

Response to: 'A 'work smarter, not harder' approach to improving healthcare quality' by Hayes *et al*

Hayes *et al*¹ highlight design-based approaches to healthcare improvement as one means of achieving patient-centred care, describing them as involving 'co-designing care with patients that result in a better fit with patients' abilities and needs'. They cite Experience-based Co-design (EBCD) as one such approach. They then go on to argue that those leading improvement work in a healthcare organisation or system should adopt similar approaches with their workforce and that, in doing so, they would gain 'a more explicit understanding of—and goal—to preserve workforce capacity and reduce the workload associated with change.'¹

We wonder whether the authors intended what could be read as an apparent separation between, on the one hand, 'co-designing' with and for the benefit of patients and, on the other, engaging with staff to ease the perceived burden of improvement work? If so, is such a separation the most useful framing when thinking about 'smarter' ways of improving healthcare quality?

The article therefore opens up questions relating to the most fundamental (and radical) tenet of co-design, namely that 'user and provider can work together to optimise the content, form and delivery of services...[it] entails service development driven by the equally respected voices of users, providers and professionals'.² In keeping with these sentiments, the original conceptualisation of EBCD was as a 'joint venture that involves users and professionals working together over a period and throughout the change process as the co-designers of a service'.³ In framing the approach in such a way the intention was to give equal weight to patient and staff experiences in the quality improvement endeavour; not only to seek to improve both but also to shape behaviours and values for the better. In this regard, Paul Bate—

the originator of the approach in 2005—always spoke of EBCD as a 'Trojan horse'; behind the explicit search for first order, incremental quality improvements lay aspirations of second-order, transformational change (to the benefit of patients and staff alike).

A decade on and our international survey of 59 EBCD projects across six countries reinforced the notion that co-design work is at the very core of the approach, underpinning service change as well as broader impacts on staff well-being and behaviours.⁴ However, a key finding of our survey was that co-design is also, in practice, the hardest aspect to implement. Nonetheless, where successfully implemented in practice, the co-design stages of EBCD have proved powerful. In projects carried out in emergency departments in New South Wales, Australia, co-design was reported to have demonstrated a number of strengths, including engaging service users in 'deliberative' processes that were qualitatively different from traditional forms of engagement and enabling the service to implement solutions that met the wishes, advice and insights of patients and front-line staff.⁵ Significantly in the context of Hayes *et al*¹ viewpoint article, the approach also allowed project staff to learn new skills and enabled front-line staff to better appreciate the impact of healthcare practices and environments on patients and carers.⁵

Despite this—and other examples of successful incorporation of co-design into routine organisational practices⁶—there remains a felt need for illustrative and accessible resources that would further clarify and bring to life the 'how' and 'why' of co-design in the healthcare context.⁴ In the same Australian project, where preparation, recruitment of patients and engagement of front-line staff were not possible or not consistent, co-design worked less well.⁷

As Iedema noted in his own response to Hayes *et al*, while 'we expect frontline professionals to somehow know how to co-design practices, and know how to be smart about what they do and what they should do...their training has not

skilled them in practice design'.⁸ To help staff achieve this, we would argue that they need to be encouraged to 'step off the pavement' and work in a much closer joint endeavour with their patients (who will bring their own unique insights to such an enterprise in the form of that specialised form of knowledge called 'experience'). Closer collaborations with service designers—with their wide range of proven tools and approaches (whether 'gadget based'⁸ or not)—is another part of the potential solution, albeit always with an eye to the unique context of healthcare organisations in which this expertise is to be applied.

We have suggested elsewhere that the adoption and implementation of co-design in the healthcare sector require critical approaches to both organisational processes and the application of design thinking.^{6,9} Digging a little deeper into the detailed implementation of approaches such as EBCD undoubtedly often reveals tensions between the intended aims of co-design and its actual forms in practice.⁹ Implicit in co-design approaches is the aim to alter power relations, but the evidence as to whether or not they do so in the healthcare setting is very scant; certainly until now we know little of the circumstances in which they are successful in this regard.

As Hayes *et al*¹⁰ have already commented, 'there needs to be a system-wide look at the capabilities and investments required to create a 'working smarter' healthcare system'. Asset-based or resource-based perspectives may help¹¹ but crucial to any such an assessment is closer consideration of what both patients and staff can bring, together, to new co-designed ways of caring. Perhaps harder work in the short term but smarter in the long run?

Glenn Robert, Sara Donetto

National Nursing Research Unit, Florence Nightingale Faculty of Nursing and Midwifery, King's College London, London, UK

Correspondence to Professor Glenn Robert, National Nursing Research Unit, King's College London, James Clerk Maxwell Building, 57 Waterloo Road, London SE1 8WA, UK; glenn.robert@kcl.ac.uk

Competing interests GR is one of the original developers of EBCD and has

been involved in the evolution and adaptation of the approach since the initial pilot project in 2005 which was funded by the NHS Institute for Innovation and Improvement. The Point of Care Foundation in England provides training in the EBCD approach and GR contributes to this.

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