The complex spaces of co-production, volunteering, ageing and care

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Abstract

The care of older people is being radically reformulated by placing the individual at the centre of care process through the introduction of individual care plans. This marks a significant transition for the care of older people away from acute responsive clinical care towards a greater emphasis on co-produced preventative health and social care and relations of care "with" older people. Geographies of volunteerism are yet to consider the effect of co-production as a dominant rhetoric in UK health and social care. In this paper we show that the Health and Social Care Act (2012) and the Care Act (2014) has the potential to fundamentally alter discourses of care by introducing new spatialities to older people's care. New spatialities of care will not only rely on the reciprocity and interdependence of care between individuals and organisations but also the mobilisation of a voluntary care-force to be attentive to individuals. Spatialising co-production reveals the institutional and professional boundaries that prevent the type of open partnership that sits at the heart of the rhetoric. Our ethnographic and qualitative methodology was developed to understand how our case study of Living Well (Cornwall, UK), as a philosophy of care, is realized in practice and to consider the main collaborators' views of different methods of co-production involving volunteers. We discuss two principal spaces of co-production, highlighting the opportunities provided for, and barriers to, co-production expressed by volunteers and other partners by attending to the relations of care that are recognised through: (1) formal meetings and coffee mornings, which provide spaces for volunteers to contribute, and (2) multi-disciplinary team (MDT) meetings, in which volunteers are largely absent.

KEYWORDS
ageing, Cornwall, health and social care, qualitative methods, UK, volunteers

Introduction

In this paper we offer a critical analysis of the role of volunteers in health and social care provision for older people in order to expose co-production as spatialized knowledge-making and practice. This is important for two reasons; first, volunteerism is often seen by governments as a means to fulfil the need for care but still achieve the redistribution of public goods (Grootegoed and Tonkens 2017; León 2014). Second, co-production has powerful rhetorical force in the health and social care sectors in the UK because continuing with the same level of reliance upon professionally designed and delivered care services is unsustainable (Bovaird 2007; Power and Hall, 2017; Verschuere et al 2012). But volunteers themselves are

sometimes treated as marginal to the work of co-production, despite their potential to work with professional providers to make care more responsive, human, and efficient (Grootegoed and Tonkens 2017). Spatializing co-production reveals the institutional and professional boundaries that prevent the type of open partnership that sits at the heart of the rhetoric. Volunteers are treated as an addition to the process of care rather than being intrinsic to practices of care. We bring the literature on co-production into correspondence with the literatures in geography on care and volunteerism to show how co-production as spatialized knowledge-making and practice is conditioning the experience and potentially limiting the potential of volunteers.

Alford defines co-production as 'the involvement of citizens, clients, consumers, volunteers and/or community organisations in *producing* public services as well as consuming or otherwise benefiting from them' (Alford 1998: 128, original emphasis). Co-production is now part of the *lingua franca* of a range of sectors from the environment to research and higher education (Pestoff 2012). The imperative to achieve successful co-production in the UK is heightened by the recognition that health and social care have historically been treated as separate sectors, funded differentially and lacking joined-up strategy- or policy-making and delivery (Randle and Anderson 2017). However, the conjoined effects of longer life expectancy, more complex illnesses, and increased care needs are placing widely reported demands on health and social care resources, accentuating calls that treatment must be 'multi-level and socially oriented' (Buddery 2015: 11).

Our paper draws on and develops work in three linked areas: i) the moral geographies of care, ethics and responsibility (McEwan and Goodman 2010) which seeks to account for the politics and ethics of care-giving (Brown 2003); ii) voluntarism, health and place – a diverse geographical literature which examines "the processes, outcomes and everyday practices of voluntarism in distinct places" (Skinner and Power (2011: 3); iii) literature on co-production which sits largely outside of geography in the fields of economics, political science, public administration, and voluntary/third sector research (Brandsen and Honingh 2016). This literature largely undertheorizes the importance of space, a consideration of which (we argue) enhances our understanding of co-production as spatialized knowledge-making and practice in which volunteers are largely excluded. The

spatializing of co-production also adds a novel element to geographies of volunteerism (Fyfe and Milligan, 2003) which, whilst cognizant of the spatial impacts of different political decisions (Skinner and Power 2011), have yet to consider the impact of co-production as a dominant rhetoric in UK health and social care.

Using the case study of *Living Well*, Cornwall, UK, this paper discusses how the spaces of co-production enable or militate against the involvement of volunteers in co-production as both knowledge-making and practice going on in and producing specific spaces in health and social care provision. *Living Well* developed in 2014 through a partnership between Age UK Cornwall and the Isles of Scilly, Volunteer Cornwall[1], Cornwall Council, the National Health Service, and other health and social care providers; it is a transformational philosophy of care that brings together a range of agencies and volunteers to support older people[2]. The Living Well partnership tested several approaches for the involvement of volunteers as co-producers of care, which form the basis of the empirical material in this paper. We examine co-production as a spatialised practice. First, revealing how new spaces of coproduction emerge when volunteers become involved as coproducers in older people's care. Second, we apply critical scrutiny at a time when the care of older people is being radically reformulated away from acute responsive clinical care towards co-produced preventative social care by caring together 'with' older people. Success in these new spatialities of care will depend on co-production achieving more than rhetorical power, including reciprocity and interdependence of care between individuals and organisations and the mobilisation of a voluntary care-force to support older people.

We begin with a short review of the current status of co-production in the UK health and social care system before examining insights and gaps in the literatures on the geographies of care and voluntarism. Then, using Living Well as a case study, we provide a critical analysis of the spaces of co-production and the inherent

[1] Age UK Cornwall & The Isles of Scilly is the local branch of the national Age UK charity which works to improve the wellbeing of people in later life. Volunteer Cornwall is a charity dedicated to building social capital and developing the wellbeing of individuals and communities in Cornwall, working in collaboration with a wide range of organisations.
[2] See Living Well: Pioneer for Cornwall and Isles of Scilly for more details: https://www.cornwall.gov.uk/health-and-social-care/health-and-wellbeing-board/living-well-pioneer-for-cornwall-and-the-isles-of-scilly/

challenges that unfold when policy becomes practice, including the multiple and complex power relations that exist between various 'experts' and volunteers.

Co-production, care, and volunteerism

We contend that co-production is fundamentally spatial and that insights from geographers and others on the geographies of both care and volunteering have much to contribute to the successful realisation of co-production in practice. 'Co-production' is a buzz word in both the academic and grey literature, promising changes in the way that people work 'together'; seeking to promote inclusive socio-spatialities by working with marginalised and/or oppressed groups (Pestoff 2013). The principles of co-production, like those of 'participation', are difficult to realise in practice because of existing norms, practices, logics, beliefs, and values amongst different public, private, and civil society practitioners and service-users (Vickers et al 2017).

The concept of co-production has its roots in service delivery and was introduced during the late 1970s in the USA by public administration scholars (Ostrom 1996). There has been a gradual and then exponential increase in the adoption of co-production as a philosophy if not actually a model of collaborative service delivery (Brandsen and Pestoff 2006). Three trends explain renewed interest in the topic: i) declining levels of trust in government (Fledderus, Brandsen et al. 2014); ii) austerity measures post-2008 (Buddery 2015; Power and Hall, 2017); and iii) greater knowledge and empowerment of citizens (Needham 2008, Loeffler and Bovaird 2016). However, there has been limited empirical research on local-level behaviours based on 'citizen coproduction' (Boviard et al.,2014: 109); while Brandon and Honingh (2015) favour professional-producers and citizen-consumers, overlooking the place of volunteers in co-production.

Two pieces of legislation define the organisation and delivery of health and social care in England: the Health and Social Care Act (2012) and the Care Act (2014). The former was intended to sweep away operational problems around co-ordination and effective joint working in the delivery of health and social care and manage the challenges of austerity, an ageing population, and mounting costs associated with improved treatments (Department of Health, 2012). Co-production is

a key rhetoric in this model for the delivery, but requires organisations to "make changes to their culture, structure and practice and to regularly review progress" (Excellence 2015). Co-production often happens at small scales in bespoke arrangements of practitioners, agencies, volunteers, carers, and patients (Needham 2008, Needham and Carr 2009), Hoorberg et al, 2015), yet the way in which co-production is a spatial practice is overlooked.

Care as an aspect of everyday life has been well documented within geography, including the way that spaces of care – including health care – have expanded from a specific historical grouping of institutions – asylums (Parr, Philo et al. 2003), hospitals, surgeries, carehomes – into family homes or community centres (Parr 2000, Conradson 2003; Andrews et al., 2012), and even shopping centres (Davies 2013). This expansion in the spaces of care has not necessarily been accompanied by a similar expansion in the spaces of co-production, which are still constituted by the presence of a nominal 'expert'.

The rise of co-production as a policy objective has reconfigured the boundary between the voluntary sector and the state, creating "wholly new geographies" (Power and Hall, 2017, unpaginated), notably of local service provision by a range of third sector organisations, companies, social enterprises and individuals. The literature on voluntarism, health and place is large (Skinner and Power, 2011), but brings into sharp focus the ways in which voluntary sector activities are shaped by place (Power, 2009), creating new landscapes of care provision (Power and Hall, 2017), and new processes, outcomes and everyday practices of voluntarism (Skinner and Power 2011). Co-production represents yet another, albeit under-explored, challenge to the voluntary sector and individual volunteers, by renegotiating relationships of care though without necessarily attending to their spatial underpinnings, vital though these are to delivery. Co-production is a profoundly relational activity, a negotiation and transaction between multiple actors including the care receiver, health and social care practitioners, and care givers (family, friends or volunteers). It is discursively predicated on a horizontal relationship between these actors which, despite its rhetorical power, is difficult to realise in practice, confined as it is to offices, surgeries, or meeting rooms (Andrews et al., 2012). Work on relational concepts of care also poses questions about the responsibilities of individuals, institutions and the state, as neo-liberal policies

continue to push care into the realm of families, friends, volunteers, and informal relationships (McDowell, 2005) without also inviting them in as participants in co-production. For proponents of co-production, the difference between caring 'for' and caring 'about' (Milligan and Wiles 2010) is an important one, reflecting relative levels of investment, concern, and commitment to identify appropriate outcomes and deliver care. In co-production, the question of who can co-produce, from what distance, levels of trust, and the role of those close to the care-recipient but outside the structures of co-production are all pertinent issues.

Case study: Living Well

Living Well is deliberately described by its progenitors as a transformational philosophy of care that brings together a range of agencies and volunteers to implement a programme that promotes the health care needs of older people[3] along with emotional wellbeing, financial stability, social connectivity, and a sense of purpose. The *Living Well* philosophy has been applied in four programmes: Newquay Pathfinder, Penwith Pioneer, East Cornwall, and Isles of Scilly. The programmes are predicated on an equal partnership between the community and voluntary sector, the local authority, health commissioners, and service providers. The aim was to reduce the dependency of older people on health and social care, e.g. through reduced non-elective hospital admissions. The Living Well theory of change shows that volunteers are integral to delivery (Figure 1) with voluntary organisations identified as members of multi-disciplinary teams (MDTs). [4]

Our methodology was developed to understand how Living Well, as a philosophy of care, is realised in practice and to consider the main collaborators' views of different methods of co-production involving volunteers. Our methods were primarily qualitative, designed to expose the bespoke, iterative characteristics of *Living Well* by exploring networks and relationships, social practices in place, and experiences from a variety of perspectives and ways of working. Our sample was drawn from frontline health and social care practitioners including GPs, district

[3] Living Well targeted people over 75 with two or more long term health conditions at risk of repeat non-elective hospital admission.

[4] Multi-disciplinary teams comprise staff from several different professional backgrounds who have different areas of expertise.

nurses, community matrons, and *Living Well* Coordinators; those working in health and social care at the managerial and strategic level; volunteers; staff from Age UK Cornwall and Volunteer Cornwall; and older people. We developed different research activities that appealed to different participants, including tea parties with older people and volunteers which recreated the feel of a village fete refreshments tent with bunting, music, tea and homemade cakes. We repeated this with senior managers and in GP's surgeries to capture the experience of health care practitioners. We conducted 44 semi-structured interviews: 19 with volunteers, 6 with older people, 8 with *Living Well* Coordinators involved with setting up and delivering *Living Well* at different stages, and 11 with strategic partners across a range of organisations. Also undertaken were 8 personal observations during coffee mornings and crafts group during which older people, volunteers and *Living Well* coordinators socialise with each other, 4 signature 'tea parties' for volunteers, older people and Age UK staff and 4 tea parties in GP surgeries. We operated under informed consent, and all participants are here referred to by job role, anonymising any identifiable details. We interpreted our richly textured accounts by identifying dominant discourses.

Below, we consider the spaces of co-production in Living Well and examine critically the belief that co-production is predicated on the interaction and exchange of ideas and practices between easily definable groups of care consumers and producers, i.e. clients and practitioners (social and clinical).

Spaces of Co-production in Living Well

We discuss two principal spaces of co-production in the Living Well programmes, comparing the opportunities provided for, and barriers to, co-production expressed by volunteers and other partners. We describe these enabling and mitigating spaces of co-production by attending to the relations of care in: i) formal meetings and informal coffee mornings, which provide spaces for volunteers to contribute, and ii) MDTs, where volunteers are largely absent.

Spaces of Co-production I: Formal meetings and coffee mornings

In West and East Cornwall the space for co-production was a formal monthly meeting at which volunteers would escalate issues and 'pass up' information about

older clients[5] to the Coordinator. The Living Well Services Manager described these as characterised by "a sense of function and work, where volunteers are carrying out a role" (2015), yet, there are a number of power relations that illustrate the limits to co-production in this model.

First, volunteers are not in direct correspondence with clinicians and therefore unable to share experiences and insights in a group setting with health and social care practitioners. Figure 2 illustrates the linear flow of information, including the identification, communication and escalation of risk: from the volunteer to the coordinator and thence to the MDT meeting. The older person is not present in this space and the mechanisms for 'closing the loop' with them are not clear. Decision-making about service provision does not occur in the space that volunteers and coordinators occupy – that happens in MDT meetings (see below).

In Newquay, coffee mornings provided an informal space for volunteers to discuss challenges and concerns with each another, coordinators, and Living Well team leads, who provided peer support. As Volunteer Cornwall's Team Manager (2015) said "we use this peer support approach in the Welcome Home[6] programme too, we know it works and volunteers like it". Peer support enabled co-production of knowledge between volunteers but there was a lack of a clear process for the escalation of risks and follow-up.

The formal meetings and coffee mornings are attended by a small subset of all the possible agents in co-production. Coordinators and team leaders pass non-medical issues to relevant agencies before entering another, differently constituted space of co-production: MDT meetings. In both formal meetings and coffee mornings, the Living Well coordinator is the arbiter of co-production between volunteers and health and social care practitioners. Although risks are screened and escalated to the right expert, team, or service, volunteers noted that there were few mechanisms to receive 'good news' stories about the positive impact of their involvement, and risk communication, so they did not feel part of a team. Clearly,

[5] Although there is debate about labelling older people as clients, they were often referred to in this way throughout meetings associated with the programme.
[6] Welcome Home supports clients being discharged from hospital with shopping, cleaning, laundry, and accessing care services.

they are neither full participants in co-production or beneficiaries of feeling as if they are an integrated part of a team.

Spaces of Co-production II: MDT Meetings

One obvious solution tested by Living Well partners in operational contexts was opening MDT meetings to volunteers. A MDT meeting "is an opportunity for a structured conversation about a person who has complex issues, potentially involving a range of practitioners" (interview with Community Matron, 2014). Each practitioner shares their own knowledge about the client and disciplinary skills to jointly create an anticipatory care and action plan, delivered by the most appropriate key worker (interview with Community Matron, 2014). The usual membership of Living Well MDTs is listed in Table 1.

The presence of personnel from multiple agencies and organisations makes MDTs a concentrated space of co-production. Its members qualify through their professional status as a health- or social-care practitioner and volunteers were only invited in a few cases. MDTs are therefore already replete with asymmetrical power relations. Here we review briefly four perceived barriers to involving volunteers in the MDT meetings as co-producers of care in Living Well. These are: i) volunteers' desire and ability; ii) language; iii) confidentiality; iv) relationships.

Volunteers' Desire and Ability

As Volunteer Cornwall's Team Manager said, "some volunteers would revel in the opportunity as they might have had previous experience in such context or want to develop their professional CV. We should definitely develop the ability and opportunity to do so, but not force it. It can't be a policy for all" (2015). This quotation illustrates that there is an assumption from proponents of volunteer integration into MDTs that i) volunteers would want to integrate, and ii) that they would have the professional ability to do so. Previous research on Living Well (Leyshon et al. 2015) has shown that volunteers' professional backgrounds, skills, and passion represent an untapped resource for further co-production in care systems, going well beyond frontline caring.

The question of whether or how a volunteer might be qualified to sit on an MDT has never been resolved:

> *"[W]hile a volunteer might have been a nurse… if they are not officially up to date on training and accreditation then they are not a nurse. This blurring of roles between past professional experience and volunteering could be dangerous with a volunteer having an over-confidence to contribute at moments in an MDT when it is not appropriate" (Senior Manager, Age UK Cornwall, 2015).*

The observation supports Thomsen's (2015) argument that an individual is more likely to co-produce if they have knowledge of how to co-produce and a strong sense of their own self-efficacy. However, as a senior manager in Age UK Cornwall (2015) pointed out, volunteers might also be discouraged by "the strategic wranglings which can go on in MDT".

Language

The language used and rapid dealing with 'cases' in MDTs are examples of where the characteristics of the organisations in the co-productive space creates barriers between insiders and outsiders (Sharma, Conduit et al. 2014), as the following three quotations demonstrate:

> *"[we use] medicalised, technical language, and abbreviations…that volunteers might struggle with" (Living Well Team Leader, 2015);*
>
> *"[it is the] difficult process of integrating the voluntary sector with the expert health sector" (Living Well Programme Manager, 2015);*
>
> *"our staff get the 'outsider feel', let alone volunteers" (Living Well Programme Manager, 2015).*

The MDT is the primary site for the medicalisation of care in the context of ageing and described as "intimidating because they are so fast flowing and cold" (clinician, 2015), yet, the solution rests on "how well organised and structured [the meetings] are by the DT chair if those coproduction benefits are going to be realised" (clinician, 2015).

Confidentially

The most regularly cited barrier to the integration of volunteers into MDT is confidentiality and data protection. Within the MDT patient information is not simply mentioned in passing – sometimes "their whole medical history is put up on a slide" (evaluation consultant to Living Well, 2015). The Living Well Programme Manager worried about volunteers being privy to personal medical data and breaking rules of

conduct and ethics. This concern about confidentiality is heightened by the fact there are no national guidelines about how such issues should be handled in MDTs.

Volunteer Cornwall's Team Manager noted that "there is a perception from medical officers that they are the only ones who can handle sensitive information. This stereotypes volunteers as untrustworthy" (2015). Living Well partners and consultants offered a number of solutions during interviews. Firstly, volunteers could sign the pre-existing NHS confidentiality agreement. Secondly, an agreement could be reached between the NHS and the older client if the client is 'ok' with their volunteer championing their needs at an MDT. Third, volunteers could attend at the start of an MDT meeting and withdraw after they had discussed their cases. However, a volunteer may have to attend a number of MDT meetings in order to feedback on all their clients. In Penwith there are nine GP practices and a volunteer may have to attend MDT meetings at more than one location.

Relationships

The final challenge is relationships. Living Well co-ordinators and /or team leaders attend MTD but, enabled by co-location, they also exchange information through informal 'corridor talk'. Long et al. (2007) argue that hospital corridors act as important conduits of clinical information flow. As a Living Well consultant (2015) explained, "this corridor chat is not just about creating trust with the doctors but it's actually where action happens, those relationships are key". In response, some Living Well clinicians suggested that the definition and practice of an MDT should therefore be widened, "making volunteers more integrated as part of the healthcare team" (clinician, 2015). A consultant (2015) concurred: "people think of a MDT as … when everyone formally sits down; that definition needs expanding. A MDT should be 24-7 and include informal conversations in the corridor as that's where we know the action happens". Practical solutions should not necessarily just attempt to integrate volunteers with the medical sector, but rather see the medical sector integrating with the voluntary sector. Volunteers should be added to MDTs synchronously with other carers and not just as an afterthought in a linear fashion. A Living Well evaluation consultant (2015) pointed out that "volunteers look at their elderly clients needs through a different lens, a much needed non-medical lens", highlighting the value of knowledge sharing incorporating different views,

perspectives, and expectations, including professional and lay conceptions of health (Owens and Cribb 2012). Barlie *et al* (2014: 205) show that co-creation is 'affected by information asymmetry that has traditionally characterised health care service, particularly the doctor-patient relationship'. The empirical material shows that the integration of volunteers has the potential to introduce a 'robust understanding of the situation and the elderly's needs' (evaluation consultant 2015) to co-production.

Discussion

Our aim in this paper has been to contribute to debates on the ways in which co-produced services for the elderly are central to the construction of new moral geographies of care (McEwan and Goodman 2010). By examining 'sites of care' such as coffee mornings and MDTs we have illustrated how new spaces of care for older people are being produced, negotiated and reproduced within a nexus of relations through the integration of volunteers alongside more formal social and clinical care. We have shown how co-production is a political process (Brown 2003) that is mediated through specific sites through reflexive knowledge-making and iterative and adaptive practice. Through gathering clinicians, care providers and volunteers together at inclusive socio-spatialies (Prestoff 2013) that are culturally credible to elderly 'clients', care services are being reformulated to reflect the needs of those individuals alongside the needs of clinical provision. This is evident in regard to health and social care provision in the case study of Living Well, Cornwall, UK. Our intention has been to move beyond the rhetoric of co-production and the production of citizen-consumers (Brandon and Honingh 2015), proffered as a solution to breaking down institutional and professional boundaries, to show that attempts to implement co-production challenges and (re)shapes the roles of experts, patients, volunteers, and carers.

Our case study illustrates that the voluntary sector, agencies, health care practitioners and service providers, are enlisted in very specific linear ways into co-production, and volunteers are treated as an addition to the process of care rather than being intrinsic to practices of care. Understanding the complexity of these processes requires greater recognition of geographies and spatialities of professional dynamics, power relations, practices, and outcomes (Skinner and Power 2017). We argue that the difference between provision in locations can be

explained, albeit tentatively by spatialising the multiple barriers to service delivery that effect the relations of caring 'for' and/or 'about' a patient (Milligan and Wiles 2010). These barriers are manifold and vary in significance and influence at different locations. They include the deployment of volunteers with different skill sets, language issues, the requirements of patient confidentiality, the difficulty of forming relationships, the extent of devolved of power and decision-making to volunteers and the practicalities of managing complex systems. Co-production therefore is a negotiation of caring for an individual but being constrained through how this may be achieved. Co-production may assist health services to support self-management, encourage active patients and produce better prepared clinicians, and have a responsive, flexible administrative structure (Realpe and Wallace 2010). However, the managerial process in the Living Well programme tends to leave unchallenged the constraints and limits placed on volunteers rather than enabling their capacity as active co-producers.

Although the Living Well model envisions volunteers as part of the co-production of care alongside clients and practitioners, our argument is that their presence alters the relational understandings of spaces of care. Here our research extends the literature on co-production in a key way. As Andrews et al (2012) note, the delivery of care from practitioner to client is usually limited to specific spaces e.g. the GP surgery or home: spaces that are organized for the efficient delivery of prescribed care. Co-production in this way is limited to organising the delivery of care into spaces, however the inclusion of volunteers into those processes alters the spaces of care by simultaneously de-clinicising them, whilst re-socialising care. The extent to which volunteers can successfully rupture those spaces and challenge existing patterns of care depends on the extent to which clinicians are willing to integrate them more fully into care regimens in formal meetings, coffee mornings, and MDTs. Introducing volunteers into those spaces exposes how much they are controlled and regulated in a linear way, and how much those spaces condition co-production in clinical frameworks of knowledge making and practice. If we are to extend the sociality of care to produce more robust and adaptable care systems for the elderly, we need to integrate volunteers more fully into care practices.

Conclusion

In conclusion, although our empirical focus in this paper is on a project with a very specific client group, our findings are relevant to a range of sectors where care is provided and co-production of outcomes is being attempted such as adult social care, mental ill-health, and pathways to employment for NEETS. There is not a generic model which provides volunteers with the power to shape how they are trained, deployed, and involved with decision-making for older clients. We argue that a variety of different spaces and mechanisms for co-production are required and provide three integrated responses to co-produce spaces of care: i) regular peer support opportunities for volunteers; ii) an expedient system for non-medical referrals, and iii) formal and informal spaces for healthcare professionals and volunteers to exchange information and learn together for the benefit of older people's care (needs). These practices would lead to new co-produced spaces, enabling rather than constraining the role of volunteers as co-producers in MDT meetings.

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