, with one academic year to design and deliver the paradigm shifting QI project, which aimed at a relational cultural intervention. This was an emphasis on relationships not structures, to ensure ongoing input from the wider system.[4]

This approach unleashed collective intelligence, power and resources, as the project was nested within the system, via a monthly steering group of 10 local organisations and community members. Power sharing was weaved into the fabric of the process, whereby the team consisted of equal numbers of staff and community members and represented the diverse communities, ages and languages spoken locally. Camillus's assertion that 'Involving more stakeholders makes the planning process more complex, but it also expands the potential for creativity'[5] is very appropriate in this context.

ART AS A POWERFUL MEDIUM OF CO-PRODUCTION

Institutional power structures inherently use technical and jargonistic reports with graphs and data, which can alienate communities from rich dialogues around service design and improvements. The use of art enabled communities to engage in the co-discovery phase, across cultures, sexualities, disabilities and using 10 languages. Art emerged as a significant co-production vehicle to challenge this discourse of power and was able to cut through the institutional opaqueness.

Phase 1 of the project initially utilised the well-evidenced CSEAD methodology (Well Communities, University of East London) for community engagement, via door knocking and world cafes.[6] This involved 188 h of door knocking at bus stops, squares and council estates around the GP practice in Tower Hamlets, in 10 languages.

At the launch event of staff and community members, all participants put post-it notes on the board and their suggestions were incorporated in the artwork. Our Volunteer Graphic artist harvested the community intelligence from the two world cafe events, in a large

drawing. This co-produced art approach was essential in tackling language barriers, and power differentials within the staff and community participants.

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Another key element of the project was asking staff what matters to them, as this aligned with the '*Triple Aim*'.[7] Capturing this information via

'digital word art' for community members was vital as it was in a digestible format, and this helped them recognise staff constraints and overlapping themes.

Phase 2 of the project was incomplete due to the pandemic, instead we held Steering groups during COVID to capture a balcony view of the system, and feedback of themes was captured via 'word-art'. The project results were co-produced with the community lead, and shared at a local and national level.

The quantitative and thematic analysis and results were made more accessible to all stakeholders, via the medium of digital 'word art'. The digital artwork was a paradigm shift away from NHS service-driven data and reports, to community-driven accessible art forms and posters (as illustrated), that created an equal footing for dialogue about the project, results and next steps.

RESULTS

The aim of five community-identified QI themes was exceeded, as we harvested eight service improvement themes (as identified in the co-produced poster). The relational community engagement led to 40 volunteer offers to facilitate groups in the GP practice. The relational community engagement approach resulted in the community contributing 346 h voluntary work,

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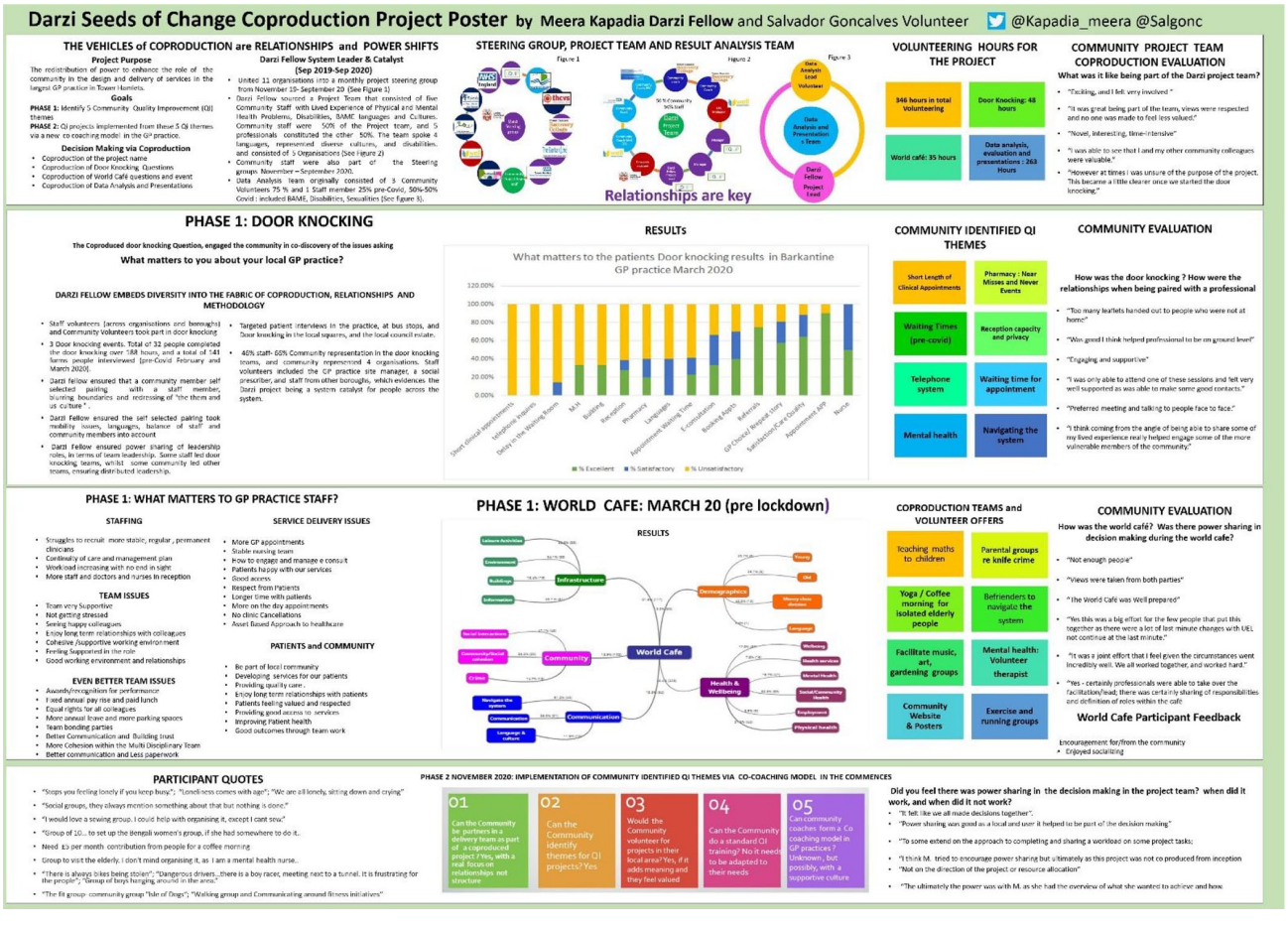

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The three world cafe questions yielded 541 comments, and five major themes and subthemes, as illustrated in the poster below.

PROJECT IMPACT

Phase 2 of the project was funded by the NHS England as a national pilot site, and resulted in the GP practice staff and the Patient Participation Group addressing one of the identified service improvement themes: the telephone system. As a result, more staff were employed to address the blockage in the system.

A GP practice volunteer facilitated fitness classes for the patients and the practice is committed to employing a volunteer co-ordinator to facilitate other volunteer offers. The project won the Health Services Journal value pilot project of the year award 2021. The wider public health benefits include a co-production model that can be used across health and social care, to identify and implement service improvements, and address wider determinants of health.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

FUNDING

The author(s) received no financial support for the research, authorship and/or publication of this article.

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