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MAKING HEALTH AND SOCIAL CARE PERSONAL AND LOCAL

Moving from Mass Production to Co-Production

Elke Loeffler, David Taylor-Gooby, Tony Bovaird,
Frankie Hine-Hughes and Laura Wilkes (eds.)

Preface

Elke Loeffler, Chief Executive, *Governance International*

The idea of this book arose from an intense conversation with David Taylor-Gooby whom I first met at a workshop of a health user group at Warwick University in 2009. His commitment to community and user involvement in health inspired Governance International to launch this ambitious publication. I am delighted that subsequently the Local Government Information Unit (LGiU) joined this project as a partner and contributed more chapters.

The fact that this book now includes 24 chapters shows that co-production in health and social care is no longer just a good idea but is already happening and making an important difference.

My thanks go to all authors for their excellent contributions. Particular thanks go to Yvonne Harley, Liaison Manager of Governance International for her excellent co-ordination, proof-reading and support during the publication journey. My special gratitude also goes to Rüdiger Kern for his superb design work.

Foreword

Andy Sawford, Chief Executive, *Local Government Information Unit*

Right now three powerful forces are coming together to fundamentally change how public services are provided in the UK. The first is the drive towards 'localism' to devolve power and decision making from central government to local government and communities. The second is the fiscal context and the unprecedented scale and pace of public sector funding reductions. The third are the wider and longer term changes in our society, such as demographic, technological and scientific change, coupled with people's changing expectations.

Public service providers, including local authorities, know that they must find very significant savings in current expenditure, and as they look down the road, they can see cost pressures and demands are rising. This is particularly so when it comes to providing social care and health related services. Shaping a positive future, in a challenging context, involves new ways of working, effective partnerships, and engaged communities.

In UK local government there is much talk of different approaches, from the 'commissioning council' to the 'co-operative council', or even the 'e-bay council'. These different models and approaches to service delivery all assume the need for a new relationship between citizens and the state, with an emphasis on co-production. Whether it's through personalisation approaches, such as personal budgets, 'nudging' or perhaps the 'big society' the idea is that service users should be enabled to take on a greater role in shaping their own services. Some will say these ideas are not new, but what is noticeable in the current debate is the extent to which the emphasis is shifting from having a greater say to taking a greater role.

This very timely book explores co-production from different perspectives, including those of local authority leaders, health and social care practitioners and leading experts. Through commentary and case studies, that cover everything from the specific experience of ground breaking new approaches to the practical '5 steps to co-production', these essays give us a glimpse into the future, with all its opportunities and challenges. I hope you will find the book a useful and interesting read and that it helps stimulate further thinking and debate about this vital area of public policy.

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The vision: Making social care and health personal and local

Why public service co-production matters

Tony Bovaird, *University of Birmingham* and
Elke Loeffler, *Governance International*

Co-production is rapidly becoming one of the most talked-about themes in public services and public policy around the world (Bovaird, 2007; nef, 2008; Loeffler, 2009; CoSLA, Scottish Government and NHS Scotland, 2011). This chapter sets out why we need to change traditional service delivery, in particular in health and social care.

The movement to user and community co-production harks back to one of the key characteristics of services in the public and private sectors: the production and consumption of many services are *inseparable*. Indeed, the creation of quality in services often occurs during service delivery, usually in the interaction between the customer and provider, rather than just at the end of the process. This means that customers do not evaluate service quality based solely on the outcomes (e.g. the success of a medical treatment in a hospital) – they also consider the process of service delivery (e.g. how friendly and responsive were the hospital medical staff and how comfortable was the ward).

Co-production is not a new concept – it was at the very heart of one of the classic texts in service management (Normann, 1984), where it was remarked that a key characteristic of services is that the client appears twice, once as consumer and again as part of the service delivery system. What is new, however, is that in recent years in the public and private sectors we are seeing a greater interest by public agencies in exploring the potential involvement of service users and communities in services. As Box 1 shows this has often been for mixed motives – not simply in order to improve service quality by "bringing the user in" but also in order to cut costs, by making the user do more for themselves. As Gerry Power shows in his chapter in this book, these cost pressures are likely to increase in the light of a growing older population. The *Governance International* & TNS Sofres Co-Production Survey has also shown that changing demographics are an opportunity for increased levels of co-production, as elderly people are more involved in improving public outcomes and services than younger people (Loeffler et al, 2008).

Box 1: Motives for increased customer's involvement in public services

- Improving public service quality by bringing in the expertise of customers and their networks
- Providing more differentiated services and more choice
- Making public services more responsive to users
- Cutting costs

This trend has already begun to change the relationship between professional service providers and service users by making them more interdependent. As a result, there is now new interest on the part of professionals in the co-production of public services and its implications for service delivery.

Moreover, it is clear from the motives set out in Box 1 that there is a considerable overlap in interest between the co-production approach and the practice of social marketing (Kotler and Lee, 2008), which is also aimed at improving service quality, providing services which are carefully tailored to the needs of specific groups and responding to the demands and needs of those who are affected by the services.

This overlap of interest is most dramatically evident in relation to 'preventative' approaches to social policy. In the last few decades, social marketing has had to 'carry the weight' of governmental approaches to behaviour change, seeking to convince citizens to take actions which would prevent future social problems, and thereby save future public spending. Much attention has been given to publicity campaigns aimed at changing public attitudes, hoping for spin-off effects on social behaviour. More recently, 'nudge' initiatives have sprung up, based on experimental behavioural psychology, which similarly seek to achieve behaviour change, by reframing how citizens see particular issues and problems (Thaler and Sunstein, 2008). Co-production complements these social marketing and behavioural psychology approaches in a very powerful way – it directly involves citizens in how public services are conceived, planned and delivered, in the belief that behaviours can be changed even more successfully if people have direct experience, rather than simply being subjected to publicity campaigns or having their choices framed for them in certain controlled ways. For example, it is believed that people who are 'expert patients', giving advice to other patients, are less likely to relapse into the smoking or alcohol abuse behaviours which contributed to their own health problems. Again, people who help to tidy up their local park or children's playground are less likely to let their dogs foul up the paths in these places. And young people who help to design and even construct public art in the spaces around their homes and gathering places are less likely to vandalise and paint graffiti.

What is co-production of public services?

Co-production puts the emphasis on the contribution made by the service beneficiary in the service delivery process. For example, in education, outcomes not only depend on the quality of teaching delivered by school teachers or university staff but also on the attitudes and behaviour of students. If students are not willing even to listen, or not prepared to carry out the follow-up work at home or the library, the amount that they learn will be very limited.

In a public sector context, the "co-operative behaviour" of service recipients may even extend to their acceptance of constraints or punishments – for example, improving community safety involves citizens in accepting speeding or parking restrictions and being willing to pay a fine when they have ignored these restraints. Fines would be unenforceable, if no-one paid them and speeding or parking restrictions would no longer have any effect.

At the same time, citizens may engage in the delivery of services on behalf of other people, which we typically refer to as "volunteering". In the UK the role of this kind of activity is currently being strongly debated under the banner of the "Big Society". For example, most social care in the UK is not provided by the public sector but by family members looking after their elderly parents or children with care needs. However, such unpaid labour would benefit enormously from more support by public services – for example, by offering exhausted mothers occasional 'respite care', so that they can take a holiday.

Clearly, real co-production of public services does not mean just 'self-help' by individuals or 'self-organising' by communities – it's about the contributions of BOTH citizens AND the public sector.

Consequently, we define co-production as "the public sector and citizens making better use of each other's assets, resources and contributions to achieve better outcomes or improved efficiency." Its core principles are that (Bovaird and Loeffler, 2012):

- citizens know things that many professionals don't know ('*customers as innovators*')
- … and can make a service more effective by the extent to which they go along with its requirements and scrutinise it ('*customers as critical success factors*')
- … and have time, information and financial resources that they are willing to invest to improve their own quality of life and into helping others ('*customers as resources*')
- … and have diverse capabilities and talents which they can share with professionals and other citizens ('*customers as asset-holders*')
- … and can engage in collaborative rather than paternalistic relationships with staff, with other service users and with other members of the public ('*customers as community-developers*').

Types of co-production

We can distinguish a wide range of service activities which can be included under the co-production umbrella:

- **Co-commissioning** of services, which embraces:
  - **Co-planning** of policy – e.g. deliberative participation, Planning for Real, Open Space
  - **Co-prioritisation** services – e.g. individual budgets, 'community chests', participatory budgeting – stakeholder representation in commissioning decisions,
  - **Co-financing** services – e.g. fundraising, charges, agreement to tax increases
- **Co-design** of services – e.g. user forums, service design labs, customer journey mapping
- **Co-delivery** of services, which embraces:
  - **Co-managing** services – e.g. leisure centre trusts, community management of public assets, school governors

- **Co-performing** of services – e.g. peer support groups (such as expert patients), Nurse-Family Partnerships, meals-on-wheels, Neighbourhood Watch

- **Co-assessment (including co-monitoring and co-evaluation)** of services – e.g. tenant inspectors, user on-line ratings, participatory village appraisals.

The *Governance International* Co-Production Star visualises the Four Co's of co-production, including co-commissioning, co-design, co-delivery and co-assessment of public services in the outer ring.

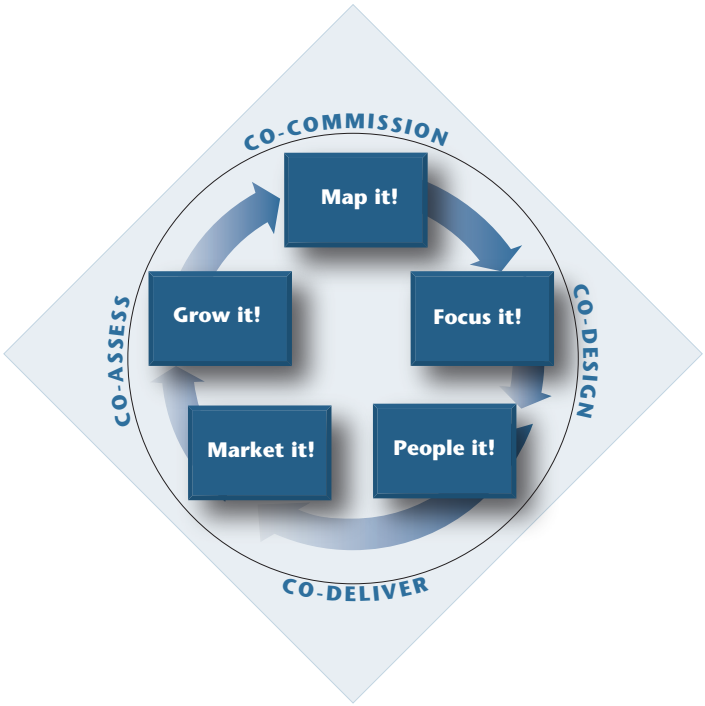

Figure 1 : The *Governance International* Co-Production Star

Distinguishing between these different service activities allows us to identify different ways into public service 'co-production'. In most public agencies it will readily be apparent that at least one of these types of co-production is already present, reinforcing the insight from earlier that co-production is not new, normally it is simply hidden (and therefore not systematically harnessed for the mutual good of the service users, citizens and public services involved). At the same time, this list also serves to make public managers aware that a much wider range of co-production activities is possible.

Implications for public service providers in health and social care

The growth of co-production has been rapid and topsy-turvy. It is not surprising that there is still great ignorance of (and even hostility to) the concept. As a radical experiment in policy innovation, it has yet to prove itself. While this book provides many case studies of successful co-production, these must still be seen as the exception rather than the rule in UK public services today.

The current drive towards co-production will only produce results if it is backed up by practical techniques to allow it to flourish, to be tested and to be rolled out in those areas where it can be shown to make a positive difference. It will be important for the public services of the future to encourage more people to engage in co-production, to ensure that their efforts are directed effectively at increasing the outcomes which people most want, and to celebrate those engaging in this way, so that they feel appreciated for their inputs and more likely to continue. If these building blocks can be put in place, the co-production approach has more chance of becoming sustainable.

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How co-producing health can add the extra value needed to help save the NHS

Paul Corrigan, *Management Consultant and Executive Coach*

The medium and long term economic dynamic for the health services of most developed countries is pretty gloomy. The great news is that more of us will live longer. But the bad news for health services is that as we live longer in our older years we are likely to suffer from long term conditions. Those years we live beyond 85 will probably see most of us suffering from several long term conditions.

The other good news is that medicine will succeed year on year in ensuring that more and more people will survive the killers such as heart disease and cancer. These successes have already turned coronary heart disease into a long term condition and increasingly year on year the same will happen to different cancers.

But the good news of our survival adds to demand for health care that will be come from people with long term conditions, as more of us survive in the future. It is this that leads to the 3–4% annual increase in demand for health care. Over 5 years this comes to roughly a 20% increase.

In five years the NHS will be lucky if the increase in resource is about 1%. In the last 5 years of this decade the best bet is that both of these figures will get worse (or better, for those of us living longer). The demand will grow faster and the resources will stay about the same.

So the NHS needs to work with a resource dynamic which has a very large increase in demand and a miniscule increase in resources.

At the moment 70% of NHS spend is on long term conditions. This means that if we are to have the game changing innovation we need to save the NHS, then it will have to come in the area of long term conditions (although, of course, it would be good to improve productivity in other areas, too)

If we treat the numbers of new people with long term conditions in the same way as we are treating those who have the diseases at the moment, the NHS will go bankrupt – it will run out of money.

What other industries and services do when confronted with this dynamic is develop innovations which significantly improve the outcomes for the same or slightly fewer resources. This is what innovation needs to provide for all industries under pressure of resources, which is the current situation of the NHS.

Most game changing innovations in business models from other industries or services come about by finding new sources of value that can contribute to the necessary increase in outcomes. Other industries look for areas of value creation that have been overlooked and they succeed by continually searching for how value can be added at much less cost.

In the past and in the present, health care in developed countries has a value equation that has been simple. Value for health care systems has only come from medical staff, their kits and from drugs. If this is the only place where value comes from, then when your health care system needs to increase the value then what you have to do is increase the

amount of value creators in those three categories. If you don't do that then value cannot be increased.

Given that over the next decade we will have such a large-scale increase in demand for health care, then this will need an increase in the value created. Yet we do not have the resources to pay for the increase in value, if we only pursue the traditional way of increasing value. We cannot increase the number of health professionals, their kit and drugs. There is not the money to do that.

The patients' role in this value equation is to receive the value created by the medical staff, their kit and drugs. What patients do is consume that value. Within this model they are a sponge which just sucks up value.

In many other industries and services, the new source of value that has been found has been realised by involving the consumer of that service in the production of value. For example much of the value produced in the retail industry involves the customer in the co-production of value that in the past was provided by staff in shops. When we select our own food in the supermarket and now do our own check out, we are adding value to the retail trade. In the past, customers cost value to the producers – now they co-create it.

Equally in retail banking – when I carry out the work that I now do in running my own bank account I am replacing the value that was in the past created by bank staff. My value creation – at a cost of zero – replaces value creation from staff.

And what is interesting about these two examples is that I love doing it. I feel empowered by this co-production – especially as I often feel that I end up with an improved service and better set of outcomes.

In health systems, we have the similar opportunity of uncovering value, which at the moment is not seen as value, through harnessing the work of patients in managing their own health care. If you have a long term condition, you are living with that condition for about 5800 waking hours a year. You may see an NHS professional for 5 hours in that year. During the rest of the time you are in charge of your own care.

Most current analyses of improving the productivity of health care looks at how we can improve the efficacy of the 5 hours work the NHS puts in. We give far too little thought to the 5795 hours that the patient is in charge of their own care.

The very best way of adding value would be to ensure that the very small input from the NHS is multiplied many times over as it works with and improves the efficacy of the rest of the time when the patient is looking after their own care. To be effective in fully using the time that people are looking after themselves needs a significant shift in how we think about the patient pathway.

This is what we mean by co production in health. It does NOT mean the patients look after themselves. It means that the small amount of time the NHS has to spend with the patient is multiplied by the large amount of time the patient runs their own health care and through this combination the health care is CO-produced. Therefore successful co-production looks at how these two aspects of care work better and better together.

For example, let us look at the taking of drugs by patients. The location where most health care takes place and where most drugs are taken, is a patient's home and not an NHS establishment. How much does the NHS know about how people live in their

homes, so that the NHS can make a bigger impact upon the efficacy of that location as the location where most health care takes place?

Let's look at how and whether patients take their drugs. The words used by health professionals about patients taking their drugs are *compliance* or *adherence*. Both these words presume that people wrap their lives around the activity that we want them to. They assume that people 'comply' with instructions and 'adhere' to a regime set by others. This is not the language of the co-production of taking drugs. And we know that sometimes, often after only a very short period, many people do not adhere or comply to the drugs regime as they are expected to. The efficacy of the treatment regime is completely undermined by this failure to 'comply' or 'adhere'. Then when people don't 'comply' we say it is their fault because they are not following orders.

Whoever's fault this is, it is certainly an inefficient relationship. If we presume that the point of the NHS prescribing drugs to patients is that people will take them, then the obvious optimum efficiency is where people take their drugs. If, as is the case with many long term conditions, the proportion taking all their drugs falls after a year to about 50%, the inefficiency of this outcome is about 50%. So let us not pretend that major efficiency increases are not available in our UK health care system!

I am suggesting this inefficiency comes from the way in which we frame the relationship with our patients. If the NHS was really interested in efficiency then it would worry about 50% inefficiency in uptake of drugs and it would look at the way in which we frame the relationship between prescriber and patient.

We might then come to the conclusion that a medical model about taking drugs which assumes patients do what they are told is 50% inefficient. We might decide that a model in which the value is created by the prescription of the drugs alone is deluded and that the value actually comes from the patient taking them. Therefore, if the patient is not involved in the co-production of drug-taking, the value produced reduces the efficacy of the drug by 50%. If we were in a situation where there was a problem with resources, we might worry a lot about that inefficiency.

My thesis is that we might worry so much about it that we might challenge how we frame the overall relationship of value creation.

That is why co-production is the only way in which sufficient value can be created to ensure that the NHS leaves this decade in as thriving a state as it entered it.

Co-production in social care: A practical exercise

Suzanne Joyner, *Walsall Metropolitan Borough Council*

Introduction

This chapter will explore co-production in social care, outlining its potential to act as a catalyst for reform in the current system of care provision.

It will examine the model of service provision we had before the more citizen centred approach, why moving to a model of co-production is a necessity in social care and what potential advantages it will bring.

Finally, it will conclude by highlighting Walsall Council's Social Care and Inclusion vision and its model of the new care system, what is being done to achieve this and the outcomes it hopes to achieve for the citizens of this borough.

The care system – a brief recent history

The NHS and Community Care Act (1990) had a significant impact on the way that care needs were assessed and subsequently delivered. The Act states that:

> *"It is a duty for local authorities to assess people for social care and support. This is to ensure that people who need community care services or other types of support get the services they are entitled to".*

Competition and care markets were introduced, as provision moved from what was deemed as low level support such as the home help service, which provided basic services like cleaning, to care and support encompassing all aspects of daily living. However, foresight was lacking, as it could be argued that more people were driven into earlier, further or faster dependency. The model missed the one thing that could have positively influenced long term impact, the previously unheard voice of the individual.

The community care assessment had the potential to be the ideal vehicle for capturing and hearing the user voice. This could have been the arena for an earlier emergence of co-production, which would have been at a point in time where any anticipated future demands could have been reduced.

Unfortunately, it did not achieve this desired outcome. The system that developed was one of resource control, where the only choice and control for the individual was, crudely put, whether to have day care, home care or both, should they indeed be deemed 'fortunate enough' to require both to meet their needs. Meeting needs became a pick list, with no flexibility for either client or professional to create a different support system, with the latter being little more than a 'gate-keeper' of the pick list. The resulting outcome was what is now referred to as the "Professional Gift Model" (see figure 2).

From a professional's perspective, social workers were being trained initially to think creatively, allowing them to draw on community resources etc, only to find that, once in post, they were constrained by systems already in place. As one staff member stated recently:

"I emerged from university full of drive and enthusiasm, fired up to change the lives of those more vulnerable, only to find that in reality it wasn't so. All I had was a defined system, whereby I could only meet needs through defined care routes, no discussion, no choice, nothing. Before long, I gave up fighting the system, became another sheep and followed, what was the point, I couldn't change it …" (Social Worker)

Figure 2: The professional gift model

The current and emerging care system

The underpinning ethos of support and care has significantly shifted in very recent years, from one of the user being a passive recipient of services that often resulted in them becoming more dependent and in need of state provision, to that of the user being enabled back to optimum independence and thus reducing their reliance on the support structures. Whilst this has predominantly been driven by the ageing population, and the subsequent demands and burdens placed on the care system during a time of economic crisis, it stands to reason that the best way of reducing demand on state provision is by tapping into the skills of people themselves. Feeling useful and involved achieves a further positive outcome of reducing social isolation, thus reducing the potential for mental ill

health and falling into other secondary care needs which could have been avoided through a co-production approach.

Co-production in social care puts service users and other stakeholders, such as family members and residents, at the heart of service planning and implementation, at a macro/strategic level. They are in the best position to know what they need, and how best to meet these needs. By being an active and equal partner in shaping the service from its embryonic stages, they enable all parties to experience the value and advantages of operating in this manner.

Figure 3: Co-production at individual level

On an individual level, the service user can co-produce their support, by constructing a range of activities and networks to meet their needs in a truly tailored and unique way (see figure 3). This micro level of planning can produce powerful results, not only in terms of outcomes for these individuals, but also for the professional and the organization. The model of meeting needs in this way encourages innovation and creativity, and indeed challenges both professionals and organizations to reconsider the very fundamentals of internal policies, procedures.

It could be argued however, that this shift in power to the individual may have catastrophic results on organizational budgets and resources, in that giving people what they want may give them the perception that they have access to unlimited resources. But in practice this outcome has not really emerged, as those in need of support are generally less inclined to 'smother themselves' with a range of services that ultimately take away their independence. Indeed, the very opposite is developing through personal budgets, whereby individuals tend to create a support package that does not spend all of their resource allocation on unnecessary services.

What better way to drive and shape the future care system, than levering the knowledge and expertise of those in need of its support to challenge and re-construct it?

Benefits of co-production

Most individuals have the desire to be needed in some way, according to Maslow's hierarchy of needs. Having self esteem is a result of feeling valued and 'of use'. Thinking about what a user can offer, rather than what they need, enables them and staff in particular, to see beyond a label, such as their disability. It shifts the power to the individual, giving them responsibility for deciding what they can do for themselves, and importantly, what they can do and offer to others. Take this to a wider community level, and it can empower individuals, even with their own social care needs, to think about their role within that community, and what they bring to the table. Immediately they are no longer the victim, being 'done unto', as they are placed in control of their own service. This helps develop and explore social capital, building on diverse skills and strengths that people have to contribute. It reduces the stigma attached to disability, which then gives value and motivation back to the individuals concerned.

Co-production values all contributions, not just financial ones. Moreover, staff who work in this way are able to develop a true partnership with the person, which then adds value to their personal sense of job satisfaction. It connects with the theory taught at university, and so when the newly qualified social worker emerges into the professional environment, they can associate with it, apply it in practice and encounter job satisfaction and high morale.

Organisationally, co-production has the potential to reduce waste, thus increasing efficiency, as services are more likely to be fit for purpose from the outset, rather than having to endure multiple reviews and redesigns. Large labour-intensive service specifications and contract negotiations should reduce, as community-based solutions emerge. The concept of 'working smarter' minimizes waste from the design and inception stages. It decreases the risk of using unnecessary resources, as it allows services to be tailored in a more focused and appropriate way.

There are also significant benefits in terms of staff retention and increased productivity, largely due to increased motivation. Motivation is further enhanced as social workers are able to apply theoretical models they have been taught into their everyday practice, underpinning the value of the educational aspects of the profession.

Walsall's vision for care and support

The potential impact of an ageing population, coupled with the economic climate and subsequent reductions in public sector funding, make it critical to shift the balance of care resources 'downstream', i.e. to delay the need for costly long-term care and support. Slowing down the demand for unnecessary care is vital, not only during these times of austerity, but because it is simply the right thing to do. However, the potential for achieving this in practice, whilst maintaining safety and quality for vulnerable people, is questionable, unless whole-system transformational change ensues across the sector. The culture of enabling and reabling is emerging as the default model, focusing resources on regaining and maintaining independence for individuals who enter into the care and health system.

This whole-system approach requires bringing the care model back a stage, so that individuals who are likely eventually to need social care support, but are as yet unknown, are 'actively' sought from within their community, before they come into contact with formal care systems. Targeting and finding these individuals, and making them known to services, is the role of the newly created Community Social Work Team in Walsall. Once known, staff, individual and other groups or networks can work with these individuals to co-produce primary prevention support (e.g. as in the *Putting People First* Concordat), brokered or even developed via community 'experts'. This approach has the potential to be a powerful force and bring about significant results. Not only does it meet the needs of that person, it can also grow and develop into a network that becomes self-sufficient, supporting a much wider group than current care users by widening the sphere of access to support.

Even better is the prospect of examining reciprocal arrangements, exploring what the individual, or group, can offer in return through co-production and developing needs assessment into a more rounded *needs plus capabilities analysis*, based on the assets of service users:

> *"Without engaging the co-operation and confidence of clients or patients, there is a danger both that welfare systems and philanthropic programmes affect day-to-day symptoms rather than underlying causes and that professionals will create dependency, convincing clients they have nothing worthwhile to offer and undermining what systems of local support do still exist. Co-production redefines clients as 'assets', with experience, the ability to care and many useful skills". (Boyle, Clark and Burns, 2006)*

This approach is emerging as an integral part of the Walsall operating model, bringing individuals in to be a part of the solution, thus building confidence and resilience into the care system, and ultimately into communities. By identifying what an individual has to offer, the balance of power shifts significantly from the professionals to that of a true partnership of co-produced solutions.

Finally, let's consider the potential impact of co-production on communities. Boyle et al (2006) suggest that 'co-production networks help to build capacity in communities in a more meaningful way than more passive resident involvement: increasing awareness and understanding of community issues and bridging social divides'.

The success of this model remains still empirically unproven, although the approach continues to grow and become embedded in many organizations, communities and individuals. Councils throughout the country have tried and tested various types of neighbourhood models of working, with varying degrees of success – indeed, some have resulted in failure, partly because they did little more than disaggregate and devolve services structurally, without any emphasis on the importance of the cultural change required to ensure success for such a model. With hindsight, or importantly, forethought, tangible benefits could be achieved through some level of support and facilitation being in position. The essence of co-production could then be embedded in everyday community activity, once the required cultural attitudes have been realigned. This would enable a

vehicle for proactive community solutions to emerge as a matter of course, with diverse and tailored networks being readily available to achieve positive outcomes.

The impact on not just social care demand but on health outcomes generally could be significant. Genuine co-production could bring communities that are healthier, more self-sufficient and resilient. Co-producing communities are likely to understand better the needs of their own members and, importantly, the relative roles of the resources their members have to support each other from within, and the resources available from the public sector.

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Citizen Leaders: Co-production through a community interest company in Derbyshire

John Jennings, *Citizen Leaders CIC*

Whilst citizen leadership in some form has been around for over 200 years in some sectors, it is a relatively new concept for the UK social care sector. It was born out of the Department of Health Academies held in 2007, which coincided with the end of the pilots for personal budgets. In all, over 150 people were trained and left the Academies with the title Citizen Leader. At present, however, not many of the original Academy Citizen Leaders are still active.

I knew that as a service user, who now had a title which opened doors that previously had always been closed, it was time to grasp the opportunity. Initially the Citizen Leaders from the East Midlands were going to try and set up a social enterprise and we received some funding from the Department of Health to explore this area. However this did not come to fruition. As a previous business owner in my 'able bodied' life, I knew that the rights to the website domains should be obtained and so I went and purchased them myself, with a view to develop my own social enterprise should the group's project not materialise. It was a good thing that I did, as the group gradually stopped meeting, due both to lack of funding and the commitments of each individual Citizen Leader.

I applied for a small start up grant from Derbyshire County Council's Social Enterprise Fund but wasn't successful and so I applied for a smaller grant from UnLtd Millennium Awards Fund. This time I was lucky enough to receive £2500, which helped me get started.

In August 2010 we decided to apply for non-profit status and became a Community Interest Company (CIC). This was done with the involvement of service users and carers and we have representation from both service users and carers as directors of the company. This enabled us to access areas of support which are only open to non-profit organisations. In our first year we have managed to raise and donate over £3500 in goods and donations to the community. We are hoping to build on this success and expand so that we can offer other services, all of which will fit in with personalisation and independent living. We hope this will create employment and volunteering opportunities for hard-to-reach groups within communities and enhance community cohesion.

During the development stage and from early 2008 I started to work alongside Derbyshire County Council on their new Stakeholder Engagement Board. From this I then progressed to being on several project boards – one in particular was a DVD project on personalisation for Derbyshire and what it would mean for new users.

A small sub-group was created which included Cynthia Voysey and Tom Crosbie, who were both service users and are now also Derbyshire Citizen Leaders trained by Citizen Leaders CIC through a training programme I helped to design and deliver. The sub-group and DVD project was overseen by Andrew Coulson, an Engagement Officer working in the Stakeholder Engagement Team in Adult Care at the Council and we started to meet to devise ideas for the DVD. The group met regularly and it was initially thought that it should be a very in-depth DVD highlighting the customer journey in Adult Care

and include case studies. However, as this was a large-scale transformation of Social Care within the county for service delivery, commissioning and planning and as it was still at an early stage, it was decided to produce a 'first steps' DVD with an overview of what personalisation would look like in Derbyshire. The whole DVD was co-produced from start to finish. Indeed, the co-production was not confined to just the content but also spread to the starring roles, design, editing and format decisions. Co-production became a key element of the whole project and was included in every step. It was crucial that all stakeholder areas were represented, with co-production involved in the specification writing, procurement and pre-production input being provided by several voluntary groups. It was ensured that service users, carers, citizen leaders and personal assistants were included as case studies in the film and in post-production activities. Translation was provided by co-producing with local BME groups, which led to transcripts being available in 7 different languages. Along with the addition of British Sign Language and subtitles, we ensured that the DVD was made available to as many Derbyshire stakeholders as possible.

In Derbyshire, co-production is now at the heart of stakeholder engagement, with the Stakeholder Engagement Board still continuing even after the end of the transition period to personalisation. Citizen Leaders CIC is represented at that board, which also includes two other Derbyshire Citizen Leaders representing their areas of experience. The Citizen Leaders act as voices within the county and are seen as vital conduits for service users to enable positive changes within service delivery, planning and commissioning. We have representation from the mental health sector, older people, carers and physical disability as well as Citizen Leaders within the learning disability sector.

We are also currently involved in co-producing a strategy for future engagement within social care for the county, to ensure that a core set of rules for engagement is created by service users and council officers, in a co-productive manner. This small sub-group was created from members of the original Stakeholder Engagement Project Board, as well as commissioning staff from the local authority. It has enabled Citizen Leaders (four of whom are on this sub-group) and officers truly to have a voice at an early stage to try and influence the way engagement will look in the future. It is working well and we hope to have finalised the strategy shortly which will be presented to strategic management within the next couple of months. This in itself has shown that co-production can create positive outcomes, using people who have a variety of skills which previously hadn't been utilised. It is testament to the early work done during personalisation and the work on the DVD towards co-production that we are now indeed recognized as 'experts by our own experiences' and that we feel empowered by being involved and taken seriously on matters which affect the lives of all of us.

As for Citizen Leaders CIC, we are looking to move forward at a steady pace and to build on the relationships we have with public authorities both locally and nationally. We have managed to create a network of Citizen Leaders within the county, through a unique training package. These people now share information and skills from their own expertise and ensure that all corners of the county can be heard in all sectors of social care. We have managed to establish credibility by creating positive results in our engagement work

with the local authority. Mindful that many changes are still happening in the overall care system, we are keen to work with and through these to create further positive results through involvement at all levels.

Wholesale to retail – the challenges and opportunities for the private sector

John Tizard, *Independent Consultant*

There has always been a significant market in personalisation in social care – particularly for services to older people. But starkly different segments are emerging within this market.

First, there has been a dramatic rise in the proportion of a growing elderly population buying their own care using their own money ('self-funders') – with no involvement, financial or otherwise, from the public sector. This is not 'co-production' but pure 'self-help'.

This contrasts with another section of that same population, for whom care is typically procured by local authorities on their behalf. However, local authorities face ever-increasing budget pressures and are being forced to adjust payment and eligibility criteria. Consequently, there has been a seismic increase in the numbers of people directly purchasing or contributing to the costs of their care – 'co-financing' – only to find that, despite making a financial contribution, they have little or no say/control over who provides the service or indeed the nature, quality and scope of that service. Hence we end up with a form of personalised financing without personalised control or choice. Yet the demand and expectation for that control and choice is growing.

Personalisation of public services is definitely here to stay – and, as it grows, it is taking on many forms, including more individual budgets and user-purchasing of some services.

Personalisation challenges the role of the state as service provider and commissioner of services. It also challenges private sector providers who must increasingly satisfy actual service users – and not just a public sector commissioner. While some of these changes do exhibit genuine, freely-chosen user and community 'co-production' of public services, in which the inputs of both service users and the public sector are valued, the current resource constraints should not be an excuse for the public sector to move from collectivism to individualism by stealth. There will be potential conflicts between the pursuit of economies of scale and personalisation.

Providers who have not previously sold services directly to clients and users are being forced to change their historic business models from 'wholesale' to 'retail', with all the implications that this implies. 'Demand risk' is moving from the public sector commissioner to the suppliers – be they public, business or third sector. This places significant pressures on providers and their business models – for example, it creates the need for additional capitalisation to manage cash flow and the need to adopt marketing practices which are more costly than dealing with a small number of public sector clients.

It follows that new entrants with deep pockets and retail experience will be attracted into these public service markets and that many existing providers will decide to withdraw from it.

Social care (especially domiciliary care) is prime territory for social enterprises, solo traders and other small providers. There is evidence of the balkanisation of service provision with a plethora of small or one person providers, where staff (and sometimes the

owners of the company) have no protection, are often on the minimum wage (or in reality because of contracts which, for example, may not reimburse travel between clients' homes, below it), have very poor terms and conditions, with no proper checks, and receive no training or development. This form of "marketisation" leads to major risks for service users, too.

As local authorities force down fees and the size of individual budgets, there could be a dangerous race to the bottom in domiciliary and residential care, forcing some providers out of the market, incentivising the kind of behaviour displayed by Southern Cross and, worst of all, producing very low standards of care – and in effect less personalised choice.

So future trends are likely to be determined by the emergent balance between these two very different pressures – on the one hand, for more personalisation in line with service user demands and, on the other hand, for providers offering a more standardised 'menu' to both public commissioners and to service users (as 'micro-commissioners'). The challenge will be to ensure that the 'menus' are comprehensive enough to meet personal choice.

Commissioning and personalisation

The increased use of private sector service providers raises some important questions about the future role of commissioners.

Commissioning must be much more strategic and regulatory – and not simply about making choices between providers.

As with benefit transfer payments, a strong case can be made that there should be no prescription on how monies are to be used. Many public sector commissioners do not see it like this and wish to retain control. This is both unacceptable and unsustainable.

Personalisation also raises fundamental questions about the relationship between the professional adviser and the service user. Users may need to be counselled to take and follow professional advice, and should have access to independent advocacy as necessary. Where a service is delivered by a private or third sector provider, the staff employed by the providers must not exercise undue influence over the choices of the service user both about who their provider should be and what the service should be.

Critically, however, personalisation implies that users are regarded as being able to exercise informed choice and, where necessary, have independent advocates who are not in the pay of the local authority or the provider.

Personalisation will fail if people continue to use the same services to existing standards simply because this is what they know. It will also fail if users purchase inappropriate and under-performing services.

Strategic commissioners have a key role to play in ensuring that the right range of choice and options are in place, but they cannot and must not act as advocates themselves – the potential conflict of interest is simply too great and risks undermining the development of a competitive supply market and real choice. They have a role to provide information and to undertake some regulatory activities but 'co-production' implies that the choices made by service users are respected (at least, up to the point where they may have adverse impacts on other citizens).

Regulation

Personalisation implies robust regulation that focuses as much on commercial regulation as it does on service standards across social care.

Recent disclosures at Winterbourne View (even though this was a health facility) and the business model adopted by Southern Cross are but two reasons for such an approach. Further, the onward (and inevitable) journey towards a greater role for private, third and social enterprise sectors in public service delivery, coupled with the dramatic growth in personalised budgets and self-funding, reinforce this need.

Services such as social care must be based on a public service ethos and deliver public value not just for their individual users but also for wider society. They should ensure equality of opportunity, fairness and equity. Regulation has to value and protect these attributes and it must ensure that commissioners and providers are fully accountable for delivering public value.

It naturally follows that while regulators must be both able and empowered to ensure professional and service standards, they must also have powers to undertake financial and commercial due diligence on providers and their owners. As in financial services, only 'approved' persons should be allowed to own or sit on boards as well as manage critical services such as care homes.

Regulators should be able to prevent the sale, change in ownership or radical changes to the business model of an organisation providing a public service without the agreement of the regulator, commissioner and service users or their representatives.

In addition, they must have powers to: require appropriate levels of capitalisation; remove directors; prevent companies and other providers from operating in certain markets; prevent anti-competitive behaviour; and, where necessary, set up industry-based, self-funded insurance schemes to protect the public sector from having to fund rescues and survival programmes.

Of course, regulation must not discourage new entrants – particularly SMEs and third sector organisations but, equally, such bodies cannot be exempted from scrutiny.

Regulation must be adequately resourced and applied with equal rigour to all providers including the public sector. It must also allow providers to make reasonable and proportional financial returns whilst having flexibility to manage the services and their organisations. And it must also avoid being bureaucratic and an impediment to new market entrants and smaller suppliers.

Regulation is not and should not be seen to be a substitute for effective commissioning, which is fundamentally important. Commissioners need to work closely with the regulators but be separate from them, and indeed commissioners themselves should be subject to regulation. Spot contracting and personalisation require effective smart regulation of a kind that may have been less necessary when services were contracted on a block basis by local authorities.

There is one further dimension to public service regulation that needs to be addressed and that is the democratic accountability that must pervade. This requires regulators to be ultimately accountable to politicians but independent of commissioner and provider

interests, and immune from political interference. This means that their position and integrity needs to be enshrined in legislation.

There must also be transparency and public accountability with full publication in accessible form of details for every provider such as:

- details of their ownership – who, their legal status, where registered and based, previous track record and wider business interests;
- their commercial model(s) – for example, the expected rate of return on investment, and the approach to ownership or leasing of premises (and if the latter, from whom, etc.);
- the employment terms and conditions for staff;
- the remuneration of senior executives and shareholder payments;
- key contractual terms;
- financial and operational performance;
- any critical issues relating to the provider's business interests elsewhere or in other markets and/or jurisdictions;
- their explicit contracts and/or implicit service charters with their service users.

Regulators should include service users and/or their representatives on their boards, and engage staff and their unions in their work. They should also work closely with commissioners and policy makers. Above all, however, regulators must have a duty to put service users and the public interest first and foremost, and to ensure that public services flourish – for the benefit of the public.

Conclusion

The social care environment is changing radically. There will be greater personalisation and a greater plurality of service provision. User and community co-production is likely to play an important part in these changes. It is essential that the interests of service users – their rights, their dignity and their safety – are always paramount. This requires well managed and well regulated not free markets

Co-production and personalisation: Two sides of the same coin or worlds apart?

Julia Slay, *new economic foundation (nef)*

Introduction

The call for care services to be 'personalised' has gathered strength over the last two decades and is now in the midst of a rapid implementation in social care across England (Leadbetter, 2009). It is also being explored through the Individual Budgets pilot programme in health (Department of Health), and the Right to Control trailblazers (Office for Disability Issues). A somewhat nebulous concept, it is most commonly interpreted in health and social care as the allocation of personal budgets to people so they can directly purchase the support they want. The hope is that, in doing do, services will be tailored to suit the needs of the individual rather than people fitting around the service.

Co-production, as I discuss later, is a term increasingly connected to the ideas and theory of personalisation, but much less commonly to the practice of front line services.

The backdrop to the rapid implementation of personalisation over the coming years is a political context which has two competing narratives at its heart: consumerism and citizenship. We have been offered a vision of the 'Big Society' which centres on social action, local determination and 'people power' (The Guardian, 2010). Yet, the language within many of the recent White Papers is one of consumption and customers. There is a strong focus on how citizens are 'consumers' of 'individual public services' and on encouraging consumer champion organisations such as Which? to play a role in increasing the accountability and transparency of public services (HM Government, 2011).

The political context is also defined by a ***new austerity*** of the state (nef 2010). Some evaluations of personalisation *have* shown improved outcomes for people, but the tightening finances of the public sector threatens the capacity of local authorities to implement personalisation and achieve its best ambitions. As the public sector cuts begin to bite, this short piece asks what challenges personalisation is facing as the detail of the vision is worked out in practice, and what co-production might offer those people who are intended to benefit from personalisation.

What is personalisation?

The concept of personalisation has been driven forward with particular vigour in social care, although it is also being trialled in health, special educational needs and substance misuse. The central idea is that services will be provided in ways that empower individuals, put people at the heart of services, and enable them to take more control over their care and support. Putting the ideas into practice is a little more difficult though, particularly with the ambitious speed and scale at which personalisation is projected to expand. By 2013 personal budgets are supposed to extend to all eligible social care recipients, preferably as direct payments (Think Local Act Personal, 2011).

The term 'personalisation' can be moulded to mean so many things that it has become difficult to pin it down and work out the detail. Increasingly, it has become a word applied when personal budgets (or individual budgets) are allocated to people as a purchasing mechanism for support. Yet this narrow interpretation ignores the much broader early vision of personalisation, mapped out by Putting People First (PPF) in four key areas: Universal Services, Early Intervention and Prevention, Social Capital, and Choice and Control (Department of Health, 2007). The idea of personal budgets was located in the last of these domains, 'Choice and Control'. The PPF interpretation of personalisation placed great importance on using existing community resources, developing peer support, and preventing needs from arising.

Personalisation has faced significant challenges during implementation, and translating policy into practice has proved difficult. Recent evaluations have shown that not all groups are benefitting from the use of personal budgets; the assessment process can often be complex and overly bureaucratic; there is a lack of information and advice services; and in some areas there is a real lack of diversity among local providers (nef, 2011). One of the biggest challenges has been to understand what the implications of personalisation are for social care staff, and how this changes the relationship between people receiving support and professionals.

What is co-production?

Co-production is a simple concept which describes an approach, or method, for delivering public services. There are many definitions of co-production, and broadly speaking they describe how everyday citizens can be involved in 'producing' outcomes with public sector staff and agencies. nef has developed the following definition of co-production:

> *"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (Boyle et al., 2010).*

To expand our understanding of the concept we have identified six features that are common across the case studies and practical examples we have studied:

- Recognising people as assets: Transforming the perception of people from passive recipients of services into one where they are equal partners in designing and delivering services;
- Building on people's existing capabilities: Providing opportunities to recognise and grow people's capabilities and actively support them to put these to use within their communities;
- Mutuality and reciprocity: Offering people a range of incentives to engage which enable people to work in reciprocal relationships with professionals and with each other;
- Peer support networks: Engaging peer and personal networks alongside professionals as the best way of transferring knowledge and supporting change;

- Breaking down barriers: Dissolving the distinctions between professionals and recipients, and between producers and consumers of services;
- Facilitating rather than delivering: Enabling public service agencies to become catalysts and facilitators of change rather than central providers of services themselves.

These features are all in place to some extent across co-produced services, and the approach can be applied across a range of sectors. One example of what co-production 'looks' like in practice comes from the Holy Cross Centre Trust (HCCT) in Camden. HCCT has extended an existing ***time bank*** at the Centre to incorporate the provision of a 'flexicare' service, which supports people to remain independent in their own homes by providing low level care and support. This care is provided by time bank members who are working towards social care qualifications: they are able to apply their skills and earn credits for their work.

Many of the people supported through the flexicare service receive personal budgets from which they can choose what support and care to purchase. These can provide a source of funds to cover vital core costs, such as staff wages, while members have access to further support through the use of time credits earned by helping one another through the time bank. So, for example, while £30 a week from someone's personal budget might usually buy only three hours' worth of formal support, additional capacity can be provided through time credits. Support workers build links for the individual, enabling them to contribute in a range of ways, and so earn more credits to build up their support package. Using this funding model, HCCT are able to build the capacity of the flexicare service. People who don't qualify for a means-tested personal budget can still gain access to support by earning and redeeming time credits.

What does co-production mean for personalisation?

As personalisation is implemented across England, a range of challenges has arisen in translating the policy into practice. A focus on allocating personal budgets to people has led to an individualised approach to personalisation that masks the opportunity to develop a more collective and collaborative system of social care which has mutual aid and reciprocity at its heart. In practice, this 'co-production' approach could involve working out which assets people and the state have, or developing more collective structures to support decision making and purchasing, such as co-operative bodies that include individuals and support staff. In fact, a recent report commissioned by Scope showed that those local authorities coping best with the cuts are those who have developed and encouraged co-production (Grant).

We suggest there are three key 'gaps' within personalisation, which may be leading to a market based, individualised interpretation of the idea that leaves people atomised and isolated from their communities with diminishing resources to fund their support. We put forward three key ways in which co-production might fill this gap; in changing the focus of personalisation from budgets to people, complementing increasingly limited financial

resources with the assets abundant in the core economy, and changing the relationship between people and professionals into one of equality and reciprocity.

Changing the focus from budgets to people

> *Personalisation has, for many, come to represent personal budgets. These budgets are the expression of an entitlement to a cash sum, and are essentially financial transactions (Needham 2011).*

Though the theory of personalisation advocates a shift in power to the consumer (or citizen) through the allocation of the budget, in reality care managers and commissioners still hold 'veto' power over people's support plans, and can block specific ideas of what to purchase. In this way, power is not fully transferred, and the tensions between people and staff, and debates over 'who knows best' can become exacerbated. Budgets on their own are not enough to create the culture shift needed to support the best ideals of personalisation. By comparison, co-production is about the methods and approaches that define the relationships between professionals and people as equal, reciprocal and collaborative. Giving someone a budget risks bypassing the critical relationship that person still has with those staff or carers who support them. Co-production helps re-focus on what skills and expertise both people and professionals can contribute, changing the way people are supported, rather than changing the way in which services are purchased and consumed.

Complementing financial resources with other assets

The policy rhetoric on personalisation has articulated a clear desire to shift power, decision making and service provision away from the state and towards the individual. There has been little focus in personalisation on how the resources of both citizens and the state can be *combined* to develop more effective support. The assets of both people and professionals are vital resources, particularly in the current context of reduced funding for social care and public services. These assets include the time, knowledge, experience and skills of professionals, people 'using' services, their carers and the wider community. Using these assets well can help to prevent more acute needs arising by providing a stronger network of support within and among communities. Professional support is expensive and staff are often highly constrained by demands on their time. Bringing in peer support and community based support is a highly effective means of supporting people outside the realm of services. But there remains an important question: under a new regime of individual budgets, will this type of peer and social support – abundant in the core economy – become commodified and sold on the market as a service? If so, will we destroy the potential to use these latent assets to complement and support 'paid for' services?

From passive consumerism to active citizenship

Giving people a personal budget does not necessarily change their relationship with the people who support them, nor does it enable people to become active citizens who are able to contribute to and engage with their communities. It merely shifts them from being a recipient of public services, into a consumer. Both are often very passive roles that do not build on people's strengths, or seek to involve them as active participants alongside professionals. Co-production brings back into focus the importance of the relationship between a person and a professional, and how this can be one that is shaped by equality and reciprocity, where both professional and experiential wisdom and expertise are recognised, valued and used to strengthen services.

In conclusion

The direction of travel for personalisation seems set towards consumption, not participation. This highlights a challenge at the heart of the transformation agenda: how can people become active participants in services rather than passive consumers? Our experience has taught us that co-production is a way to square the circle, and to encourage a culture of reciprocity and equality between people and professionals. Co-production offers a route away from a passive consumerist model of personalisation and towards one of active citizenship, equality, and mutual support. It offers a positive vision of how, in a time of increasingly constrained financial resources, we can still improve people's lives and wellbeing. We can do this by transforming the relationship between professionals and people and effectively using the assets that are abundant within the core economy.

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New ways of collaborating with users and communities in social care

Whose Shoes? The benefits of getting all those involved in personalisation to understand each other's perspectives

Gill Phillips, *Nutshell Communications*

The personalisation agenda necessitates thinking about public services in a totally different way. It provides an opportunity to make social care services more responsive and flexible to an individual service user's needs and desires rather than being restricted to the mass production of rigid services. This fundamental change in care provision requires a transformation of the values, norms, attitudes, and behaviours of providers and public authorities to support personalisation. Significantly, personalisation has different implications for providers, commissioners, front-line staff, managers and experts by experience – the people who use services and their carers.

Where divergent viewpoints or lack of understanding exists, it is a recipe for alienation, conflict, inefficiency and limited progress towards the key goal of personalisation: tailoring services to reflect the outcomes chosen by individuals. This chapter will highlight several examples of how the *Whose Shoes?* interactive learning and engagement tool is being utilised by local authorities to facilitate culture change by enabling the key players in the service journey to understand each other's differing perspectives and work together to co-produce sustainable solutions.

So what is *Whose Shoes?*

I developed *Whose Shoes?* after more than 30 years experience in the world of social care. It is an interactive board game, helping people to understand sensitive issues from

Figure 4

other people's perspectives to help different groups to work more effectively towards personalising services.

The perspectives of these four social care stakeholders are explored in the game (see figure 4):

- Service users and carers
- Providers and commissioners
- Staff
- Managers

In the game four players or teams work collaboratively to build "the path to personalisation" to achieve the following outcomes for users (directly reflecting the seven outcomes of the "Our Health, Our Care, Our Say" White Paper:

- Exercise Choice and Control
- Improved Health and Emotional Wellbeing
- Personal Dignity and Respect
- Improved Quality of Life
- Freedom from Discrimination and Harassment
- Economic Wellbeing
- Making a Positive Contribution

Each outcome is met when players have laid four different coloured tiles (representing contributions from each perspective) which collectively complete one block on the pathway. Players move along the board after rolling a dice to land on colour coded footprints or the special *Poet's Corner* feature. When they land on a footprint, they pick up a card of that colour with a statement expressing a point of view associated with that specific role. Reading this card aloud will trigger relevant discussions and the player will follow instructions to place or remove a tile of a specific colour on the board. This means that each turn will build or impede the pathway to the realisation of the seven outcomes that represent personalised services.

Overall, the board game is made up of over 160 scenarios, including *Poets Corner* poems, to start discussion amongst participants. Each scenario encourages players to discuss the challenges, opportunities, frustrations and fears associated with the personalisation agenda. Some of the issues that are touched upon by these scenarios include:

- achieving the right balance between choice and risk
- new types of working and changing roles
- the feasibility of greater personal control for people who lack mental capacity
- handing over power
- collaboration
- the importance of adequate information and advice and the role of advocacy.

How does this tool help?

By stepping into each other's shoes, participants are able to develop a greater understanding of the drivers and constraints affecting other people, helping them to empathise with their aspirations and concerns or to understand why delivering truly personalised services, particularly in difficult economic times, can be challenging. It allows public providers to develop a more in-depth knowledge of what services users want in their daily lives and how they wish to live and confront problems that may arise.

Whose Shoes? is also a useful tool in allowing all involved to realise that no one group sees the full picture and can work alone. This increases awareness of the need to improve communication and for collaboration amongst professionals and service users.

Uniquely, by providing a non-threatening informal and open atmosphere, the game allows individuals to broach complex and difficult issues, harnessing creativity to help people find ways to overcome barriers. It means that ingrained practices and assumptions can be challenged without creating resentment. This provides equal voice to all involved, facilitating the spread of innovative practice, the exploration of ideas and agendas for making progress.

The tool is flexible and can be tailored by its facilitators to concentrate on a particular issue, or for different settings or purposes (such as staff training, or community engagement).

Whose Shoes? has received national acclaim including an endorsement from the Department of Health praising the approach as an innovative and effective communications tool. It is used by *Skills for Care* for induction of their own staff.

Examples of how it is being put to use and the outcomes it is fostering.

Leicestershire County Council's Adult Social Care department has utilised the *Whose Shoes?* tool, initially for team meetings and training days. The tool was used as part of a learning and development programme to engage their staff from across the social care field (home care, social workers, community support workers and so on) to have a greater understanding of what putting citizens at the centre of services entails and how to transform their systems towards its achievement. This took place through an innovative one-day training workshop entitled 'Put Yourself in My Shoes' that Sarah Wigley from the Council worked with me to develop and then delivered in-house. The workshop sought to:

- raise awareness of person-centred approaches to social care;
- understand personalisation from the perspective of the four groups;
- reflect upon current ways of working with individuals and options for moving forward;
- enable people to develop skills to work in an outcome-focused way.

The day began with an ice breaker exercise to demonstrate no choice, limited choice and purchasing power choice. This enabled people to explore their feelings and expectations around choice and control and to carry this forward into their work with clients.

During the game, video clips from the Department of Health, Ripfa and InControl were shown to the teams to bring to life the perspectives of the four different groups. As the game was played, questions raised during the in-depth discussions were captured on post-it notes. These were revisited during a question and answer session with a senior lead staff member that concluded the day's training. This final session ensured that all queries and potential issues were discussed and pathways for them to be dealt with established.

Sarah Wigley indicated that participants felt that the day's training helped them to understand major issues that affect services from different perspectives – particularly from the service user's point of view. The game's inclusive approach enabled all of the participants to have an equal say. The department considered it to be a very useful tool in setting the scene for the agenda, stimulating debate, enabling them to identify and address concerns and helping with action planning.

Social care staff felt that the training had helped them to realise that aspects of how they currently work with service users could block the personalisation process. Importantly staff members felt the collaborative forward thinking approach allowed them to question their own systems and work towards improving their efficiency. An example of this came from a card stating 'As social workers, we are able to share problems and extend examples of good practice'. This caused the participants to question whether they had adequate peer support networks for social workers. To ensure that they do, regular meetings are now held to ensure the agenda is properly implemented.

Staff felt the training helped them to visualise the benefits to be gained from citizen-centred services – critical in ensuring their buy-in to make the necessary transformation. The overwhelmingly positive feedback indicated that people now understood that it is everyone's responsibility to work towards ensuring that service users' perspectives and inputs are constantly incorporated in their work.

Following the training day, which was repeated with different groups, over 100 social care staff have been trained in the game and it has since been used successfully by the council in facilitated sessions with service user and carer groups and at care provider forums as part of a wider engagement programme.

The University of Wolverhampton has also used *Whose Shoes?* as a tool to support a major workforce transformation project across four Local Authorities (Walsall, Dudley, Sandwell and Wolverhampton) and corresponding Primary Care Trusts. This project set out to develop new ways of working, facilitating partnership approaches across four health economies in order to encourage culture change through partnership working and personalised, seamless service provision. The University has provided research and evaluation expertise and acted as the learning hub for shared learning. This has included developing a care pathway for frail elderly individuals and people with dementia.

Ann Saxon (Head of Continuing Education and Workforce Development at the University of Wolverhampton) saw the potential of *Whose Shoes?* and commissioned me to run a series of workshops for practitioners. The preparatory first workshop, held in December 2010, involved a relatively small group of health and social care practitioners, mainly from Walsall Council and Dudley PCT. They tested the approach to collaborative working and gathered feedback. The next workshop was hosted by Walsall Council and

introduced by Paul Davies, Executive Director, Social Care and Inclusion, this time involving over 60 staff and service users from across the whole region. *Whose Shoes?* was successful in getting people around the table, building relationships and exploring issues affecting their respective services – for many, a unique opportunity. With a huge buzz in the room as everybody pitched in to have their say, there was lots of laughter and some serious moments. For example, some workers from very different "perspectives" on mental health (commissioners and hospital workers) found themselves on the same table and thrashed out some important points around new practices.

A further *Whose Shoes?* session, specifically for service users, took place in December 2011. This workshop was further enhanced by the graphic facilitation services of New Possibilities to create a wonderful graphic record of all the points raised by participants. The graphic representation serves as a tool to identify and record gaps in provision, feeding back improvements to public providers and helping to ensure that suggestions are listened to and actions are followed through.

Whose Shoes? has also been used for social work education and inter-professional working. I have worked alongside Ali Gardner, Senior Lecturer at Manchester Metropolitan University, who uses the game regularly with her students. This ensures that the next generation of social work professionals understands the importance of walking in the shoes of services users, and ensures that services reflect their priorities and enable them to utilise their capabilities.

And for the future?

As well as building on the success of *Whose Shoes?* to date, particularly by adapting it to be used in an even wider range of health and social care contexts, development work is taking place to co-produce new content and make this available in a computerised version. For example, a series of focus groups has been held with older people living in different settings, with and without formal support, to explore issues around nutrition, mobility and staying connected in the community. The electronic version will bring this resource to new audiences, including shift workers and small organisations and will make the game even more fun to play.

On a different tack, I am working with *Governance International* to strengthen the use of *Whose Shoes?* as part of a Capabilities Assessment tool in working with service users and carers – and, indeed, with other stakeholders in social care and health services.

References

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Co-designing a new website for adult social care: *My Care, My Choice* in Stockport

Jude Wells and Sue Griffiths, *Stockport Metropolitan Council*

In 2007, Stockport Council's Adult Social Care Department undertook research that indicated that information provided on their current website did not help to support informed decision making. In England, all local authorities are required to provide information to the general public on the range of options available, and also to ensure that people who fund their own care have access to good quality advice as part of the personalisation agenda. However, 43% of enquiries to the department's Contact Centre were not associated with Adult Social Care and it was clear that the remaining 57% could be reduced by improving the quality and ease of finding information on the web. Critically, 90% of all requests were made through the Contact Centre. Too many enquiries were about information on costs and charges that should have been available online. Also, 14% of all calls were abandoned due to poor quality – causing unnecessary stress to both service users and staff. This was wasting the Council's and taxpayers' resources and preventing service recipients from achieving their desired outcomes.

To improve the process, research was undertaken with service users, carers, partners and staff to co-design a new website to guide people through the 'social care maze', with a full commitment to providing adequate information. This chapter shows the enormous potential for major savings and improved outcomes of service through co-design in Adult Social Care.

Figure 5: Service users, carers and partners

How the project worked

The department's objective was to create a website that provided:

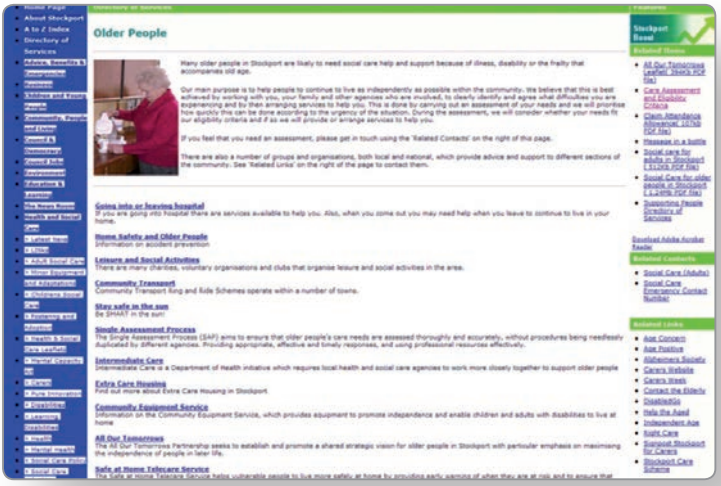
- A clear and easy-to-use pathway for all to understand what social care services are available locally.
- A platform for Stockport Council to deliver personalisation – so that service users can make informed choices about their care.

Stockport Council partnered with CSED (Care Services Efficiency Delivery) and Quickheart, a specialist website design company, to rebuild their website, working together with service users and other stakeholders. This involved using ethnographic methodology to understand how people wanted to see information, what language was important to them, their perception of social care as a 'place of last resort' and the importance of clear and easy navigation tools on the site.

The first step was the ethnographer independently recruiting a range of customers from across Stockport; the important element was that they were not people nominated by social care. The methodology used means that instead of the traditional workshop method, the ethnographer worked with people in an intensive way. This meant speaking to a small number of users (30) to understand their views of social care and how they want to receive information and particularly, what was important to them in relation to social care support.

The ethnographer carried out research with customers in their own environment in order to establish what they thought of the way online information was provided. The research showed that:

Figure 6: The old and the re-designed website



- Adult Social Care needed to improve information and advice to the public about services – the existing content was confusing, hard to navigate and deemed not fit for purpose.
- Due to demographic pressures and the need to support increasing numbers of people, Adult Social Care needed to provide better information to support service users and their families to enable better informed decision making.
- Adult Social Care had to reach people before they got into crisis and to promote prevention options and choices in line with the requirements of the UK's Putting People First programme – in particular, to promote universal services and to support self-funders.
- Adult Social Care needed to develop an online financial calculator that gave people an idea how much their care charges would be if they received services.
- An information hub was needed that could be used by staff, and partner agencies such as GPs and nursing staff, as a point of referral to our services.

Alongside this research, a mystery shopping exercise was undertaken with a group of customers on the existing webpages and the learning from this was used in the new site design. This involved asking people to search for particular information whilst being timed; some spent up to 40 minutes struggling to find the information they wanted, and even then they often ended up with just the PDF of a standard leaflet or advice that they

should ring the Contact Centre. This process convinced the department they were doing the right thing in involving stakeholders and that this would radically improve the website.

The local voluntary sector partners were involved to ensure that the design of the new website addressed the needs of a diverse customer base. Each of the major voluntary sector organisations recruited a number of testers to work with the Council in developing the website and their feedback on the layout, pictures and language used was incorporated. An editorial board of staff from all service areas was set up to ensure the 'buy in' of operational teams. A copy writer advised on the language used on the site to ensure it was accessible and did not present jargon and 'expert speak'.

The site was built over a period of three months using bright, colourful and positive images. A set of standard templates helped to reflect the customer journey in a consistent manner ensuring that all the 'information pages' followed the same style, with the common headings:

- 'What is the service?'
- 'Who can get the service?'
- 'How much does it cost?'
- 'Can I get help with the cost?'
- 'How to get in touch'

What has this achieved?

The site has been live now for over two years now and has been received very positively by customers, staff and partner agencies. During that period, the website has received over 100,000 hits. People are now accessing the correct information much more quickly than before and there have been interesting stories of relatives overseas using the website to register concern for a family member living in Stockport.

Observations after the first year alone showed that contacts, enquires and observations at the Contact Centre had gone down by 29%, freeing up resources. The number of 'abandoned' and 'closed' contacts had also reduced by 38% so fewer people were 'dropping out' midway through the assessment process due to issues such as not being informed that there was a charge for services.

The number of enquiries and observations received by the Contact Centre that resulted in a referral to the 'back office' (i.e. Social Work teams) has been reduced by 36% and providers listed on the site tell us they are now receiving direct contacts from service users.

Feedback has been very positive, and observations are used to further develop and refine areas of the site. Occasionally, this has involved changing text and images on the site after people felt they were inappropriate or liable to misrepresent a service

The site is also being presented as a best practice example to other local councils in the UK, for example the London Borough of Kensington and Chelsea. Some of these have developed a similar site themselves using the templates and design processes and concepts developed, which are available as open source software.

Return on investment

Figures from the first year review estimate that the introduction of the new website has saved the department about £300,000 per annum. (See the post-evaluation Business Case in Appendix 5 of the ASC Information & Advice Strategy) at *www.stockport.gov.uk/services/socialcarehealth/adultsocialcare/transformingsocialcare/*

The cost of building the site was about £75,000 which included an online financial calculator, online care home search functionality, undertaking the research with customers, and staff time. The site was built and is now maintained by the Information & Publicity Team; no additional staffing resources were required except for the secondment of an Information & Advice Worker from the Contact Centre for six months to support the build process of a site that now has over 400 information pages.

Lessons learnt and new developments

Co-production with customers is really key to delivering success and ensuring the creation of a website that fits their needs. Staff and partners use the website as much as customers and it is seen as a valuable information resource. Not only does this boost efficiency in delivering the service, it has helped staff to take pride and feel ownership of the service. Moreover, it means that Stockport Council benefits from their ideas for continuous improvement. Staff and partners also provide a great vehicle for promoting the site – never underestimate the power of 'word of mouth'.

As part of reaching people who are not traditional users of services, the website provides another 'front door' through which they can access our services.

Following the success of the website, Stockport are working to develop an online resource allocation system (RAS); a method used to decide the amount of money available to a person who has social care and support needs. Sometimes a difficult process, the system under development is based on realistic costings for services and support, using the detailed knowledge of trained Social Workers as a benchmark. Co-produced with input from existing customers using similar ethnographic methodology, it aims to be an open, equal system that is sustainable to support the differing needs of Stockport's citizens, including self-funders.

Due to go live' in 2012, the RAS has been piloted on mobile devices (such as the iPad, Motorola etc) and to date 100 cases have been tested, using ten Social Workers working out in the community in people's homes. The feedback gained during this pilot has been incorporated into the continuing development work, resulting in improved accuracy and usability. The use of mobile devices has also resulted in a heightened sense of interactivity, emphasising an outcomes focus, maintaining a positive outlook on service provision and importantly making the individual feel engaged and involved. Also, at a sensory and visual level this method has been useful in engaging individuals with dementia. Work to stimulate local micro businesses and to stimulate and develop an online marketplace where providers are able to offer their services directly to customers is also ongoing with the aim of creating a vibrant and diverse range of support.

This work is aiming to create a citizen portal where an individual can complete a supported assessment, develop their support plan based on their outcomes, and look for support and services in an online market place. This is part of an overall process of moving service users from being recipients of care to exercising choice of control over their daily living.

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Mosaic Clubhouse – Co-production in mental health

Hilary Belcher, formerly *Mosaic Clubhouse*

Introduction

There are many charities providing day care for people with mental health problems. What makes Mosaic Clubhouse in the London Borough of Lambeth different and innovative is its strong focus on co-producing with its members everything that it does for its members. The result is a strong sense of participation amongst people who have often been amongst the most excluded and isolated in the past.

In *Mosaic Clubhouse*, people do not 'hang about', as everybody has a job to do. Indeed, many people visiting *Mosaic Clubhouse* cannot tell who is a staff member and who is a service user.

The objective of *Mosaic Clubhouse* is to help people who have experienced mental ill health to stay out of hospital and to engage them in a valid social role.

This includes:

- encouraging *Clubhouse* members to provide mutual support for each other in their journeys towards recovery;
- assisting members to regain self-confidence, self-belief, and self-esteem by identifying their current strengths, as well as developing new skills;
- enabling members to move on in their lives and to achieve their own personal goals.

In particular, the *Mosaic Clubhouse* provides opportunities to return to both paid and voluntary employment through a successful employment programme. The *Clubhouse* also encourages its members to access basic, further and higher education.

How does it work?

Mosaic Clubhouse was founded in 1994 as part of an international network of over 400 independent Clubhouses in 28 countries. The work of *Mosaic Clubhouse* is based on a non-clinical approach, so there is no group therapy. Instead, the *Clubhouse* provides its members with a structured eight hour *work-ordered day*, paralleling typical business hours. Staff and members work side-by-side to carry out the work of the *Clubhouse*, from administration to cooking meals in the kitchen.

As a first step, the support workers of the *Clubhouse* engage members to participate in the *work-ordered day*. This enables members and support workers to share in the responsibility of running the *Clubhouse*. It also helps build meaningful relationships, based on respect, trust and mutual support. These relationships help members to overcome individual challenges and to develop ways to manage their lives. It is through the *Work Day* that support workers are able to help members identify their individual talents and skills providing a broad range of opportunities for growth and development.

Members' individual goals are captured through *goal planning*, which helps them to identify their individual goals, on a one to one basis, with their chosen Support Worker. The goals are broken down into easily manageable steps and reviewed regularly.

After participating in the *work-ordered day*, members have the opportunity to join *Mosaic*'s *Transitional Employment Programme*, where they get the chance to work in meaningful part-time paid jobs developed by the *Clubhouse* with businesses. Members who are given a placement are not expected to go through a competitive application or interview. They are trained by another member, who has done the job previously, or by a staff member and given as much time as needed before they start working independently.

Outside of the *work-ordered day* environment, the *Clubhouse* has an *active social programme*, so its members can feel they belong to a vibrant community. Social events include walks and picnics in local parks, and seasonal events such as an Easter Chocolate Festival. The *Clubhouse* also has a football team.

The work takes place within a clear framework of rights and responsibilities which apply to members, staff and board members of the *Clubhouse*.

Performance indicators and outcomes

In the year 2010/11, the *Mosaic Clubhouse* had 314 members attending. Of these, 110 were involved in the design, delivery, management, review and development of services provided at the *Clubhouse*.

The *Clubhouse* helped:

- 168 members increase their social and community activity;
- 42 members into education and training;
- 16 members obtain new paid employment;
- 8 members gained a new voluntary placement;
- 45 members achieve their personal (non vocational) goals.

Working alongside staff as equals provides members with dignity and the feeling of being a valued member of the community. This sense of belonging is powerful in promoting positive mental wellbeing and integration into the job market as the cases of Sandra and Asad demonstrate.

The case of Sandra

Sandra joined *Mosaic Clubhouse* after a 20 year period of being unemployed. Initially, Sandra was engaged in the *work-ordered day* in a catering capacity.

As her confidence increased, Sandra identified education or administrative work as potential goals. At this stage, she moved to the Education and Employment Unit to learn basic computer skills. This was supplemented by her attendance at the Computer Class at *Mosaic Clubhouse*, provided by Lambeth College on an outreach basis.

Soon, Sandra was sufficiently motivated to attend an intermediate Computing Course at one of the main sites of Lambeth College, which worked with the *Mosaic Clubhouse*

to encourage Sandra and raise her expectations. The following year, Sandra began studying for 'A' Level English Literature. Developing the intellectual rigour required for Level 3 study was a great achievement for Sandra and *Mosaic Clubhouse* supported her by providing one-to-one help with study skills and essay structuring.

Shortly after beginning her 'A' Level studies, Sandra also took the major step of joining a group transitional employment placement at iwantoneofthose.com and this was her re-entry into paid employment. The following year, Sandra began a more advanced employment placement with SELSSP, our local primary care trust. This involved computer work and was an opportunity for Sandra to build upon the skills she had developed at the *Mosaic Clubhouse* and to engage in the complex business of balancing work, study and family life.

Sandra's employer was so pleased with her performance at work that she was subsequently taken on for a further employment placement and was recently offered permanent employment there. Sandra's new role involves assisting her employer by helping to train new workers from *Mosaic* on their transitional employment programme. This means that Sandra has now come off benefits and has the dignity and self-respect of earning her living independently, while also helping others along the same path.

Sandra continues to contribute to the work of *Mosaic Clubhouse* by encouraging other members to take advantage of educational and employment opportunities and by participating in *Clubhouse* training programmes, both in the UK and abroad.

The case of Asad

After becoming a member of *Mosaic Clubhouse*, Asad identified education as a route to the achievement of his goals. He joined the weekly Life Skills Class held at *Mosaic Clubhouse*, conducted by a tutor from Lambeth College. This led directly to progression to a "Bridging Course" at one of Lambeth College's main sites.

Asad was supported by regular goal-planning meetings with his *Clubhouse* Support Worker, enabling him to identify further routes for progression and possible barriers to the achievement of his goals. He also began working voluntarily for Oxfam, which was important for his social inclusion needs.

Asad began studying for an NVQ Level 1 course in Engineering Operations and he has, in each subsequent year, been motivated to study and achieve Level 2 and Level 3 qualifications in Electrical Installations at Lambeth College.

Throughout this time, Asad's immigration status had been a subject of conflict between the Home Office and Borders Agency and his legal representatives. Until this situation was resolved, Asad was unable to access paid employment. Therefore, *Mosaic Clubhouse* assisted him by helping him access voluntary positions with Mr. Electric and with Battersea Arts Centre. These positions supported Asad's career aspirations as an electrician, kept him busy and engaged with his community, and moreover generated letters of support regarding his honesty, integrity and hard-working nature. This ultimately helped the Home Office resolve Asad's immigration problems in his favour.

Asad's educational journey with the *Mosaic Clubhouse* has helped him to become a highly valued member of his local community. He has been able to:

- advise his housing association on electrical testing and installations;
- participate effectively in the *work-ordered day* at *Mosaic*;
- access a wide circle of friends and colleagues through his college and voluntary work commitments.

This has kept him motivated and healthy despite his immigration concerns.

Asad currently works as a professional electrician while continuing to contribute his time and skills to the *Mosaic Clubhouse* community. He is now seeking a higher position and permanent contract as an electrician.

Costs and savings

The majority of *Mosaic*'s funding comes from Lambeth Council and Lambeth NHS. The public resources are more than matched by the work being performed by *Clubhouse* members. This means that in addition to the 444 hours per week of support workers' time, *Clubhouse* Members provide 849 hours per week. Clearly, without the inputs of the *Clubhouse* Members almost double the paid support workers would be needed to help run the centre.

Furthermore, the *Clubhouse* arranges for members to obtain transitional employment placements, which generally last between six and nine months, after which, another member fills the position. Given that the previous *Clubhouse* member trains the incoming member, there are no training costs for employers. In addition, the *Clubhouse* guarantees absence coverage to all their transitional employers. This approach is unique to the *Clubhouse* and provides the most supportive and risk free opportunity for both its members and their employers. Furthermore, the ability of the *Clubhouse* to find employment for its members makes it particularly attractive both to members and funders.

Learning points

The *Mosaic Clubhouse* highlights the benefits of identifying the assets of service users and building people's assets into the service process. This not only helps to provide services in a more cost-effective way but meets a large part of the needs of *Clubhouse*'s own members. So instead of providing expensive therapy for people with mental health challenges, *Mosaic* embeds rehabilitation into the actual experience of members, as they support one another to achieve recovery outcomes together. Support and encouragement from people who have experienced mental ill health is often more valid and powerful than support from "professionals". Within the *Clubhouse* model, the central task of "staff" is to engage members in real and meaningful work and to facilitate the peer support between members that is the "glue" of the *Clubhouse* community.

A second important learning point is that becoming a valued member of a community fosters self-worth and recovery from mental ill-health. While most people would agree to this, it still common practice for GPs to prescribe pharmaceuticals or transfer people with mental issues to other professionals. The *Clubhouse* model shows GPs a new way of

commissioning services with benefits to the target group concerned and with cost savings for the NHS and the benefits system.

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LIFE Programme in Swindon: Transforming outcomes for families with complex needs

Cllr Rod Bluh, *Swindon Borough Council*

Introduction

The LIFE Programme in Swindon has run for three years, and is a joint venture between Swindon public sector partners, including the Borough Council, and *Participle*, a social enterprise specialising a new generation of public services and partners in Swindon.

Objectives

The programme aims to transform the lives of families with complex needs so that life chances of family members increase. These are families that exhibit multiple, complex risk factors and require intensive use of public services and resources.

As part of joint working among public sector agencies in Swindon, the need for a new approach to families with chronic needs was recognised by Swindon partners, including Swindon Borough Council, NHS Swindon/Primary Care Trust, police and probation services. Families with the most complex needs had been identified as over-represented in Swindon, particularly families where there were children in need and young offenders.

Swindon partners joined with *Participle*, believing that the public sector's role should be one of increasing the capacity of families and communities to help themselves, thereby reducing the dependency on public services. The aim was co-creation of a new way of working based on the values of compassion, creating independence and empowerment. This would mean using the expertise of families directly affected by multiple difficulties in designing a new way of working, led by them.

How was it achieved and who was involved?

To develop its new approach and fully understand the reality of the lives of the families that they were trying to support, a small team from *Participle* rented a council house in Swindon for six months and lived alongside them. These are families in chronic crisis, demonstrating up to ten or more risk indicators, including: children on child protection plans; children in need (supported by a social worker); poor achievement at school; exclusions; poor attendance; young offenders; looked after children; domestic violence; parental mental health; special educational needs/disability; anti social behaviour and substance misuse.

12 families were initially selected by Swindon partners (out of 400 identified families), mainly through children's social work services, Housing and the Anti-Social Behaviour team. *Participle*, a project manager from children's services, members of the families and 150 staff worked together over a period of six months to understand the realities of families and develop a new approach.

The initial learning presented to Swindon partners was that families in their relationship with current services felt:

- oppressed;
- as if they were treated as the "child" in the relationship;
- isolated;
- exhausted with fighting the system;
- that there is no safe space to ask for help;
- that there was a lack of trust, honesty, and transparency;
- hopeless, believing that change is not possible.

These perceptions and feelings were mirrored by professionals who also said that they felt:

- they were only working to the agencies' agendas and not the families' agendas;
- they were forced by the system to act like a parent holding power and control;
- actions they took were based on enforcement;
- they were forced by the system to adopt a particular professional stance and felt that their professional language often alienated families;
- service design was not relevant to people's lives;
- they were in the role of rescuing families and not empowering;
- there was a lack of trust, honesty, transparency;
- hopeless, believing that change was not possible.

Following this analysis, *Participle*, families and staff embarked on designing a new way of working with families.

The new approach

The LIFE approach invites specific families in crisis to join. It focuses on developing their capabilities in order that they can find new opportunities and possibilities. It is not about being directive, but about enabling and empowering families to open up about issues and about what they want to happen in their lives. It tries to get to the root of the problems holding them back. It is about creating a space where they can talk about what they aspire to and giving them the right support to build their capabilities and connections and to know how to access the kind of resources they need to realise their aspirations.

Twelve families were involved in the programme development stage, four in building the prototype, and hundreds of staff in designing the programme. The design focused on:

- building something radically different that would produce outcomes wanted by families, their neighbours and the wider community;
- providing greater chances for long term sustainable outcomes in health, education, future prospects and stability for families;
- finding a way of using government resources as an investment in people's lives, rather than as a risk management system.

The LIFE team consists of a manager, assistant manager, six LIFE team members, an administrator and analyst. LIFE promotes team working with the family, the development of a family-led plan, and space for workers and family members to establish relationships and build capabilities within the family to support themselves and achieve lasting change.

Outcomes, performance indicators, costs and savings

The pilot in Swindon has demonstrated impact for families and significant cost savings for the local authority. As of July 2011 the data, based on 55 family members, shows:

- 73% improvement in mental health conditions for those reporting this as a risk factor;
- 86% of children where school attendance was an issue reported improvements;
- 70% of children re-engaged with education where this was an issue;
- 69% adults are seeking/in employment or training;
- 86% of families have a rent payment plan in place where this had been an issue;
- 92% of family members building positive relationship between themselves;
- 90% improvement in mental health conditions for those reporting this as a risk factor;
- 80% reduction in police call outs;
- 10 children not taken into care;
- 13 children no longer have a child protection plan;
- 6 eviction orders were stopped;
- 2 individuals are seeking help for drug and alcohol abuse.

Moreover, four families (14 individual family members) have now exited the programme.

In 2010, £760,000 was notionally saved across the public sector in the first year of running the pilot, of which £485,000 represented expected costs which were prevented. Many of these 'notional' costs relating to the LIFE families are not currently bringing about bottom line cost savings, as the cohort of families involved in the LIFE Programme is small so the level of prevention achieved has not yet accumulated to a level where staff posts can be saved across Swindon as a whole. These costs are therefore seen as cost avoidance.

Similar levels of notional savings are expected in the second year. The main financial benefits of the LIFE team approach will acrue over the longer term as families cease to represent significant financial burdens on public sector agencies.

Learning points

Working with families across the whole system

Participle, Swindon Borough Council and partners, learnt through spending time with families and reviewing other initiatives, that the new system needs to focus on the need to be an open service, that is attractive and aspiring for both the families involved, their peers and workers – a 'golden ticket' to building the life they want to lead.

The current LIFE model is truly family-led, and builds capacity for families to lead their own change process and creates opportunities to support families as they progress through the programme and into the community. We have learned that supporting families in building their own aspirations for their future is critical and has led to individuals seeking opportunities for employment and gaining new skills.

Community capacity-building

The current implementation of the LIFE programme has focused on supporting families and it now intends to develop opportunities for social networks in communities that support change and enable families to re-engage with their local communities. This work will link closely with Connected Care, which operates in two areas of Swindon and is led by a partnership of agencies in Swindon with TurningPoint.

Statutory interventions and child protection

It has to be acknowledged that the current LIFE model creates some tensions within statutory services who work with families. For example, currently in families where a social worker is involved, the social worker remains and fulfils the statutory requirements in relation to children in need and those in need of child protection services. The LIFE Programme Model will be developed further to build an integrated approach to families with complex needs, including a link with statutory interventions. It will also involve development of the programme to include learning from models such as Strengthening Families and the Family Nurse Partnership.

Impact of LIFE on the wider system

LIFE, together with the learning from integration of services and focus groups of families and local people, has acted as a catalyst for fundamental paradigm change in the way public services are delivered in Swindon, as well as being a key part of delivering that change.

Public services need increasingly to work in different ways that better empower local residents and communities to do more things for themselves where it makes sense for them to do so. They need to support local residents and communities where necessary and to get out of their way when not needed to enable them to find the solutions that really work for them. Whilst public service agencies can bring useful specialist knowledge and expertise, they need to recognise that individuals and communities are often better placed to know what works best.

The hallmarks of the new way of working are: building deeper relationships in the community; collaborating in setting priorities and shaping solutions; and building and harnessing more effectively the capability and capacity in the community.

This is now reflected in new job roles for senior leaders within the local authority, which include a new set of expected behaviours, including building meaningful relationships, demonstrating integrity, clarity of intention, resilience and self-awareness.

Enterprising people co-producing local solutions

Helen Allen, *Community Catalysts CIC*

Community Catalysts is a Community Interest Company supporting the development of sustainable local enterprises in delivering services that people can buy to live their lives. People in communities have many untapped gifts and skills and with help can use those to provide real choice of small scale, local, personalised and high quality social care and health services (in the broadest sense) which can be valuable in helping other local people looking for support and services.

These 'micro-entrepreneurs' can come from a number of backgrounds. Some may use services themselves, care for a loved one or have previously worked in social care. Some have no previous 'social care' experience but have a passion or an interest that they want to introduce to people in their community – some of whom happen to have some support needs. Services may be delivered on a voluntary basis, as part of a cooperative or as a small social enterprise or business. In all cases, because of their size they are more likely to be responsive to individual or quirky requirements and to be co-created, co-designed and co-produced with the potential service user.

Community Catalysts works with local partners such as local authorities, and health agencies who recognise the potential of 'people on their front doorstep' to deliver local personalised solutions for other people in their community. Partners recognise the importance of the tailored help that *Community Catalysts* provides to people in order to make sure that the services they provide are good quality, legal and sustainable.

Micro-providers work co-productively by:

- harnessing the power of informal networks;
- creating opportunities for people to shape their service;
- enabling people to be equal partners in the design and delivery of the service.

The three micro-enterprises described here show different ways in which co-production can work in practice.

INSIGHT for Carers – Harnessing the power of informal networks

INSIGHT for Carers Service, known as *INSIGHT*, is an independent, not-for profit organisation for carers, run predominantly by carers in Dudley. The project was set up in 2009 by Marc Carter who had a vision of creating a hub for carers in Dudley, as he is passionate about empowering carers and people who use services. As a carer himself of two autistic children, Marc believed that the needs of carers were being ignored and that bureaucracy stood in the way of people who genuinely wanted to air their views, issues and concerns.

INSIGHT works hard to meet the needs of carers, developing and delivering the services that they want, rather than those that 'the system' thinks they need, while at the

same time reducing isolation and empowering carers to lead fulfilling lives. The Carers Café offers all of this in a relaxing, welcoming atmosphere, providing a space for carers to take time out, talk to other carers and be heard and understood.

Helen Timmins, a parent/carer first met the *INSIGHT* team earlier this year. Her son had recently been diagnosed with autism. Helen says "*Receiving and dealing with the diagnosis of your child's lifetime condition is a stressful, upsetting and, at times, bewildering experience. Having people to talk to who understand this from their own experience makes a huge difference. I would be happy to work with the team to help look at ways of supporting other parents through this.*"

In addition *The INSIGHT* project provides volunteering opportunities for vulnerable adults – from people with learning or physical disabilities, those suffering mental ill health to disaffected young adults who are struggling to obtain employment. Their aim is to help people to increase their confidence, gain the necessary skills to obtain employment and achieve a sense of fulfilment.

A volunteer at the café explained "*before I came to the Carers Café I was depressed, low in confidence and felt like a failure; and now I am the happiest I've been in a long time. I have lots of support from this amazing team and thanks to them my confidence has improved and depression are long gone …*"

The project provides a service that is based on carers' own experiences and embraces the support of the local community as well as statutory bodies – capturing the essence of co-production.

Funky fitness and fun – creating ways for people to shape the service

Micro-provider Carita Smith set up her enterprise in Oldham in 2008 with the aim of using her own interests, skills and experience to provide a safe, secure and fun environment where adults with a learning disability, physical disability or mental ill health can meet and take part in a range of activities to enhance their overall wellbeing.

The service runs on two days each week at a local community centre. Members tell Carita about what type of physical exercise that they would like to engage in over forthcoming weeks and she commissions it on their behalf – hence tai chi, dancing, aerobics, cheerleading, Elvis dancing, have all been included in the weekly sessions.

Michael has attended Carita's service from the outset and pays for it using his personal budget. Michael used to attend a more traditional day service run by the Council. He did enjoy this but disliked the inconsistency of staffing and the inability of the service to always adapt what it provided to meet his needs and wishes. In contrast Michael is very positive about the service that Carita provides saying that *'Carita is her own boss and can do it'*

The sessions bring custom to the café within the community centre which is run as a social enterprise, as it provides a healthy range of food options for the members. Bringing people together has further opened doors for some members, who have now gained voluntary work at the café and are undertaking qualifications to further their chances of employment in the future.

Pulp Friction CIC – equal partners in the design and delivery of the service

Pulp Friction is a Nottinghamshire-based enterprise that works with young adults with learning disabilities to develop their social skills, independence and work-readiness skills. They provide opportunities and individual support for people to run pedal-powered smoothie bars at different community events.

Jill Carter and her daughter Jessie, who has learning disabilities, set up the enterprise when Jessie, like many of her non-disabled friends, could not find meaningful employment in the local area (working in a posh restaurant!) – a real job which would be seen to be really important for Jessie.

After seeing a smoothie bike at a local festival and speaking to a few of Jessie's friends who loved the idea, Jill provided support to put an application into the Youth Opportunity Fund for £1800 to buy a smoothie bike for themselves. They were successful in their bid and the *Pulp Friction* Smoothie Bar project was born!

People who are involved with *Pulp Friction* have commented;

> *"I've been with Pulp Friction for a year now and when I first started I wanted to build up my confidence and skills more by serving the customers. I go to local places and other locations, too, helping out with the pedal powered smoothie bar."*

> *"I liked doing Pulp Friction, it was good meeting new people. It was helpful for me and I got a job."*

Initially *Pulp Friction* operated as a youth and community group, recruiting non-disabled young adults to work alongside the regular members, so that people began to build friendships and work as a team.

Whilst on their journey, Jill enrolled on a course for people interested in developing social enterprises, which was run by the East Midlands School for Social Enterprise (EMSSE). As a result of doing the course, Jessie and Jill decided to set up *Pulp Friction* as a social enterprise.

They launched their Community Interest Company in June 2011 and in November Jill won the Nottingham Social Entrepreneur of the Year Award and Jessie won the Nottingham Young Social Entrepreneur of the Year Award – funnily enough, part of Jessie's award was getting to work in a posh restaurant!

Conclusions

Co-production is at the heart of all three services described in this chapter. They are all successful in their own right but owe some of that success to the way in which *Community Catalysts* is able to harness the energies of entrepreneurial people, carers, families, citizens and the local authority, helping them to work together to effect change. With the right support, local networks of micro-providers will give time, energy and effort to work collaboratively and non-competitively, sharing assets in order to create the right

environment for individuals, with or without a personal budget, to access the right service to meet their needs. Network members will also provide mentoring to gifted people with support needs to 'have a go' themselves – pooling different kinds of knowledge and skill, and working together.

People like Jessie and Marc are often pigeon-holed as 'service user' or 'carer'. But they should be seen as the people they are – people with great gifts and assets that they want to and can use for other people in their community. Their entrepreneurial spirit should be recognised and valued for the good work that they undertake and the effect they can have within their local neighbourhoods, co-producing local solutions for people.

An extra pair of hands

Emilie Whitaker, *University of Birmingham* and Associate, *Governance International*

Introduction

Across health and social care there is growing interest in co-production. Policymakers, government and statutory services are beginning to explore how by harnessing service user knowledge and experience, they can build more responsive, more efficient and effective services. Children and families engaged with statutory services do hold many of the answers to their own challenges and to those of their wider communities. They have untapped skills and knowledge that when recognized and supported by services can create innovative solutions to seemingly insurmountable problems. Co-production is a new vision for public services which offers a better way to respond to the challenges we face – based on recognising the resources that children and families already have, and delivering services *with* rather than *for* them, their families and their neighbours. The idea, put simply, is that people's needs are better met when they are involved in a more equal and reciprocal relationship with professionals and others, working together to get things done.

Why does co-production with families matter?

Families co-produce outcomes alongside professionals on a daily basis. Whenever a parent makes sure their child gets to school on time, wears the right uniform and does their homework, then that is co-production. When a teenager attends a doctor's surgery on time and takes their medicine that, too, is co-production. It is purely and simply the interaction of children, families and producers of services – teachers, pupils and parents, doctors, care workers and patients in the delivery of services. But the social care system as it currently operates does not often recognise or value the role families have in delivering positive outcomes for their child. It tends to focus on the 'needs', 'deficits', or 'problems' the family faces, rather than emphasising the positive strengths, the crucial knowledge and vast experience families have built up successfully.

Families with a disabled child face multiple challenges in daily life that the majority of us never have to consider. Simple things – like doing the weekly shop, visiting relatives, arranging transport to and from school – require considered planning, resilience and patience. Despite a plethora of policy guidance seeking to improve the life chances for disabled children and their families over the past decade, these families still face poverty, exclusion, isolation and a struggle to get the right support they need. The social care system was set up to ensure that those who need support get it. But families with a disabled child too often find that support is missing, inappropriate or baffling and frustrating to reach. The focus on 'needs' rather than family strengths, combined with a rigid and depersonalised assessment process, can leave many parents feeling disempowered and demoralised, particularly when the right support is often as simple as accessing an extra pair of hands.

Making it local, keeping it simple: time for families

Gloucestershire County Council and North Cotswolds Community Time Bank together recognised the challenges families with a disabled child were facing. They had sensed that that these local families were becoming isolated from more informal, community supports and resources. In talking to community groups and families they realised that access to a wider support network could help children and families feel less isolated, less stressed and help them to access leisure activities.

Families and organisations felt that time banking was the ideal solution as help is available as and when needed, without having to struggle through a formal process. Families don't want to have to make a fuss, or complete endless forms to get a bit of help now and then. Put simply, everyone felt that families with disabled children just need the neighbourly support that helps many parents and children in their day to day lives. Together the Time Bank and the Council felt that there was a gap in local provision and that families could really benefit from community resources, developing neighbourly links and local sources of help and advice. This is how the Time for Families Project was born. The Project was set up in its current location in early 2011 and is funded by The Barnwood Trust.

Figure 7: One satisfied customer! Tom is pleased to have this helping hand.

The Time for Families project supports families who have a child with a disability, special needs or who require additional support in some way. It helps families to access practical help and support through the Fair Shares Time Banks, drawing on local community resources and neighbours to support families to access an extra pair of hands when they need it. The Time Bank is led, developed and grown by its members. There are currently 150 Time Bank members and numbers are increasing. In only three years, over 19,000 hours of time has been exchanged.

How it works

Help is provided to families in two ways. Parents provide peer support and share their experiences and knowledge to other families, and to organisations such as playgroups, childminders, schools and social groups to raise awareness of each type of disability or need. They also help parents who are expecting a baby with disabilities, so that they have greater informal support to prepare for this. Parents earn time credits for supporting each other. The project gives each family five time credits when they join, so that they can get support as soon as possible.

Figure 8: Pitching in! Time banker helping Margaret and Tom get to their hospital appointment.

Families can also get help from the wider Time Bank network, including practical support or just someone to talk to. For example, help with transport either to school or to leisure activities, or an extra pair of hands, can make all the difference.

Real support in real time

Donna* is a single mum with two children, one of whom has a disability, the demands from which were making it difficult for her to spend equal time with both children. Through the Time for Families Project she was able to connect with a local woman who was keen to support the family. The family through the informal, neighbourly support they receive from the local woman now enjoy regular days out where all the family can enjoy themselves, spend quality time together and relax. All the family needed was an 'extra pair of hands.' The woman is part of the Time Bank and through her practitioner experience was well equipped to support a family under stress. But the most important element was the community spirit the Time Bank generates; the nature of the social care needs of the family was secondary to the desire of local people to help each other out.

Lucy* is a single parent to a boy who has Downs Syndrome. Lucy was struggling to have the space she needed in her own life to flourish at work and socially. Through the Time for Families project she got in touch with a local woman who was keen to take the boy out on school holidays. This enabled Lucy to have some respite, meet up with friends and catch up on her own social life.

Margaret* is a grandmother to Tom* who has additional needs. They live rurally and were struggling to find the time and financial resources to get to hospital appointments several miles away in Cheltenham. Through Time for Families three local members of the Time Bank volunteered to run a rota to collect and return the family for these appointments. The commitment is rock-solid, and all have benefitted from this 18month agreement. In talking about this basic yet crucial support Margaret was clear that, "I'm getting what I need – a lift to Cheltenham each week. I couldn't get to the appointment without this kind of help."

In every case, timebanking is used as means of enlisting the human resources of local families to support each other in the co-production of better outcomes.

Empowering families to co-produce

When families make initial contact with the Time for Families Project, they are often under a great deal of stress or may be at crisis point. The project, by being rooted in the local community and by connecting local people and resources to these families can put in place the right support at the right time. The project recognises that at the beginning families are not in a position to give back straight away so it doesn't matter that families go into debit. But parents and families once they feel more stable are keen to share their experiences and to actively co-design future supports for fellow families.

* names have been changed.

One such parent is Carol, she now leads the local parent carers support group, which is an informal group for parent carers to come together and share their stories and experiences, and to support each other. Her engagement began when she realised she needed support and encouragement herself with the demands of coping with her son who has complex difficulties including autism and dyspraxia, along with her other two children. Carol said, "You feel that things that are worrying you and things you want to ask questions of another parent, (not a professional), just like with an ordinary child you chat with other mums, and just to know that you are not alone in having a child with a problem." Carol found there was a lack of support, "I felt isolated and alone in this area which severely lacks facilities for families and children with learning difficulties – no youth clubs or anything – you have to go to Cheltenham or Gloucester for anything." This spurred her on to create and run the successful parent carers group, and enabled her to give back locally.

She is now involved in a training event in conjunction with a local secondary school which looks to develop better ways of supporting families under stress. This event will train four local people as parent befrienders. Through her own personal experience she is now deploying her skills and knowledge to shape the way services are designed and delivered.

Family benefits

The project is about empowering families with a disabled child. It recognises that "families build up an awful lot of skills, knowledge and experience in caring for a disabled child, and that more often than not they know better than everyone else in how to deal with situations that arise" (Jo Goldie, project manager).The project values this expertise and knowledge. Through timebanking the project offers an outlet to families to share their skills with parents, professionals and universal services whilst building up their own time credits to use when and how they choose.

Families engaged with the project want to be respected and valued as neighbours, members of the community and as friends to others. They, like all of us, do not want to be defined by the medical or social care needs of themselves or their children. The Time for Families project explicitly recognises this by giving families choice and power over the support they receive – and support is in turn shaped and developed by the families that use it.

A long-lasting benefit to families is the community connections they build through the project. These are intensely local relationships that grow and flourish over time. The project offers a way for families to meet friends and neighbours and to have someone who understands them and their family at times of difficulty. There are no long waiting lists, no complex assessment procedures and no information asymmetries in getting the right support quickly.

Co-producing together

The project works because it harnesses community spirit and neighbourly desires to help one another. But this would not be possible without support and encouragement from Gloucestershire County Council. The Time for Families Project helps them in their work as they seek to better design and tailor services to local needs and wants.

A core outcome by having the project on their doorstep is a reduction in inappropriate demands to statutory services which enables professionals to better target their resources more wisely.

The involvement of staff from the local authority has opened up an array of learning opportunities for statutory services to learn from and work alongside local families who have a disabled child in co-productive ways. The next step for the project is to develop statutory and non-statutory local services based on insights from families engaged with the Time Bank. The Project hopes that as it continues to grow and families become increasingly empowered they can work even more closely with nurseries, schools and health settings to co-design services which build jointly upon the expertise of families and staff to deliver positive outcomes. As services become better designed they are more likely to be used and valued by families thus reducing gaps in provision and the costs associated with poorly utilised services.

Time for Families is a conduit for harnessing the power and desire of local communities to empower and support their neighbours at a time of stress and difficulty. It brings together local people to build networks and friendships that in many cases prove to be lifelong. Through the Time Bank families with a disabled child are empowered to take control of their lives, to recognise their genuine expertise, skills and knowledge and to disseminate this across a wide range of services. One family member being supported by the project said, "I had 16 years experience working with children with severe difficulties though I hadn't got the proper qualifications, but it all started bubbling up and I started remembering what I used to do – it made me realise what the group is meant to be – it made me realise I do have some skills."

The uncomplicated access to an extra pair of hands, the equality of relationships and the ability to give back are hallmarks of the project. As the co-manager Jo Goldie put it, "There are an amazing range of skills that are out there, we just help families recognise their expertise and connect to others." Parents are now beginning to co-design services with professional and statutory services. They are supporting fellow parents and are making a real difference to the ways in which statutory services work with families in the local area.

New ways of collaborating with users and communities in health and wellbeing

Public involvement in the NHS – a step towards co-production?

David Taylor-Gooby, *Lay member of the Durham Dales, Easington and Sedgefield Commissioning Group*

There is much talk about public involvement in the NHS, but less about what it should actually do. Is "involvement" something which can be developed into co-production? It is always assumed in the literature to be a "good thing". In this chapter I will try to identify what it means, and how the concept has developed, drawing on some survey work which was done in Easington where volunteers and professionals stated what they thought involvement in the NHS should be doing (Macdonald and Taylor-Gooby, 2010).

Background: involvement and the NHS

The whole issue of volunteer involvement in the current financial climate can be problematic. The current government is enthusiastic about the "Big Society" (Cabinet Office, 2010) although what it means is not always clearly defined. Many professionals fear that this could lead to a reduction of services and the substitution of volunteers for professionals. Nevertheless the NHS has always encouraged involvement – it is not a new phenomenon, as this brief historical overview will show.

When the NHS was established in 1948 it incorporated a variety of institutions, all with their own forms of governance and connections with the public. (Timmins, 1995; 2001; Webster, 2002). The priority at the time was dealing with epidemics, infectious diseases and putting right the ravages of the war (Webster, 2002). Aneurin Bevan even boasted that "the sound of a dropped bedpan in Tredegar would reverberate around the Palace of Westminster" (Glasby *et al.*, 2007). Central control and delivery were the orders of the day. Not much thought about involvement.

The next significant reforms, those of the Conservative Government in 1974, placed all health services under the control of Health Authorities, although welfare and social services remained with local authorities (Timmins, 1995). Health now had an area focus, rather than being centred on institutions. A major change in 1974 was the establishment of Community Health Councils (CHCs), which could be seen as a move towards public involvement. These were intended to represent the public interest and included councillors (Timmins, 1995). The CHCs were able to investigate complaints and refer them to the hospitals' complaints procedures. They were also able to investigate issues and challenge the hospital authorities (Levitt, 1980).

The performance of the CHCs varied, but they continued until the 2001 Health and Social Care Act and the establishment of the Commission for Patient and Public

Involvement in Health (CPPIH) in January 2003. Many people still remember them fondly.

The CPPIH which was established in 2003 was again changed into Local Involvement Networks (LINks) in 2008, and LINks are to receive greater powers and become "Healthwatch" under the present Government proposals. LINks and Healthwatch scrutinise health services and suggest improvements.

A major new development was the introduction of "Practice Based Commissioning" The document which set out NHS thinking in 2006, "Our Care, Our Say", set out a new direction for health and social care within the United Kingdom. (DoH, 2006, p7) Its stated objectives were:

- better prevention services with earlier intervention;
- giving people more choice and a louder voice;
- doing more to tackling inequalities and improving access to community services;
- more support for people with long-term needs. (DoH, 2006)

Notice that these proposals are very similar to those proposed in the 2010 White Paper. The essential difference is that Primary Care Trusts were to continue to provide oversight and support of the process whereas GP groups were doing the commissioning or purchasing of services. The Labour Government did however amend these suggestions to make the NHS the "preferred provider" of services. The new (2010) proposals refer to "any willing provider"(AWP), a significant and controversial difference.

There is a substantial section on local involvement in the commissioning process, "Ensuring our reforms put people in control" e.g. at the same time as giving people greater choice and control over the services they use, there is also

> *"a need to ensure that everyone in society has a voice that is heard. When people get involved and use their voice they can shape improvements in provision and contribute to greater fairness in service use "* (DoH, 2006: para 7.4).

There is also great emphasis on customer feedback, which would seem to be particularly important if providers other than the NHS are to provide services.

Aspects of these proposals, such as the involvement of patients and the public in the actual planning and delivery of services, could be described as "co-production". It seems that involvement can comprise the following:

- scrutiny of NHS services;
- joint planning or commissioning by professionals and the public;
- partnership working, such as the management of long-term conditions;
- customer feedback – identifying failings and suggesting improvements.

We can see elements of co-production in all four.

The research in Easington

Easington is a former coalfield area situated on the East Coast of England between Hartlepool to the South and Sunderland to the North. The District has traditionally suffered from poor health. Townsend's report on health and deprivation in 1987 (Townsend, *et al.,* 1987) cited Wheatley Hill as being the unhealthiest ward in England.

The aim of the study was to find out the perceptions of those involved as to what is being achieved through involvement, and how effective it is. The work was of a qualitative nature, involving in-depth interviews. (All quotes are from research participants).

The Practice Based Commissioning Board (PBC) in Easington consists of representatives from the 17 GP practices in the area. The Board meets monthly, as does the Monitoring and Advisory Board (MAB), which consists of lay people and advises the PBC Board. Members of both boards were interviewed.

All the people interviewed were enthusiastic about involvement. The professionals saw it as a way of improving services, and wanted to work with volunteers where they could.

> *We hope to get benefits from involving patients … I suppose it is a form of market research. We want to know whether services are doing what they should.*

The volunteers wanted to have a say in shaping the NHS and in particular their own treatment.

> *I do not like leaving everything to the professionals – they can make mistakes. You know more about your own disease and particular situation.*

But both professionals and the public wanted to go further. They wanted to work together to improve services and to improve health.

> *I helped identify patients to become members of the Practice Forum, and set up support groups for Diabetes and COPD. I also promoted the Expert Patient Programme and set up a CHD Group – which a patient now chairs. Patients with long-term conditions need to work in partnership with the health professionals in the NHS.*

> *These small projects can save the NHS money. Lights will prevent falls, and hip replacements. Community organisations can prevent loneliness and depression. Many organisations promote physical fitness.*

> *The "Get Active" scheme has been promoted through public involvement. A weight management scheme was very successful, but funding was limited.*

When asked how the process could be improved, all thought it should be made more effective.

The Chair of a local Health Forum put the case for resources in a different way.

> *Abolishing the local Health Forums, which could actually do something in the community, would be a retrograde step. The NHS invites comments from people, but is better at telling people what it is going to do than listening to them.*

What they appeared to want was what I identified as "Active Involvement", that is being part of the process, rather than simply "Passive Involvement" – going to a meeting and being informed what someone else was going to do. This could be described as "co-production".

Conclusions and a way forward

There already exist mechanisms to take surveys of consumer satisfaction, and local authorities have scrutiny processes. The role of the MAB and Practice Based Commissioning seems to be more than this. If it worked effectively it would mobilise local people, patients and voluntary organisations to work in partnership with GPs and other health professionals locally to deliver an improved, localised NHS, with the emphasis on promoting better health and preventing illness. Some treatments could be taken out of hospitals and delivered in the community. Examples would be "stop smoking" or "weight management" programmes, or diabetes and COPD treatment. In Easington volunteers were already involved in support groups for COPD, CHD and diabetes. Health professionals provide the expertise necessary, but local people and organisations can publicise the schemes and involve the people who need to be reached.

The research showed that people are keen to have an influence over how NHS resources are spent locally, and to be involved in campaigns to improve health. Having this influence encourages and mobilises volunteers.

The crucial point is, however, that they want to be playing an active part. The NHS may need to devote resources into volunteer support and the administration of volunteer groups, but if, through a process of active involvement and co-production, better long term care and programmes to promote healthy lifestyles can be delivered, it is certainly money well-spent. It is also a practical way of reducing health inequalities.

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Localism, co-production and healthier communities

Catherine Staite, *University of Birmingham*

Localism: a means to better health and wellbeing?

Localism is a recurring theme in the discourse of the public sector but what does it really mean and what could it achieve? Ideally, for many local authorities, it would mean the end of being treated as the delivery arm of central government and the beginning of greater autonomy; to raise and spend revenue and to have more influence over major local policy issues such as health and employment. Central government sees localism more in terms of a transfer of power to local people, to have greater influence over the services they receive and the future shape of their neighbourhoods, rather than a transfer of power to local authorities. Ironically, the Localism Act 2011 was trumpeted by the Coalition Government as heralding a new dawn of localism but it creates few new opportunities for local authorities to improve the health and wellbeing of their communities.

The Health and Social Care Act, on the other hand, does offer a great deal more support to the localist agenda. Public health is to be transferred back to local government. The establishment of Health and Wellbeing Boards, under the leadership of elected members in upper tier authorities, provides a forum for the strategic planning of local health and social care services, including those to be commissioned by GPs, through the Clinical Commissioning Groups. Such an arrangement is currently untested, as the Boards are still in shadow form but it does give local authorities a crucial leadership role in creating a coherent response to the health and wellbeing needs of their population. At a time of great financial stringency, some may view this as less of an opportunity and more of a poisoned chalice. However, it is those difficult circumstances which may be the key to success for the new arrangements. At a time of rising demand and reducing resources, the *status quo* is not an option. Central government plans to cut public spending by £81 billion over four years and local authorities have lost £4.7 billion in income this year. This means that local authorities and their health partners will have to enter a dialogue with the people they serve about what services can do for them and what they'll need to do for themselves, as well as identifying the hidden capacity of people who are often defined solely by their needs. Thus, a key step towards localism brings with it some powerful drivers for better engagement and more co-production.

Co-production of health and wellbeing outcomes can range from the very passive – merely taking the prescribed medication – to the very active. Active co-production can include expressing views, stating needs, making choices, contributing to service delivery or taking on responsibility for the governance of organisations which provide services. These are all ways in which people can contribute to their own health and wellbeing and that of their families and communities. None of this is new but the desire of some users and communities to have more involvement in the way in which services are planned and delivered and the necessity of finding better, more efficient ways of delivering outcomes, are driving the search for ways to maximise co-production of better health and wellbeing.

Co-production and reducing health inequalities

Health and Wellbeing Boards will be focusing their attention on health inequalities and the impact they have on people's lives. The Marmot Review ('Fair Society, Healthy Lives') highlighted the extent to which factors such as education and housing are the 'wider determinants of health'. Unless those issues are tackled, people's life chances and health will remain poor in areas of deprivation. People living in the poorest neighbourhoods in England will die seven years earlier and spend an average of seventeen more years of their life with a disability than those in the richest neighbourhoods, even though health inequalities are largely preventable. This is not sustainable, not only because of the need for social justice but also because of the cost. It is estimated that the annual cost of health inequalities is between £36 and £40 billion through lost taxes, welfare payments and costs to the NHS.

The challenge then for Health and Wellbeing Boards is to commission services which focus on promoting wellness, on the prevention of ill health and on early intervention, as well as on treating disease. This will require a profound change in the way in which services are planned and delivered. It will also require change in the behaviour and expectations of individuals and communities. Although it seems that the most deprived people have the least capacity to help themselves, there is a growing recognition that the welfare state has overlooked and limited the power of individuals to do things for themselves. Dependency is not a problem only of the most disadvantaged. Colleagues from local authorities who have suggested to prosperous local communities that they do something for themselves, e.g. run their own 'one o' clock club' for their own children or clear the snow off their own drives, have been met with the question –' what do I pay my council tax for?'

Changing behaviour to support co-production of healthier communities

Changing the behaviour which undermines individual health and wellbeing such as smoking, excessive drinking, drug use and the health and wellbeing of others, such as poor parenting, anti-social behaviour and drink driving, is vital in achieving better health and wellbeing outcomes. The theories of behavioural economics suggest that it is possible to change behaviour by the use of certain stimuli, such as peer pressure and by the judicious use of incentives and disincentives (some of which can be described as 'nudges', predisposing people to behaving in certain ways). Local authorities and their health partners are now thinking about the sort of incentives and disincentives which will encourage people to co-produce their own health outcomes, by living healthier lives and their own wellbeing outcomes, by more individual and collective self-help. The 'ladder of intervention' describes a range of ways in which behaviour can be changed. The trick will be to combine the right mix of interventions, aimed at the right groups of people, at the right time. The campaigns to reduce smoking have included education about the harm caused, disincentives through high levels of tax on tobacco and prohibition, through the ban on smoking in public places and resulted in health gains for ex-smokers and those who previously shared their smoke.

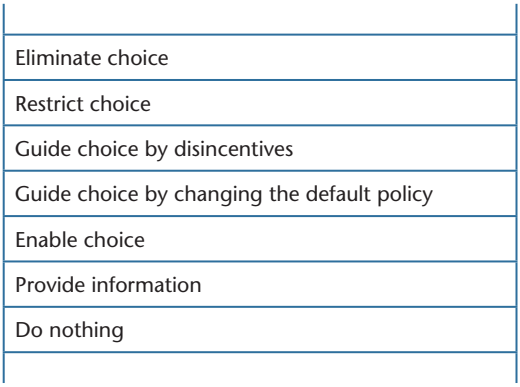

Figure 9: The ladder of intervention

The incentives which will encourage behaviour change and increased co-production of wellbeing outcomes include investment in support for people to take more control of their own lives. The Swindon LIFE project (described by Rod Bluh in another chapter in this book) has enabled families, which were characterised as 'chaotic' and were the subject of multiple but uncoordinated interventions from a range of services, to take back control over their lives and reduce the stress they were suffering and also causing to others. In Tower Hamlets, the Bromley by Bow Centre provides health training for people whose first language is not English, for example, raising their awareness of the symptoms of cancer and empowering them to actively improve their own health and that of their families. They have spread the message among their own communities. The Southwark Circle, provides opportunities for older people to support each other and the benefits include an increased sense of self worth and stronger social connections. In order to be successful, ventures like these require a willingness on the part of services to let go, to support experimentation, encourage autonomy and to take risks. These changes are hard for professionals. It is hard to let go of the idea that professional expertise is the answer to people's problems and it is hard to take risks when the default response to failure is 'blame', often combined with 'name and shame'.

The cuts in funding for public services are just beginning to be felt. The current rounds of cuts will almost certainly not be the last. When efficiency savings can't fill the gap, the only option will be to renegotiate the 'deal' between individuals and communities and the state. Some of that dialogue will be at a national level but much will be at a local level, between local authorities and their partners and their communities. It is just possible that if that dialogue is managed well, localism and co-production will help create healthier communities.

Competition or co-production? Which way for governance in health and wellbeing?

Bob Hudson, *Durham University*

The NHS Act represents an important point in the way in which health and wellbeing is produced and governed. The changes have been articulated as the end of 'top-down' command and control, and a decisive shift towards decentralisation and the empowerment of patients and professionals. But what does this add up to, and how does it relate to co-production?

Developing a framework for analysis

An important starting point is to define terms and think about a framework for understanding these changes. Drawing on the analysis of Freire and Sangiorgi (2010) we can conceptualise the relationship between changing paradigms of healthcare and their associated 'modes of production' as shown in the box below.

Healthcare Paradigm	Mode Of Healthcare 'Production'
'Mass Production': Expert knowledge to treat acute illness	**Professional design and delivery of support:** Service efficiency; patient passivity
'Mass Customisation'/ Personalisation: Better understanding of differentiated needs of patients	**Co-Design/Individual Co-Production:** Professionals and patients jointly design support with professional-led implementation
'Mass Collaboration'/ Participatory Health Care: Ongoing patient engagement to deal with complex chronic conditions	**Co-Creation/Collective Co-Production:** Patients and communities central to design and delivery of services and support

These distinctions help us to understand an important narrative about the changing nature and treatment of health and wellbeing. The '*mass production*' paradigm characterises the early phase of the NHS where the focus was on dealing with the legacy of untreated acute diseases and infections. Passive patients gratefully received treatment based upon expert professional knowledge. In the '*mass customisation*' paradigm the focus is around patient need rather than standardised professional delivery, with the notion of 'personalisation' perhaps the most common description. Here service delivery is 'co-designed' between

professionals and patients ('individual co-production') but will tend to be delivered by professionals.

With '*mass collaboration*' the healthcare system tries to respond to the challenge of people with complex long-term conditions. It has been estimated that an individual in this position spends 5500 hours a year living with the condition of which only five hours is spent interacting directly with a medical professional. This suggests great scope to be an 'expert patient', especially when connected to others sharing the condition through 'communities of interest'. In this case there is scope for 'co-creation' in which patients, neighbourhoods and communities of interest are central not only to the design of services but also their commissioning, delivery, assessment and continuous development – 'collective co-production'.

Co-Production in the NHS and Social Care Act

At first sight the NHS Act seems to be proposing a significant shift away from 'mass production' and towards an individual co-production paradigm. The policy rhetoric that has accompanied the reform narrative describes an attractive world of shared decision-making ('*no decision about me without me*' said the White Paper) with the cosy and familiar GPs surgery said to be '*the new headquarters of the NHS*'.

Given that the underlying principle of co-production is that people's needs are often better met when they act as 'primus inter pares' with professionals and others, this constitutes a promising development. The Act's decentralised model of professional-patient interaction seems to offer an attractive palace of varieties including better sources of information for patients, listening to the patients' experience via Patient Reported Outcome Measures, recognition of the 'expert patient' in the case of many long-term conditions, the roll-out of personal health budgets and – most importantly – the prioritisation of patient choice in the 'any qualified provider' (AQP) model.

This is not an agenda without virtue but it rolls together two models of the patient – those of consumer and citizen respectively. The privileging of choice over any other consideration (such as equity, quality and continuity) puts the 'patient consumer' model at the forefront. This approach rests upon the unlikely assumption that patients (making use of new forms of information) will readily assume the role of rational consumers in a market of healthcare choices. On the other hand, the extension of a robust personal health budget programme alongside a commitment to developing further the expert patient programme could help to create new and interesting models of 'individual co-production'.

The more radical model of 'collective co-production' appears to have no place at all in the proposed changes. Insofar as there is some change in the relationship between citizen and state it is in the realm of representative rather than participatory governance. Here again much is promised – the 2010 consultation paper on democratic legitimacy, for example, boasted that "*for the first time in forty years there will be real democratic accountability and legitimacy in the NHS*".

There seems to be much on offer in this respect but closer scrutiny suggests a potentially flawed approach: Health and Wellbeing Boards will have few formal powers

and could easily degenerate into talking shops or even cockpits of conflict; Clinical Commissioning Groups will have little transparency and only vague obligations to engage with their localities; Foundation Trusts will in the future be accountable only to feeble governing bodies elected by a small membership; and the new Local HealthWatch organisations will be weak and underfunded. Meanwhile the really big beasts – the NHS Commissioning Board and Monitor – will hold huge sway over local decision-making yet be totally unaccountable to localities and will constitute a reversion to traditional top-down decision-making. Individual citizens and local communities wishing to help shape their local services will not find it easy to gain leverage in this world.

A future for co-production in healthcare

What the above analysis seems to suggest is that whilst there is agreement on the need to move away from the 'mass production' paradigm, the alternative policy offer is one of weak democratic legitimacy and a consumerist version of individual co-production. What we have not yet had a debate about is a collective co-production model which engages the public better in managing and improving their health and wellbeing. It is important that this is not confused with an argument for a minimal state; rather it is about the extension of citizen capacity and capability as a means of improving the relationship between the state, services and people. 'Quality' is the prime imperative but it will be achieved through co-production rather than 'consumer' choice.

This is not virgin territory. Much valuable and practical work has been undertaken by such initiatives as the Commission on 2020 Public Services and the Think Local Act Personal programme, as well as by bodies like the Health Foundation, the new economics foundation (nef) and NESTA (National Endowment for Science, Technology and the Arts). And on the academic front there is joint work underway at the University of Dundee and King's College London to strengthen our conceptual understanding of co-producing health.

Although it would be naive to underestimate the practical difficulties in developing robust models of co-production, there is no doubt that the main barriers are political and ideological. In the case of healthcare the main thrust of the NHS Act is clearly to open up diversity of supply, predominantly on the part of private sector providers – an aim that will be buttressed by also giving the dominant role in commissioning support to the private sector. Transparency and accountability do not figure highly in this model, and co-production will inevitably play second fiddle to ostensible empowerment via market exit. It's not the right model for co-production, and it's not the right model for high quality healthcare.

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Co-producing mental health services with communities: Making the case

David Morris, *University of Central Lancashire*

Co-production and complexity

Co-production is about embedding a different kind of relationship between the world of services and that of communities. It means working with communities appreciatively for the diversity and multiplicity of interest, identity and need that they represent. This is readily missed in a context for community-centred service design which may admit the importance of personalisation, choice and user empowerment – but which nonetheless, mirrors reductive patterns of clinical categorisation; privileging professional over lay perspectives, minimising the comparative value of process in relation to outcome, and, in the everyday setting of assessment and treatment options, defining the individual largely without reference to the social and community networks of which they are part.

Communities of possibility

An age of grim austerity in which communities are asked to bear the burden for a politics of greed, is one which is likely to impact dramatically on the level of services within those communities and on the inequalities which, in part at least, determine demand for service provision. This may seem an inappropriate moment for the co-production argument to surface. Certainly, public confidence requires clarity of argument as to the purpose of our task. Co-production is not about displacement of responsibility for services from state to volunteers. Rather, it is about reshaping the way in which we conceive these services in relation to the communities for which they exist. 'Big Society' policy seeks to define community possibility within a frame of severe budget reduction and this is visible in the public response. Yet, in spanning the years of comparative economic plenty, the policy trajectory towards localism, community engagement and civic renewal has its own importance in defining ideas for '*good* society'. Community-based health and social care services need to be shaped by the potential that follows this shift. A co-productive approach to services reflects this potential. Its intrinsic value is multiplied by its scope for creating community wellbeing and resilience in times of stringency.

This, however, is not all. The argument for community resilience and wellbeing, extensively evidenced in the literature on public mental health has been articulated in successive policies for 'upstream' or population-level interventions aimed at public health gain. Significantly less attention has been paid to strategies for enabling people at the margins of communities to secure their stake in public health gain at community level or to contribute equally to the civic life – and therefore, to the health – of their communities. This is perhaps particularly the case in mental health where the potential of people with mental health problems is likely to be systemically constrained by barriers to inclusion in many spheres of community life and it has something to do with the way in which the

role of health and social care services is conceived – organisationally and professionally – by the agencies that commission or provide them.

Usually working from one of the several specialist community mental health teams established from the1999 National Service Framework, professional staff in mental health are likely to be concerned with forms of care and support that respect personal choice and recovery goals and which attend to the identified elements of individualised care plans. What they are less likely to do is to work in alliance – that is *co-productively* – with the social and community networks in which the individual service user is, or aspires to be, a participant. Service organisations funded on the basis of stepwise progress against clinical guidelines; that recognise the practical importance of recovery as a specialist function rather than universal value, may not be organisations that lead or empower staff to catalyse the ordinary forms of community connection that can turn the individual recovery ambitions of a care plan into real life achievement.

The roots of this reluctance for service organisations to support the engagement of staff in and alongside mainstream community organisations and networks are many. They include competing claims on time; aversion to ideas of community development or its role in health; issues of confidentiality that could impact personally as well as professionally; a view that community engagement is inconsistent with effective management of risk as a dominant public interest issue or a concern with maintaining professional boundaries and distance.

Conversely, the value of a co-productive approach is its acknowledgement both that social networks and processes of connection are crucial for recovery and effective clinical care outcomes and that the starting point for these outcomes is not the singular identity of the person as 'patient' or 'user' but the multiple identities of citizens. A case in point is the co-productive approach of Mosaic Clubhouse in London towards delivering mental health outcomes (see the chapter by Hilary Belcher in this book).

In the way that possibilities are defined, co-production is shorthand for rebalancing professional and lay knowledge and revaluing the way in which the latter can be deployed to reduce the social distance behind exclusion and social isolation. This is fundamental in a health domain where the rights and benefits of social participation are conditioned by the particular impact of stigma and discrimination and where the potential of ordinary social connection and activity may go unnoticed, as action is constrained for fear of public response.

Connecting communities and working for the ordinary – what is to be done?

Where policy to eliminate discrimination has focused on national campaigns for attitudinal change, we need to focus on the behavioural gain of community level activity in which social distance is minimised and people are empowered as citizens by the diversity of their community contribution. This is much less about what takes place in the clinical setting than what happens in ordinary social spaces.

While community participation is not principally an issue for clinical services, services may well circumscribe its potential through forms of professional or managerial control

or by conferring on the user of the service a sense of expectation as to what is personally achievable that is significantly lower than their own. So, in enabling people to tap into and benefit from the connections afforded by ordinary social spaces, health services need to be commissioned for community-capability; for awareness of the mainstream social spaces and to be able to work collaboratively with the community organisations within them. This means:

- supporting effective social networks in practical ways and playing a part in the interventions by which they are promoted;
- being familiar with the communities of greatest significance to individuals; and supporting their pursuit of inclusion and recovery potential wherever identified;
- working with and alongside local mainstream community spaces – cultural, recreational, spiritual and commercial – to enable their capacity and enhance the value of their health and social capital;
- deploying the lay expertise within health and social care agencies – for example, Trust Board members and local authority councillors – to advance practical achievement of inclusion aims;
- link with initiatives for extending local democracy and participation in governance; engage with communities to promote accountability *and* co-produce services.

This is work for which third sector or small community and social enterprises are often already contracted because they are more accessible, acceptable or adaptable than statutory counterparts. Where this is so, we need to ensure that commissioning arrangements are sufficient and responsive enough to sustain them. In any event, there is an obvious fit here with the responsibilities of Primary Care for advancing the health and wellbeing of the neighbourhoods that they serve and, within them, particular communities of interest and marginalised individuals. For commissioners and providers of community services alike, a co-production model of service development, design and provision may well represent a sizeable challenge for learning, knowledge and leadership. Working as equal partners with the 'core economy' – the rich networks of informal activity and social connection to be found in any community – and sustaining this work, will mean replacing the pursuit of sometimes tired ideas and outdated technologies for user involvement. We need a new practice for engagement with multiple communities. This may entail significant cultural shift and is thus more transformational than instantaneous. Where professionals in health and social care have long worked with communities in this way, their skills and commitment should be nurtured for leadership.

The fast changing contract between citizen and state and the economic conditions of our time could make this the second major wave of community care. If so, co-production in health and, specifically, in mental health, could become a necessity, but in being so, it would be no less an opportunity.

What services should be provided? Individual choice or public value?

Jonathan Tritter, *University of Warwick*

Greater inequality is the most likely outcome of promoting the personalisation and localisation of services, as they are based on empowering individual service users to choose the services that they want to receive. The greatest constraint on exercising choice is not information but the range of available services from which to choose. The process of prioritising which services should be available, identifying providers and contracting with them to make the services available is the most important element of a system and should incorporate the involvement of patients and the public as key decision-makers. This chapter discusses an approach to framing involvement in health and social care before

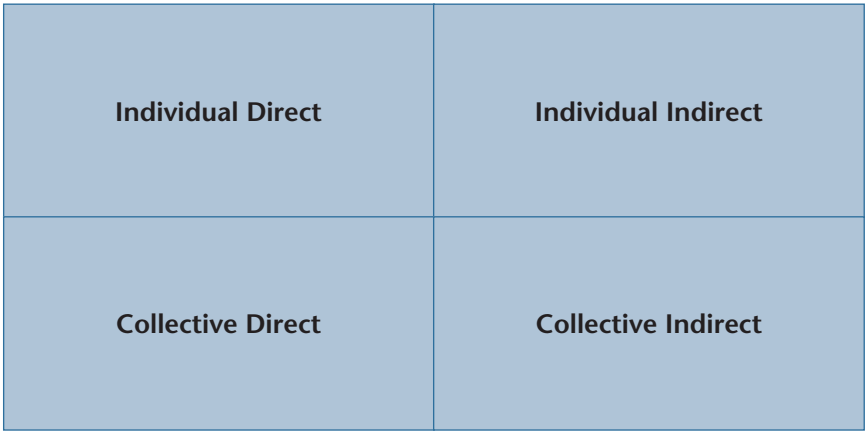

Figure 10: A matrix of involvement

exploring prioritisation and the tensions implicit in ensuring that such processes are inclusive and responsive to local people and service users. It concludes by arguing that to ensure the creation of public value rather than individual benefit from the localisation and personalisation of services, the public must be involved in the prioritisation of services.

Service user and public involvement

The personalisation of services is premised on service users being involved in decisions about their own treatment and care. The concept of involvement is contested and takes different forms. For me involvement is: "*The ways in which service users can draw on their*

experience and members of the public can apply their priorities to the evaluation, development, organisation and delivery of health and social care services".

There are other forms of involvement than individual decision making that are essential to create a responsive health and social care system such as service user's involvement in *service development,* or the incorporation of user views in the *evaluation of services*. Indeed the *education and training* of health and social care professionals has long relied on service users participating in teaching and training through sharing their own experience and increasingly service users and members of the public are being asked to engage in all aspects of the *research* cycle. Clearly, there are interactions and linkages between these five different categories of involvement. For instance, service development may have a direct impact on the range of individual treatment options that exist, and service evaluation may identify inequities in access that affect individual participation in treatment.

Service users and members of the public

The personalisation of services tends to be focused on individual service users while debates on the context of such choices and their knock on effects are far less clear. Should all service users get the same choices or should they be contingent on what is locally available? If the local matters, then individuals can only be understood within the context of communities and the local public. In some ways members of the public, if they are not currently service users, can be conceived of as potential service users. Publicly funded services are accountable to the public as citizens and taxpayers. But the interests of the public are different from those of individuals; what I want to choose is not necessarily the same as what I think everybody should have access to.

The Health Protection Agency has a duty "to protect the community (or any part of the community) against infectious diseases and other dangers to health" (HPA Act 2004). It does this through providing expert scientific advice to the NHS, emergency personnel and government, but it also has to engage with the public. To sensitise the Agency to the public's expectation and better understand how to communicate with them it has established a People's Panel of 1000 individuals across the country, recruited through a representative random sample of the population. The People's Panel helps ensure that the users of the HPA's services do so in a way that meets the needs of the public.

One way of differentiating between the involvement of service users and members of the public is to distinguish between individual and collective involvement (see Figure 1). For individuals, an example of direct involvement might be choosing to have a particular procedure, or choosing not to have chemotherapy. Collective direct involvement might be involving a breast cancer support group in designing a new breast cancer clinic in a local hospital. In each of these cases the involvement activity includes the power to participate in making the decision.

Examples of indirect involvement at the individual level include making a complaint or providing input about a positive experience of care. At a collective level, indirect involvement might be a report submitted by a patient support group about their recommendations for service improvement. In all these cases the involvement activity

generates information, but the decision to act on the information, and indeed what aspects of the information to take in to account, is retained by the health professional or manager.

Personalisation of services is individual and reactive; a decision taken at the point of diagnosis. To develop a responsive health and social care system requires proactive involvement. Many organisations have recognised that developing and supporting user groups or working with voluntary and community organisations is beneficial in generating relevant intelligence on service design, and helping to target resources and services to the needs of the local community. The organisation is likely to seek users' views on plans or documents and send them to the group for review and feedback. Other organisations may ensure that a user group has representatives on the Board of the organisation and that there is a standing agenda item at every meeting that creates an opportunity for the group to raise issues that requires a response.

Often involvement is mediated through voluntary and community organisations. Such bodies have particular expertise and motivation to improve services, typically for people with a particular condition such as breast cancer. This particularism is both their strength and their weakness; a breast cancer support group is in favour of better services for people with breast cancer, it is not against service improvement for kidney cancer but this is not its primary focus. Similarly, participation in voluntary and community organisations is by definition voluntary and is based on self-selection; a voluntary organisation can seek to promote the interests of a category of people but it is not representative of them. Recognising the limitations of involvement via voluntary and community organisations is essential but their strengths should not be discounted.

What services should be provided: the challenge of prioritisation

The need to legitimate what services are provided based on public funding has been a long-standing concern of many health systems. Approaches that have sought to involve the public in the prioritisation of services have a long history and the Oregon Experiment is often seen as a watershed in the development of such approaches. The decision by the government of the state of Oregon to extend health coverage (under the MEDICAID programme) to all residents falling within the federal definition of poverty led to a process to decide what pairs of conditions and treatments would be funded. The process drew initially on the views of doctors and medical organisations to judge the benefits of treatments but then undertook telephone interviews with 1001 members of the public to help rank or prioritise the 709 pairs of conditions and treatments. This allowed a decision about which of the treatments should be funded, based not only on the judgement of doctors, but also on the public funding the programme.

Ironically, as MEDICAID was a programme that received central government (Federal) funding the plans had to be approved by the Bush administration which rejected the 'subjective' prioritisation involving the members of the public. Instead they sought 'objective', clinical or technical decisions. Decisions about what services should be funded and provided from public resources is an example of a 'wicked problem'. Such problems

are those that have not previously been encountered or resolved, where there is incomplete information, and where there is no clear solution.

Deciding what services are available for a community is not merely a technical decision but a moral judgement and therefore must involve the members of the community in making those decisions. There are other reasons, too, for the involvement of those who are directly or indirectly affected by prioritisation decisions. Giving the public ownership of the problems – how to ration and what services to make available for whom – will lead to a greater appreciation for those charged with administering and delivering those services. It will also support co-production of health and wellbeing; the recognition of scarcity and opportunity cost make it more likely that people will value what is available. What services are available to individuals in a community must reflect and maximise public value. Recognising the need for collective decision-making to legitimate what choices individuals have lies at the heart of making health and social care services responsive and locally determined and creates a framework where personalisation need not produce inequality.

Well London Project: Communities working together for a healthier city

Alison Pearce, *Well London Project*

Background

London is culturally and economically one of the world's leading cities with good employment and educational opportunities, a wealth of open spaces, and a huge variety of cultural and entertainment attractions. However, there are great differences in the key health outcomes within the population. Compared to London as a whole, people living in the most deprived areas have lower life expectancy, can expect to live fewer years without disability, have lower mental wellbeing, and their children are less likely to have reached a good level of development as they start school. Over a million Londoners are living in relative poverty, even before the additional costs of living in the capital are considered.

Well London

In 2007 the BIG Lottery Fund awarded the London Health Commission (LHC) and its six partners £9.46m to deliver *Well London*, a community action for health and wellbeing programme, in 20 of London's most deprived neighbourhoods.

Our vision: A world city of empowered local communities, who have the skills and confidence to take control of and improve their individual and collective health and wellbeing.

Our mission: To develop robust, evidence-based models and benchmarks for community action for health and wellbeing that will influence policy and practice to secure real enhancements to wellbeing and reductions in health inequalities across all communities in our capital city and beyond.

Key Objectives:

- To develop a locally focussed, integrated, community-led approach that improves community health and wellbeing and is effective and sustainable in even the most deprived neighbourhoods;
- To engage and empower people to build and strengthen the foundations of good health and wellbeing in their communities by:
    - increasing community participation in activities that enhance health and wellbeing,
    - building individual and community confidence, cohesion, sense of control and self esteem,
    - integrating with and adding value to what is already going on locally,

- identifying, designing and taking action on health related needs and issues,
- building capacity of local organisations to deliver activities and making strategic links locally and regionally so the improvement in health and wellbeing is sustainable for the longer term.

The LHC brought together seven organisations, who had not previously worked together, to form the multi-sectoral *Well London* Alliance partnership.

- London Health Commission – hosted by the Greater London Authority
- Arts Council England – London
- Central YMCA
- Groundwork London
- London Sustainability Exchange
- South London and Maudsley NHS Foundation Trust
- University of East London

From the outset, each partner in the *Well London* Alliance shared a firm commitment to community development and capacity building approaches; offered complementary expertise, experience and skills; and extensive experience in successful community-led intervention and practice. Over the past 4 years the Alliance has achieved great synergy and effectiveness by working together, and benefited from the strategic level influence of the London Health Commission and its member organisations.

Evaluation

Key to *Well London's* philosophy is a desire to capture the learning and experience gained through the programme at community and city wide levels and to use this to influence policy and practice at local, regional and national levels. Given the lack of evidence as to what works in addressing health inequalities within a community setting, University of East London has designed a cluster randomised control trial to test out the efficacy of the model and generate robust evidence about its impact on health and wellbeing. This has secured significant additional research funding from the Wellcome Trust and has been supported by the London School of Hygiene and Tropical Medicine and Westminster University.

The results of the randomised control trial will be available in 2012.

The BIG Lottery funded programme had five themes:

- increasing levels of healthy eating and access to healthy food;
- increasing opportunities for people to take more physical activity;
- promoting positive mental wellbeing and tackling the stigma around mental ill health;
- healthy open spaces;
- culture and the arts.

Target areas

All 20 first wave target communities were defined by lower super output area (LSOA) which each have around 1,500 to 2,000 residents. All 20 LSOAs were selected from amongst the 11% most deprived in London.

The LSOAs were situated in the following 20 London boroughs

Figure 11: *Well London* Boroughs

Projects

The programme comprised a suite of fourteen projects: six projects termed *'heart of the community'* which focused on increasing community participation, volunteering, skills and capacity. We consider these essential to our approach.

Eight projects were based around the five *Well London* themes of physical activity, healthy eating, mental wellbeing, improved 'healthy' spaces and culture and the arts. Projects were designed to be fun, bring different people together, help people develop skills and confidence, and encourage them to pass on their learning to family and friends.

'Heart of the community' projects	'Themed' projects
CADBE	Activate London
Well London Delivery Teams	Buywell and Eatwell
Youth.com	Healthy Spaces
Training Communities	DIY Happiness
Active Living Map	Be Creative Be Well
Wellnet	Changing Minds
	Mental Wellbeing Impact Assessments

The *Wellnet* project is a learning network for communities and professionals, and has shared the learning from the programme through e-bulletins, events and case studies.

A community engagement and development approach was integral to the programme. The CADBE project used a series of innovative community engagement mechanisms including community cafes, appreciative enquiry workshops, aspirational visits and community walkabouts, to capture target communities' own accounts of their needs and aspirations, and incorporated their views and local intelligence into the design of the *Well London* portfolio. At the same time this process was invested (including through direct training provision) in building the capacity of the target communities to contribute to the development and refinement of the delivery programme throughout the project and beyond.

Three cross cutting issues affecting the health of the community were identified by residents across all the target areas:

- lack of sense of community,
- lack of feelings of safety (often connected to young people),
- and lack of pride in place.

Action on these issues was built into *all* project activity.

Well London sought to build community cohesion through every aspect of its work, bringing different people and groups together as part of the needs assessment process, in the development and delivery of projects, through steering groups, and through social and cultural events, such as the Community Feasts and Festivals. Culture and Arts projects and food often provided the catalyst for such connectivity.

Overall impact of *Well London*

Outcomes far exceeded the targets set by BIG Lottery Fund. By the end of project delivery in March 2011 a total of 14,772 people had participated in *Well London* activities of whom:

- 79% reported an increase in healthy eating;
- 76% reported increased access to healthy food;
- 77% reported higher levels of physical activity and 82% said they felt more positive.

A range of additional outcomes were also achieved:

- Significant numbers volunteering: 401 in '*Well London* Delivery Teams' project alone across the 20 areas (the target was 200).
- Significant numbers accessing training and qualifications – over 800 training opportunities were created by the Training Communities project.
- Evidence and inspiring case studies of people progressing to paid employment.
- Increase in community skills and confidence: A wide range of local groups and enterprises established and delivered by local residents. These include football academies, tenant and resident associations, gardening groups, parent support groups and many others, all continuing beyond the *Well London* programme.
- Local organisations, including businesses, provided with training, mentoring, business support and new opportunities that have helped them work in new or more integrated ways.
- Evidence of a more co-ordinated, responsive, collaborative and networked approach between and within statutory and community and voluntary sectors.

Learning points from *Well London*

- The factors affecting health and wellbeing are many and interrelated – therefore an integrated, community development based approach is crucial so that people can be empowered to tackle these issues themselves.
- Inclusive and transparent community engagement is essential. Even so, it is difficult to translate the findings into clear plans of delivery and this needs time.
- Characteristics of the place are as important as characteristics of people in determining levels of health and healthy lifestyles and need local work and community knowledge to identify and target.
- Training opportunities are a great incentive for people to participate and help to create strong outcomes.
- Don't underestimate issues relating to young people. Fund work with young people appropriately.
- Make extra efforts to recruit volunteers to the programme right from the beginning and train them early so they can encourage other residents to take part from the start of project delivery.

- When coming in new to an area, you need time to build relationships and trust, with both the target community and with local service providers, and to find out what is really happening in an area.
- Lines of communication need to be clear from the outset. Communications and marketing should be properly funded especially at the local delivery level.
- Whilst it is important to target communities and necessary to keep them very local, they need to be natural geographical communities. Target boundaries should not cut across natural boundaries or join communities that don't see themselves as joined.
- Strong, positive partnerships with other strategic players will make interventions more successful.

What next?

Well London delivery, funded by Big Lottery, in the first 20 communities finished at the end of March 2011 and the emerging evidence from the project and programme level evaluations point to significant, positive impacts and outcomes on a range of measures. The results of the cluster randomised control trial will be available in 2012. In the meantime Alliance partners are determined not to lose the momentum in realizing the great potential for replicating, scaling up and further developing this *Well London* approach in other communities.

The *Well London* approach is of direct relevance to the new policy context, including Big Society, Localism etc. We have produced a *Well London* 'tool kit' which comprises the interim evaluation, *Well London* 'commissioning framework' for commissioners, and a practical guide for future local delivery organisations and partnerships.

Here is the link to our website www.welllondon.org.uk

Empowering patients to need less care and do better in Highland Hospital, South Sweden

Jörgen Tholstrup, *Clinic of Internal Medicine, Highland Hospital, Eksjo, Sweden*

Introduction

In 2001, the unit of gastroenterology in the Highland Hospital in Eksjoe (in the South-Swedish Highland with 115,000 inhabitants) had long waiting lists and therefore decided to redesign the care process. The unit looked carefully at the values fundamental to its work and came up with a set of innovative approaches to involve patients more intensively in their own care.

Objectives

The initiative was designed to rebalance the work of the unit, to reduce the frustration of doing work which was rather fruitless and which prevented staff from focussing on the really important tasks. The objectives were to diminish waste and to define which efforts created real value to the patients/customers/users, in the expectation that it would be possible to produce high quality care, with better outcomes, and with less effort. In addition, there was a desire to cut waiting lists through providing more appropriate and cost-effective medical treatment.

Change management

Given the waiting lists in 2001, we decided to undertake a fundamental review of the values behind the relations between our patients and the healthcare system. In particular, we analysed our service from a patient perspective. This analysis suggested to us that we needed to redefine the roles of the patients to give them greater personal responsibility for their health. As we redesigned the unit, we also had to find a way to monitor quality, as it was unacceptable to both patients and the hospital that quality should deteriorate and we realised that a shift in attitudes like this (which can be characterised as a paradigm shift) would be criticised. It was essential to us to prove that quality was at least preserved and hopefully improved.

We knew that the problems were deep-set in the system – indeed staff were just as frustrated as patients themselves, who were understandably dissatisfied at having to wait for treatment. Moreover, making patients wait probably had adverse effects on their health, sometimes resulting in deterioration of their condition and causing worse flare-ups and longer hospital stays than would have occurred if care could be delivered at the proper time. Also patients experienced insecurity and uncertainty, further diminishing their quality of life and health experience.

We realised that, traditionally, meetings between the physician and the patient, were, by their very nature, repressive. The physician was the 'top dog', his/her views were

considered to be the central element of the process. Both the patient and the other staff were simply seen as being supportive to this central process. We decided that this had to be changed - we had to create a setting where the team and the patients are partners and where the patients are responsible for their own health. This view actually has a deep impact on the way we are working, as the care team has to negotiate with the patients instead of 'ruling' over them. So we designed a team where all participants, including the patient, would be involved, using their individual competences. We wanted each participant to feel in charge of at least part of the process. The patient is actually in the middle of two teams – the 'community team', made up of their family and friends and support system, and the 'medical team', the staff here in the hospital. The hospital team's role is to support the patient in his/her "real" team, where the patient expects to be a well functioning individual, with full control over his life (see figure 13).

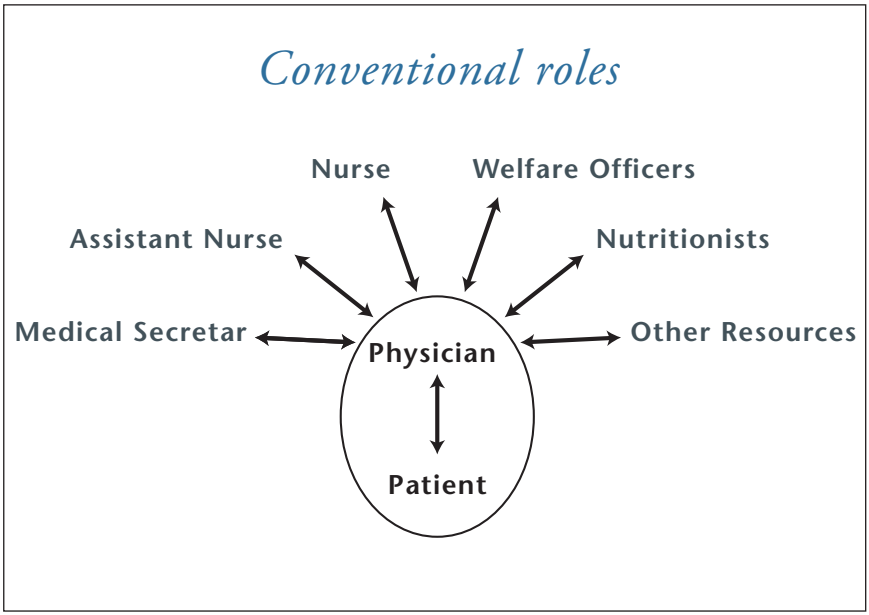

Figure 12: Conventional roles in a hospital

The first thing we realised in the analysis was that it was essential to change the patient monitoring system. The underlying principle had previously been that the healthcare system tried to monitor the patient's health status through regular visits, instead of adapting the system to meet the patient's actual needs. We realised that we were actually doing too much for some patients, and doing too little for others. At the same time, we were unable to guess when was the right time to intervene – this was when we realised

that patients actually knew better than us when their disease was getting worse. This made us realise that we actually harmed some patients, as we could not deliver help at the time the patients actually needed care (partly because of an overcrowded system, the capacity of which was often used up in efforts that did not create real value for the customers). We therefore redesigned the unit to set up a team-based healthcare delivery system in which all participants, including our patients, put their individual competences to use in a proper way. This immediately helped us to cut out some of the inappropriate work which had previously been done, even though it had not produced any real value for the patient.

First, we decided to completely change our contact system. Depending on severity of the disease, need of monitoring AND the wishes of the patients, we stratified patients into several groups, each of which would be treated differently, rather than forcing all of them into the same system, as we had done previously.

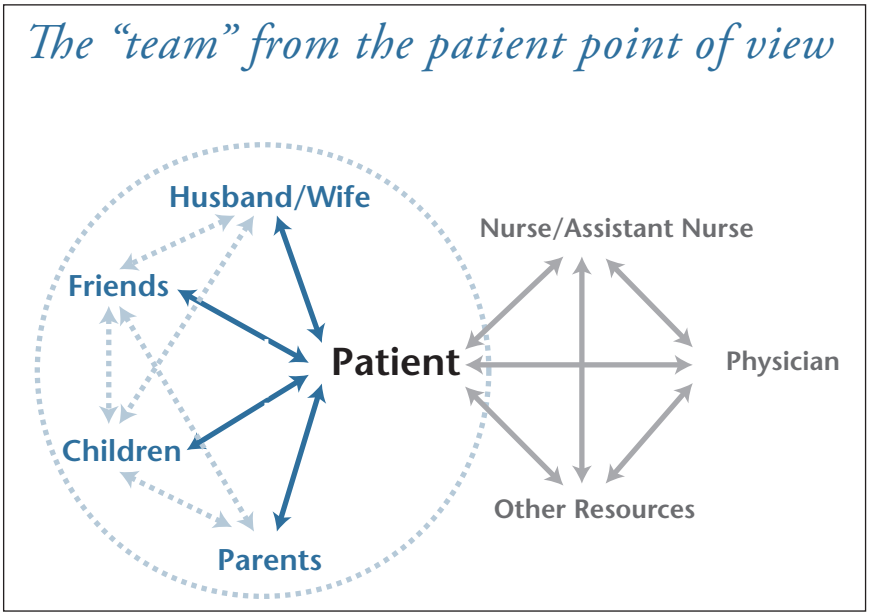

Figure 13: The 'team' from a patient's point of view

We were aware that many of the annual visits were of little use – at scheduled visits, we often found patients had no obvious health problems. These visits took up a great deal of our time on the ward, did not create any real value to the patients and, of course, were stressful and disruptive to the patients. Moreover, most of the flare-ups of the disease took place during the rest of the year – patients should, of course, have contacted us when flare-ups occurred, but we didn't have appropriate routines in

place to encourage that (nor the time to deal with such contacts, given that we were constantly dealing with the 'well patients' who had come in for their regular check-ups). Consequently, patients' flare-ups were often more serious than they would have been if they had been picked up in time. Indeed, the very worst case can occur where a flare-up occurs when the patient has already made an appointment for some time in the future and decides to wait for that appointment, rather than contacting us. This will often allow the flare-up to become worse – in this way, having a scheduled appointment will actually harm the patient.

Consequently, we moved to offering the group of patients with a stable condition (excluding patients on heavy medication, those with learning difficulties and those (few) patients who wanted to meet the clinician) an annual phone contact with a nurse and the opportunity to contact the surgery whenever they felt they wanted to discuss their condition. Instead of coming in to the ward once a year for a check-up, patients are asked once a year to send in a blood test and to fill in a short form asking quality-of-life questions (using the SHS – Short Health Scale). Then a nurse contacts them on the phone for a detailed conversation, covering their overall health condition, any troubles since the last contact, their potential need for prescriptions and any other issues the patient wants to discuss. They are offered a visit to the doctor, if they want it. However, they are encouraged to get in touch with the unit immediately if any signs appear that the disease is getting worse or if they become worried for any other reason. When patients make these unscheduled calls, the nurse can recommend self-care, where it is suitable, or offer an appointment to see the clinician at the hospital within three days. (Patients can also contact the clinic via e-mail, if they prefer).

Of course, this approach wasn't appropriate for all patients – it applied to that half of the patients, whose disease was in a stable condition but it wasn't suitable for patients who were receiving treatment for an unstable condition with immunosuppressive drugs or for patients who could not be considered responsible for their own actions – these were asked to make their traditional follow-up visits to the clinician. Even patients who desired to meet the clinician had a "traditional" follow-up, although actually only a few patients choose this follow-up, as the prime goal of most patients is to stay well – not to see a doctor.

A further change we made was in the way we worked with in-patients. We realised that we seemed to apply a different set of values in the ways we treated in-patients compared to out-patients. Instead of the medical team 'doing the rounds' every morning, and inspecting each patient in their bed, discussing their case 'over their heads', we have reversed the procedure. We invite each patient to come to our team room for a planning meeting, where we can put up the relevant charts, X-rays, etc. relevant to their case. Here they can interview us about what has changed since our last discussion, how they feel, what they are worried about and what we are suggesting might be done. What we do is actually to create a scenario which is designed for negotiation instead of top-down prescription.

This creates an experience of responsibility, power and control over their health and their disease, factors that are necessary if they are to keep the disease under better control and which give them the confidence to recognise when to contact us in the future, if they have concerns.

We also realized that we were holding daily discussions on cases where it really wasn't appropriate – e.g. where there was an ongoing course of treatment with no sign of any problems. To monitor the patient's progress more appropriately, we started to use a "process control chart" – a white board with coloured magnetic dots, indicating where patients were in the treatment process and where it would be appropriate to have a planning meeting.

Outcomes

Overall, the outcomes can be summarised as better access to information and treatment for all patients, high quality care for those patients in need of immediate treatment, lower morbidity for patients with flare-ups in their disease, satisfied and secure patients and satisfied staff, and lower use of health care system resources. In many ways, these outcomes were unplanned – the original intentions were essentially to treat patients more in line with our values and give them a greater role in their care, while also reducing the waiting lists. We believed that we could achieve these things while maintaining the quality of patients' care. In practice, quality has improved considerably, a much better result than we expected.

Moreover, we have seen a substantial improvement in adherence to recommended drug regimes: 68% of patients with total ulcerative colitis have taken out from the pharmacy more than 70% of their prescribed dose, and for left-sided colitis the figure is 58%. These rates of adherence are considerably higher than those found in other investigations, where the adherence rates are as low as 30–50%.

Performance indicators

In order to ensure that this approach to treatment did not decrease the quality of care, an extensive performance measurement system was used, covering the medical results, the patients' health and illness experiences, waiting times for referral visits and waiting time for endoscopic procedures. These involved questionnaire investigations of the patients' experience of care (both at home and as in-patients), and, in order to monitor medical results, use of our computerised medical register of diagnoses, simple biochemical markers and patients' experience of health. We also did one-off investigations, e.g. analysis of our pharmacy records to assess patients' adherence to recommended drug treatment.

Health condition: The patients self-assess their health on the Short Health Scale form, reflecting four aspects of their health - symptom burden, function, experience of anxiety and general condition. Positive results are reported by the following proportions of our patients:

- symptom burden: 98% for ulcerative colitis, 96% for Crohns disease;
- functionality in daily life: 96% for ulcerative colitis, 86% for Crohns disease;
- anxiety: 94% for ulcerative colitis, 90% for Crohns disease;
- general health condition: 95% for ulcerative colitis, 95% for Crohns disease.

Satisfaction: Patient and staff satisfaction are measured by questionnaire. Both groups have reported high levels of satisfaction with the redesigned care system.

Availability: Referrals are registered in a computerised system and the number of patients coming for revisits in the ward is recorded manually – all data is presented once a week at the clinic review meeting. The goal is to have no waiting lists for re-visits, less than 14 days waiting time for referral patients, less than 3 days waiting time for urgent visits and immediate availability for all phone contacts. In practice, there is now no waiting list for planned revisits nor for urgent visits. Telephone availability is good – 93% of incoming calls are answered within 3 minutes. For referral visits, the average waiting time for non-prioritised referrals in 2006 was 23.5 days. (The first 7 days is taken up in handling the referral, before it is passed to the clinic, so the actual time taken from when the referral is made to the clinic until the patient actually visits us is only 16.7 days on average).

Adherence to drug treatment: Available international studies show that adherence to recommended treatment with 5-ASA-preparations (an important maintenance treatment) is as low as 30–50%. Our records show 68% of patients with total ulcerative colitis have taken out from the pharmacy more than 70% of their prescribed dose, and for left-sided colitis the figure is 58%.

Medical: The number of hospitalisations of patients with inflammatory bowel disease decreased 48% during the period 1998–2005, compared to the nationwide decrease of 4% reported by the National Board of Health. Our clinic has moved from above the national average of in-patients per 100,000 residents to being almost half the national average during this period (see figure 14).

The number of unscheduled visits of patients with flare-ups in their condition decreased from two a day in 2001 to two a week in 2005, mainly, we believe, because patients are taking more responsibility for their own care and therefore are contacting us much earlier when there is a flare-up in their condition, before they become really ill.

Medical quality: We have used as an important medical target that 95% of the patients should have a Hb > 120 – this has been achieved for 97% of patients with ulcerative colitis and for 94% of patients with Crohns disease. We know that the use of haemoglobin levels as a quality indicator is not widely accepted; however, we know from several studies that anaemia frequently follows on from IBD – indeed, in some studies 30% of patients are anaemic. The number of patients with anaemia should therefore be an indicator of the unit's ability to discover and treat anaemia, so that being able to keep this number low is probably an indicator of quality.

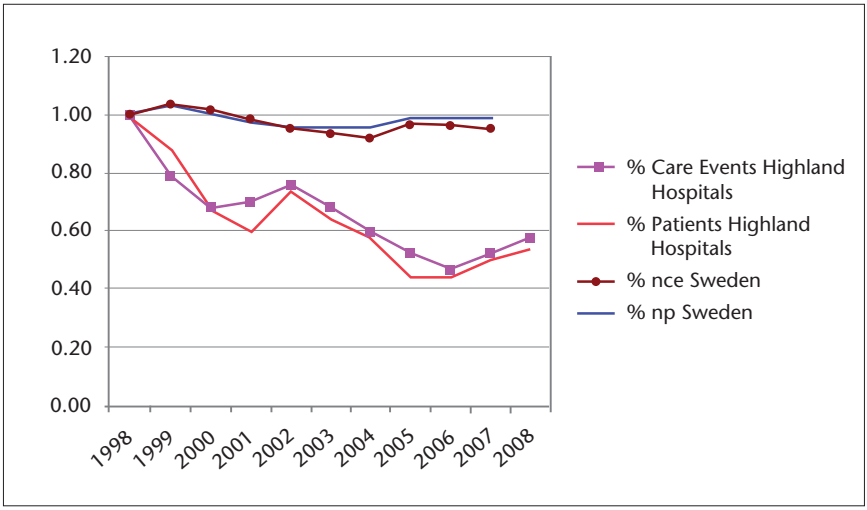

Figure 14: Highland Hospital has about half the Swedish average of hospitalisation of patients with bowel disease – and it has fallen rapidly since 1998

Costs and savings

The key determinant of the costs of the unit is the size of the ward – the number of beds for in-patients. In the years after 2000, it seemed likely that the increasing number of in-patients would mean that the ward would have to be increased substantially in size. However, this new way of working has made that unnecessary. In fact, the number of hospitalisations of patients with inflammatory bowel disease decreased 48% during the period 1998–2005. In consequence, the unit has been able to remain within budget since that time. Not only have we saved the costs of expanding the ward but we have been able to devote far more of our staff time to helping those patients with chronic but non-acute conditions, so that their quality of life is substantially improved and their risk of flare-ups of the condition are reduced.

Learning points

What has made the project particularly successful is the fact that we have been able to improve care both from the perspectives of the patients and from that of the staff – indeed, all involved have been winners.

Ensuring that this is the case has meant continuous monitoring of how the system is working. Every week, staff meet to plan the schedule for the coming weeks and to sort out any problems identified – this ensures that all staff are involved on a regular, systematic

fashion, assuring the process and demonstrating their commitment to the philosophy underpinning it.

Basically what we did was to change the way we delivered healthcare to a model which is consistent with our views on how anyone should behave toward a fellow human being. To avoid "dropping back" to the traditional repressive way of behaving, we had to discuss and agree the basic values we believed in amongst the staff. We also had to discuss with our patients how we wanted to change the "rules of engagement" – although, in practice, this proved to be a minor problem, as it turned out that they were very keen to work with us in this way.

The most important lesson to us, in the end, was that patients do not cause the healthcare system to «overflow», when they are put in charge. On the contrary, patients are rational people, so they don't seek health care when their needs have been met. Basically, they use the system responsibly to improve their own health, and in so doing they decrease the unnecessary calls on the time of physicians and nurses. Actually, the results seem to be better when the patients are in charge than when we in the healthcare system try to force patients to do what we think they should.

For further information, see case study at www.govint.org/best-practice/case-studies

On the transformation road: Challenges and opportunities for local councils and health

What co-production will mean for health and social care planning and provision in Scotland

Gerry Power, *Joint Improvement Team, Scottish Government*

Context

Data from the General Register Office for Scotland (GROS, 2010: 22) suggests that Scotland will experience increases of 50% in its population of over 60 year-olds and 84% in the over 75s between 2008 and 2033.

Estimates suggest that if current models of care are to meet the consequential growth in service demand then Scotland's care budget for older people will need to grow from its current base of £4.5 billion to £5.6 billion by 2016 and £8.0 billion by 2031 (Joint Improvement Team 2011: 10). This is, however, against a wider economic backdrop where the Chief Economic Adviser to the Scottish Government (Scottish Government, June 2010: 10) suggests a shortfall in the Scottish public purse of £39 billion over the next 16 years.

The inevitable challenge facing public sector organisations in Scotland, therefore, is how they respond to a significant increase in service demand during a period of sustained decline in their financial resources.

In responding to this the Scottish Government Ministerial Strategic Group on Health and Community Care has developed a 10 year change programme for 'Reshaping Care for Older People' (Joint Improvement Team, 2010) which promotes the development of co-production and community capacity building as one of the key work-streams to be taken forward in addressing this economic and demographic challenge.

In driving this programme forward, the Scottish Government has 'put its money where its mouth is' by creating a four year older people's services Change Fund of about £70 million per annum as a catalyst in achieving the necessary shift in service models and organisational mindsets.

In support of the co-production and community capacity-building work-stream, the Joint Improvement Team (JIT), which is co-sponsored by the Scottish Government, the Convention of Scottish Local Authorities (CoSLA) and NHS Scotland, has appointed two National Leads to assist the 32 locally based Partnerships across Scotland (including NHS, councils, third and independent sector organisations) to develop their responses.

Policy influences

The inclusion of co-production as a central plank in Scottish Government health and social care policy has been significantly influenced by the work of Sir Harry Burns, Chief Medical Officer for Scotland, through his promotion of Aaron Antonovsky's philosophy of *salutogenesis* (Scottish Government, December 2009: 11) as a basis for developing an 'assets-based approach' in planning and delivering health and social care in Scotland. It also links to the "person-centered ambition" outlined in the Healthcare Quality Strategy for NHS Scotland (Scottish Government, May 2010). This promotes a healthcare model for Scotland based on *'… mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making …'* (ibid: 7), all of which clearly resonates with definition of co-production of Boyle and Harris (2009: 11)

This 'mutual' approach to service delivery was reinforced in June 2011 by the publication of 'The Commission on the Future of Delivery of Public Services Report' (Christie, 2011) which encapsulated the challenge facing public services as "*… unless Scotland embraces a radical new collaborative culture throughout our public services, both budgets and provision will buckle under the strain…"* (Christie, 2011: viii)

In order to achieve this, Christie (2011: 26) argued for urgent and sustained reforms of public services in Scotland with the first key objective being *"… to ensure that our public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience …"*

Christie clearly references the principles of co-production as the basis for this objective and points to examples such as the Self-Management Fund operated by Scottish Government and the Long Term Conditions Alliance in Scotland (LTCAS) as examples of achieving co-production through 'personalisation' i.e. user-led service planning and provision. Christie cites research by Alzheimer Scotland in 2010 which demonstrated "*… when empowered to direct their own support, families effectively combine state resources around their own natural supports to create truly personalised support …*" (ibid: 26)

Government's response

In its response to Christie, *Renewing Scotland's Public Services*, the Scottish Government has embraced many of the commission's recommendations and recognises the need for public service reform including that of closer collaborative working between services and the individuals and communities they serve, i.e. *"… the focus of public spending and action must be to build on the assets and potential of the individual, the family and the community rather than being dictated by organisational structures and boundaries. Public services must work harder to involve people everywhere in the redesign and reshaping of their activities …"* (Scottish Government, November 2011: 4).

Commitment to this approach has been further evidenced by confirmation of the Older People's Change Fund over the spending period 2012/13–2014/15 and the

publication of a National Strategy for Housing for Older People with clear links to this agenda (Scottish Government, December 2012).

Two new Change Funds which seek similar results in early years intervention and reduced reoffending have also been announced.

From the perspective of early years intervention this builds on the three linked social policy frameworks of *Achieving Our Potential* (Scottish Government, November 2008); the *Early Years Framework* (Scottish Government, January 2009) and *Equally Well* (Scottish Government, June 2010) which adopt an assets-based approach in tackling inequalities impacting on the development and future life opportunities for children. This is also consistent with Government's support for programmes such as the Family Nurse Partnership Programme in Scotland, phase one of which has recently been evaluated (Scottish Government, July 2011).

Practical opportunities and challenges

As recognised by Sigerson and Gruer (2011: 1), in their recent paper on asset-based approaches to health improvement, the size of this investment means "… *the challenge now is to assess the impact and cost effectiveness of assets based approaches in Scotland within a robust and sensitive evaluation framework …*"

Whilst it is acknowledged that there is some evidence that co-production and assets-based approaches do contribute to the wellbeing of individuals and indeed financial bottom lines (Loeffler and Watt, 2009; Sigerson and Gruer, 2011) this is mainly qualitative and it is difficult to make precise links between the cause and effect of investment in co-production with its specific impact on health and financial outcomes. The need for an explicit evaluation methodology which can legitimise this approach is therefore clear and authors such as Sigerson and Gruer (2011: 6–7) have reflected on the form this might take.

One method, which has been used by public health and health improvement specialists for some time, is that of Contribution Analysis. This is currently being explored by the JIT in line with guidance published by the Scottish Government (December, 2009). The method was originally developed by John Mayne in 2001 "… *for situations where designing an 'experiment' to test cause and effect is impractical. Contribution analysis attempts to address this head on by focusing on questions of 'contribution', specifically to what extent observed results (whether positive or negative) are the consequence of the policy, programme or service activity*…" (ibid: 1). Unlike conventional cause-effect analysis this method does not attempt to prove that any one factor, e.g. a policy, 'caused' a specific outcome but rather builds a credible 'performance story' demonstrating the influence certain activities have had in driving change, possibly along with other factors. Work on using this methodology is at an early stage and the author hopes to report further progress during 2012.

The 'logic' of co-productive approaches in helping to address the supply/demand gap in health and social care in Scotland would appear to be increasingly recognised by partnerships. The practicalities of implementation are, however, proving harder to realise. JIT has identified that one reason for this is a lack of a logical process or 'toolkit' which

can support partnerships develop co-production in and between their organisations and the communities they serve.

Working with *Governance International* JIT therefore commissioned a programme of training opportunities to help partnerships develop practical approaches to co-production in their areas. This programme commenced in January 2012 and will continue to be rolled out over the next 12 months.

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Public health – for the public, by the public

Cllr Edward Davie, *London Borough of Lambeth, Chair of the Lambeth Council Health and Adult Social Services Scrutiny Committee*

If ever there was a time to shift from top-down health and social care design and delivery to a more efficient, personalised, co-produced model, the time is now.

A good society empowers its citizens and the evidence suggests that services designed and delivered by the people who use them, properly resourced and trained, are far more efficient.

But the sad truth is that despite all the government's 'big society' rhetoric it is private companies who are getting the work to support the new commissioning structures, not service users, voluntary groups and social enterprises. In London alone, Clinical Commissioning Groups have been strongly encouraged to use private consultants to deliver their support – so much for the 'free market', let alone 'no decision about me without me' and the promised end to 'top-down reorganisation'.

Despite central government's disingenuousness, in Lambeth our 'co-operative council' approach is delivering real, resourced devolution, whilst in my day job with NSUN network for mental health, it is an approach we want to develop England-wide.

Lambeth's NHS and Public Health Commission, which I chair, is set to recommend a number of changes that aim to devolve power to service users, because the evidence we have heard shows that it is best for them and best for the public finances.

One of our commissioners, Nicola Kingston, a public health manager in Hammersmith and Fulham, as well as Lambeth LINk co-chair, has helped to design a community health champion programme as part of the *Well London* scheme and has found it has improved the health, sense of community, employability and confidence of many in the deprived White City ward.

It began with people from the area being asked at a public meeting, arranged in partnership with the tenants association and other local groups, what their needs were. Then, in conjunction with the Primary Care Trust and other agencies, 40 volunteers, most of them unemployed people from the estate, were trained to Public Health NVQ Level Two. The assessment they undertook resulted in exercise classes, smoking cessation sessions, healthy eating workshops and a range of other resident-led initiatives. The University of East London evaluation called this White City health champions project the 'jewel in the crown' of the *Well London* programme.

The White City project has involved over 2,000 people, with the result that 82% now make healthier eating choices, 85% take more exercise, 79% feel more positive about their life and the same number have a better understanding of their mental wellbeing. In addition many of the volunteers have got qualifications for the first time, found jobs and started related businesses like exercise classes.

In mental health and social care the challenges and opportunities are, if anything, even greater, though of course mental and physical health are intrinsically linked.

NSUN is currently helping the joint Director of Commissioning for the London Borough of Hackney and its PCT cluster to develop a network of mental health service users to act as an advisory panel to those commissioning services in the future.

Already workshops have involved scores of service users designing what such a network should look like, how it should work and what resources it should get. This process alone has engendered a sense of community, peer-group support and self-confidence in many participants. If it continues to be properly resourced and listened to, the network will provide expert, service user-led guidance to commissioners, who will in return produce more efficient services based on the actual needs of service users, rather than what has been deemed appropriate in the Town Hall or PCT office.

NSUN aims to develop these kinds of groups across England where they can support each other, develop their own skills and design and deliver the services they use. We are exploring other ways of empowering service users by, for example, producing a service user-led personalised budget management system. Personalised budgets are set to be rolled-out nationally but not all individuals can cope with this sort of responsibility – indeed some mental health problems are the direct result of, or are exacerbated by, an inability to budget properly in everyday life. For those people a management system delivered by well regulated and supported fellow service users could be a way of having the benefits without the stress and potential pitfalls.

Turning Point, the health and social care third sector organisation, has a Connected Care model, which involves the community in the design and delivery of integrated health and wellbeing services. Local people are trained and paid to carry out a detailed audit, and with the assistance of frontline staff and commissioners, conduct a service redesign and cost-benefit analysis in order to make the business case for change. This leads to bespoke services which are inherently more efficient, because the service is so closely tailored to need and the community is automatically engaged.

Prospective modelling of a Connected Care service redesign proposal in Basildon (undertaken by the London School of Economics), suggests that for every £1 spent, £4.44 could be saved through reduced demand on public services, rising to £14.07 when the value of quality of life improvements are included.

This approach is backed by John Middleton, vice-president of the UK Faculty of Public Health and Sandwell public health director, who has started similar projects in his area and told me that this was the most efficient way of arranging local services.

Lambeth's co-operative model intends to embrace these ways of working in health and social care for the good of our service users and the wider community through a better use of dwindling resources. Partners in the voluntary sector, like NSUN, can help bridge the gaps between people and institutions like councils, PCT clusters and clinical commissioning groups.

The evidence suggests that if councils, facing bleak financial times, help the public to co-design and co-deliver public health then there are opportunities to improve wellbeing and reduce demand on costly services in a truly virtuous circle.

Changes to public health governance: An opportunity for improved local engagement

John Tatam, *John Tatam Ltd* and Associate, *Governance International*

Public health has never had the glamour of mainstream medicine; there are no popular Saturday night television series devoted to environmental health officers or epidemiologists. Yet it is universally accepted that public health measures in the nineteenth century, notably improved sanitation, made the greatest contribution to improvements in health.

Today, despite dramatic progress, there remain startling differences in health outcomes not only between areas of the country – women in Kensington and Chelsea can expect to live ten years longer than those in Manchester – but also within a single local authority area – life expectancy across the wards in Westminster varies by a staggering 17 years. Indeed, it is sometimes said that travelling east from the City of London, you lose one year of life expectancy for every tube stop: having commuted for years from West to East London, it certainly sometimes felt like that. There is clearly a big job still to be done in improving public health and reducing health inequalities.

Among the clamour and confusion surrounding the Health and Social Care Act one proposal has been widely supported – to give local authorities the duty to improve the health of their local populations and to be responsible for improving the strategic coordination across local NHS, social care, children's services and public health.

Local authorities as leaders on public health

There are several reasons why local authorities are well placed to take on this role:

- They are enthusiastic – many have often looked back wistfully to days when local authorities had a much greater involvement in health provision. A total of 134 out of 152 top-tier authorities volunteered to become 'early implementers' of Health and Wellbeing Boards (discussed below).
- They already have a duty to promote the 'social, economic and environmental wellbeing' of their areas.
- Determinants of public health are broad (for example, housing, environmental health, economic development, transport or school meals). Local authorities can take a much more wider-ranging view than any other agency of what services will impact positively on people's health, and combine traditional 'public health' activities with other activity locally to maximise benefits.
- Since around 2000, most local authorities have had experience of leading Local Strategic Partnerships (LSPs) which brought together a range of public agencies such as the police, health, and local colleges with business and community representatives to take a strategic view of ways to deliver the wellbeing agenda. Although LSPs have been abolished or mothballed in many areas, this experience remains invaluable and similar partnerships are likely to be reincarnated in some form in the future.

- They are focused on localities. Local authorities should know their communities and be concerned to map their changing composition.
- A desire to engage with local communities is central to a local authority's activity and perhaps offers the greatest potential for new approaches to public health offered by the changed responsibilities.
- Finally, local authorities exist and provide a core of stability at a time when all other structures, including the Clinical Commissioning Groups (CCGs) are still very much in flux.

Health and Wellbeing Boards

Local authorities will exercise their new responsibilities through Health and Wellbeing Boards (HWB). These will be responsible for producing joint strategic needs assessments and developing a joint health and wellbeing strategy for their local area. Boards will be comprised of:

- at least one local authority councillor;
- the director of adult social services for the local authority;
- the director of children's services for the local authority;
- the director of public health for the local authority;
- a representative of the local HealthWatch organisation (which represents patients) for the area of the local authority;
- a representative of each relevant commissioning consortium;
- such other persons, or representatives of such other persons, as the local authority ;thinks appropriate.

This feels like the right mix of representatives but there is of course a huge difference between assembling the right bodies and forming effective partnerships; those who experienced the Joint Consultative Committees (JCCs) established in the 1970s will know of the dangers of 'talking shops'.

The HWBs will be bringing together people with very different experiences, cultures and expectations – and perhaps – suspicions of each other. Public Health has always had an ambivalent relationship with medicine; some Directors of Public Health are said to be unhappy with being channelled into local authorities; the interface between GPs and public health has never been easy and GPs' involvement in public health tends to be largely around disease management and early detection. There is little experience, and considerable suspicion about dealing with elected members.

Considerable time and effort will need to be spent to develop effective HWBs with robust governance arrangements. There are encouraging signs that in many areas that work is being done with the support of local authorities and national and local health organisations.

Concerns have been raised, by the King's Fund among others, that HWBs have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. For example, while consortia

must consult HWBs in drawing up their commissioning plan, there is no requirement for them to have regard to their views.

This is an important qualification, but ultimately for these new arrangements to work much will depend on establishing effective relationships. The right relationships can overcome bureaucratic limitations; no amount of legislation can compensate for an unwillingness to work together. So this underlines the importance of sufficient time and imagination being spent to forge such relationships. Local authorities have experience of this from their LSPs – the best of which have been excellent. Moreover, the growth of many effective partnerships between local police and local authorities in recent years should be an example to give us all encouragement.

Engaging with local communities

Local authorities are about locality. They have clear responsibilities for, and interest in, effectively engaging with their communities. The enhanced possibilities for engaging with local people that the greater involvement of local authorities in public health can bring is perhaps the most exciting element of the new arrangements. Improvements in public health, more than any other aspect of health, require people to be involved in changing behaviours.

The new arrangements under the Health and Social Care Act include the establishment of local Health Watch groups to represent the voice of patients and replace local patient involvement networks (LINks). Health Watch will be represented on the HWB. But engagement needs to go way beyond this 'representation'.

Mapping and understanding the community

Many areas are changing fast – particularly in cities. Levels of internal and international migration have been high. New communities can arrive and grow quite quickly, such as the Somalis in Bristol or the Portuguese in Boston, Lincolnshire. Understanding the diversity of an area and keeping on top of how it is changing will be an essential task for the HWBs. Different communities raise different public health challenges: heart disease in some Pakistani heritage communities; teenage pregnancy in some white working class girls. And effective ways to engage these different groups will also of course vary greatly. The 2011 Census results will provide an important base line but Censuses will always be out of date and too far apart to rely on completely.

From engaging to co-designing and co-producing

Although there are some impressive examples of effective national campaigns – Jamie Oliver's School Dinners being an outstanding example – if we want to change people's behaviour, then one of the best ways is to get peers to present the messages: Pakistani heritage women are likely to know the best ways to approach other Pakistani women; gay men are more likely to trust advice from other gay men.

For example, Lambeth established a peer education project to address high levels of teenage pregnancy. Groups of young people aged 14 to 19 delivered hundreds of workshops in local schools and colleges. The workshops were very well received by

students and staff, rates of teenage pregnancy have fallen steadily, and the peer educators have developed valuable skills and confidence. The full case study is at *http://www.govint.org/good-practice/co-production/*.

Lambeth ('the cooperative council') is also an example of an authority which has wholeheartedly embraced user and community co-production of public services. It is currently seeking to drive "community-led commissioned activities" in four pilot areas to explore neighbourhood approaches to designing and delivering public services. This includes building community capacity, so that residents can support their own needs assessment and move towards leading commissioning processes.

These examples are far from unique but illustrate the considerable potential for new and imaginative ways of involving local people in improving public health which the leadership of local authorities can promote and facilitate. It is an opportunity we should not miss in the debate about structures and responsibilities.

Five steps to making the transformation to co-production

Elke Loeffler and Frankie Hine-Hughes, *Governance International*

Earlier in this book a range of authors have discussed the principles of co-production and how important they are in a series of case studies in health and social care. This chapter moves beyond the conceptual importance of co-production and outlines a Five-Step change management model for embedding co-production within services and rolling it out across the organisation.

The inner ring in the *Governance International* Co-Production Star outlines our 5 Step Public Service Transformation Model for rolling out co-production across the organisation and its partnerships. This involves mapping existing co-production initiatives, focussing on those with the highest impact, involving the right people, inside and outside the organisation, who can make the strategy succeed, marketing it to the sceptics and growing it within and beyond the organisation.

Step 1: 'Map it!'

Figure 15: The *Governance International* Co-Production Star

If you don't know where you are,
how can you get to where you want to go?

It is crucial for an organisation to know how well it is doing at co-producing with its stakeholders. If you don't have an accurate picture of what's going on, you don't know the level of your service quality, you aren't able to build on existing co-production activities, and you will not be able to identify the potential for new activities.
Self-assessment workshops for managers, staff, and service users and communities can map existing co-production activities, looking at:

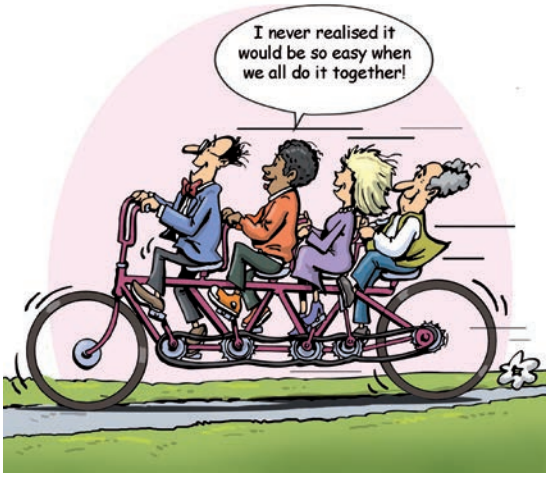


Figure 16: Are we nearly there yet?

- What's happening (initiatives that are already making use of co-production)?
- How much co-production is embedded in these initiatives? Who is involved?
- Where are there new opportunities? Where is co-production NOT being used, although best practice from national and international case studies suggests it might be?

These workshops should ideally draw on local databases showing how citizens are already engaged with public services – but actually this kind of information is rarely available. Another cost effective way to undertake this mapping process is through staff and citizen mapping exercises, exploring the level and quality of co-production in which they are engaged themselves. Such mapping exercises should separate the four forms of co-production co-commission, co-design, co-delivery, and co-assess (outlined in the Bovaird and Loeffler chapter earlier in this book). This allows for a more detailed and nuanced

picture of the current state of co-production. For instance, a local authority may have advanced levels of co-delivery, but may have very little co-assessment, so that it is not able to use good feedback from citizens in continuously improving service quality.

Governance International has devised a detailed mapping instrument, the *Co-production Explorer*, to help organisations to undertake a detailed and systematic mapping of co-production in their area. A short (and free!) 15 minute on-line version of the Co-production Explorer can be found at *http://www.govint.org/our-services/co-production/raising-awareness-and-getting-buy-in-for-co-production/*.

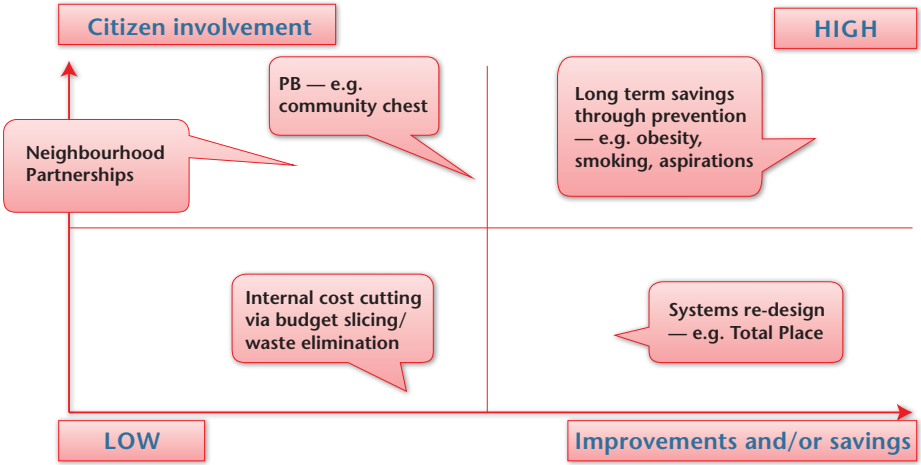
Step 2: Focus It!

Fools rush in!

Once you know where you currently are at with co-production, you can start to think how to prioritise your next steps. Generally, it would be foolish to waste efforts by trying to do too much, too quickly. Focus is critical. Moreover, in a context of fiscal austerity and open government, every penny of taxpayers' money is being scrutinised and therefore it is essential to be able to justify your activities. In step 2, the issue is how to focus strategically on the areas where co-production is likely to work best and be the most cost-effective way of achieving outcomes.

The Co-production Priority Matrix is a simple technique to help choose and grade activities, distinguishing which are priorities – and which can be dropped. Clearly 'quick wins' (high impact, low effort) are the obvious starting point – these can be used to establish success around projects that can then act as a catalyst, by attracting people who

Figure 17: Example of a Co-production Priority Matrix



want to be involved and to associate with success. Conversely 'hard slogs' (low impact, high effort) should be avoided as they will sap time, energy, resources, and are liable to alienate staff, service users and the community.

Beyond the 'quick wins', where the case for doing them is often obvious, it is usually important to develop a business case that sets out the potential for realising efficiency gains and improving outcomes. This is likely to be especially valuable for those co-production activities which involve significant spend or which mean a major change in direction in a service.

Step 3: People it!

'Get the right people on the bus and in the right seat' – Jim Collins

Step 3 asks the question of who's going to do it? How can you involve the right people in your organisation and in the community in your co-production activities? Involving committed, motivated, and skilled individuals will go a long way towards ensuring that co-production makes a big difference.

Surveys of citizens and community organisations are the best tool to identify which local people are already co-producing, what they are doing, what more they would be prepared to do, and how they want to get involved. *Governance International* first undertook such surveys in five European countries in 2008, on behalf of the French Presidency. In the last year, it has repeated these surveys in five English and Welsh local authority areas in co-operation with the Universities of Birmingham and Southampton – this approach is now catching on quickly.

Having marshalled this information, so that the right citizens and staff have been identified, who are either actual or potential co-producers, they need to be brought together to work with each other in co-production labs to co-design practical new co-production initiatives in which they themselves want to be engaged – this is the 'getting real' step!

These co-production labs need 'buy-in' not only from citizens but also from staff members – otherwise initiatives can be doomed before they have properly begun. Other stakeholders, too, can be critically important. 'Stakeholder Power and Influence' analysis can help to decide who to involve:

- **High Power – High Influence stakeholders:** should generally be treated as partners and champions, as they are central to the success of your initiative. Some, of course, may be 'potential enemies' – again you need to work closely with them, either to change their mindset or to offset their interventions, to limit any damage they might do.
- **High Power – Low Influence stakeholders:** tend to be 'arms length' to your decisions – but you should generally inform them and get their support, without over-involving them.
- **High Influence – Low Power stakeholders:** important to inform them of what you are doing, ensure they are appreciated, and encourage them to join in – if

they get annoyed about NOT being involved they may find ways of making such a fuss that they become 'High Influence – High Power' – with a very negative attitude.

- **Low Influence – Low Power stakeholders:** these are part of the 'silent majority' – it's important to find out what they think and to communicate to them why you are doing what you are doing – their fears and misunderstanding could reduce public support for what you are doing. However, this group is unlikely to provide much positive help in co-production.

As an example of what might be done after Stockport Council had involved users and carers in co-designing an improved website for adult social care, it engaged ten staff very closely to ensure they recommended the new website to social care recipients and their peers – and to other staff. This approach multiplied the impact of these 'early adopters', so that their example spread quickly through the authority.

Step 4: Market it!

Make it simpler for people to want to be involved, and stay involved!

Co-production can only work if the stakeholders involved are committed to making it successful. It is important to find ways of keeping them on board – and of attracting new people who want to join in. This means identifying attractive incentives and 'nudging' stakeholders to have a positive attitude towards co-production. The 'mother of co-production', Elinor Ostrom, stresses the need to find incentives to encourage inputs from both citizens AND officials. Incentives can be simple – like reinforcing a citizen's 'feel good' factor by thanking them for doing something good for others. Sometimes they may involve more formal mechanisms such as 'recognition awards'. Some public agencies even give especially active co-producers subsidised access to some public services (usually services with low marginal costs, e.g. free swimming sessions or free use of community centre rooms). To incentivise other stakeholders, celebratory events can be used or private sector sponsors can be given a promise of publicity. 'Nudges' prompt favourable individual behaviour by a positive reframing of people's perceptions of the outcomes from co-production – and the effort it involves.

One way of predisposing users and other citizens to take part in co-production is to promote co-production charters, which explicitly outline the roles, responsibilities, and incentives for service users, citizens, and staff. This can reassure potential co-producers that their commitment is close-ended and that any dangers concerned (e.g. in relation to accident insurance or potential charges for negligence) have been taken care of. It reminds them of their rights as co-producers (e.g. that they should not be coerced into co-production activities – these should remain something which they do willingly). It also shows in a powerful symbolic way that their effort is part of a wider movement, in which many other citizens are pleased to be involved, and that their efforts are appreciated by the public agency involved. Finally, it reminds people that they also have duties and responsibilities when they agree to be co-producers.

Step 5: Grow it!

Thinking big and scaling up

After getting co-production working in the services you have prioritised, it needs to be rolled out across your agency and partnerships.

Key to this will often be identifying and showcasing 'co-production champions', whose example can inspire others and who can help to mobilise other members of their communities.

Thorough service reviews where co-production is being used are likely to be an important mechanism to help you grow the influence of co-production. They help to identify how successful co-production initiatives have been and how they can be scaled up. Even more importantly, they can act as a catalyst, suggesting how similar approaches could be applied to other services, or in other areas. Of course, this is especially likely to work if a wide range of relevant stakeholders is involved in these reviews.

Management systems can also play an important part in helping to grow co-production. It's especially important that performance management and human resource management systems are aligned to ensure that staff are being given the right signals to work for sustainable co-production.

Furthermore, co-production roadshows can showcase successful initiatives to pass the message to more managers, frontline staff and, of course, service users and other citizens. What is especially powerful here is to get presentations from the people involved in the co-production – service users, other citizens and frontline staff – enthusiasts breed enthusiasts!

And if we may, we'd like to end this Five-Step model by recommending one more step than advertised…

STEP 6: JUST START !!!

Taking co-production forward – the challenges and opportunities

Laura Wilkes, *Local Government Information Unit*

As all authors in this book make clear, co-production in health and social care is not about service users looking after themselves; it's about them giving their time and using their skills to run their own care *with* professionals.

There are many reasons to believe that the co-production approach to public service delivery is essential – particularly if we are to tackle some of the big issues facing society today. This approach shouldn't be exclusive to health and social care, but should be at the centre of how local government will transform for the future. Indeed, the co-production and 'Big Society' approach to public service provision is at the heart of the government's political vision for local government service transformation.

Why the co-production approach?

We know that some of the problems facing society can't be tackled by governments alone – they are too complex in nature. Climate change and an ageing population, for instance, require citizens and government to work alongside each other to find solutions for the future. Co-production is essential for a series of reasons, principally: to innovate, ease pressure on the public purse and to encourage citizens and service users to take greater responsibility for their own lives.

Local authorities have a huge opportunity to transform their services – with citizens at the centre. Real innovation can come directly from the service user, who has the in-depth knowledge of what their requirements are and the best way to meet them. Opening up services to users will ensure that the right services are prioritized, and will give the space and opportunity to find new solutions to getting services right first time.

Let's not pretend that it is all about service improvement and innovation; we are in a reality where local government has to save money. Co-production is a credible means to generate free resource – one way of contributing to the massive savings that need to be made to the public sector purse. Tony Bovaird has written that co-production is about regular, long term relationships between service users, members of the community and service providers – where each make resource contributions. Co-production then, is a means through which local government can capitalise on the free resource that citizen involvement generates.

Finally, co-production should encourage citizens to take more responsibility in their own communities and for their own health. For a council to put recycling bins in place will be pointless unless citizens themselves take the time to use them. This is a simple example, but the principle is important. Citizens have to take responsibility for co-producing services, including their own care, if we are to find a sustainable way of delivering these services in the future.

Taking co-production forward

Local government has a key role in enabling and influencing co-production, by providing opportunities for participation. In doing this, local authorities should take advantage of the opportunities available.

Using the tools

There is a series of powers and opportunities that will be coming on-stream and available to local government in the next few months. The Localism Act provides many of these, in the shape of: the General Power of Competence, Community Right to Challenge and Community Right to Bid. Using the commissioning process in a different way and adopting a community budgeting approach also offer local authorities a way to involve communities, provide opportunities for them to participate and shape the priorities that are set.

Councillors as community leaders

The role of the councillor is evolving and changing every day. More and more councillors are seeing themselves as community facilitators and leaders of place; people who have the access and ability to bring together diverse sections of their communities to understand priorities and concerns. Councillors are the direct link between the local authority and community – as such, they are ideally placed to coordinate and facilitate opportunities for their communities to have meaningful involvement in the process of co-production.

Make it easy

There is no use in putting together opportunities for people to get involved, but offering these at times, or in places that are inaccessible. This is a basic point, but an important one. We should be making it as easy and attractive as possible for people to be involved in co-production; this should include making opportunities available at the right time and place, but also making the opportunity something that people will *want* to get involved in. The essential thing here is to tap into what people care about locally and what will encourage them to get involved (this is where councillors should come into their own – they will know what people really care about).

Communicating two-way with our communities

Local government should let the community understand what possibilities are available to them. Unless people know what their options are, including; examples of where involvement has led to something worthwhile, and information about the process of involvement in co-production, it may be difficult for people to fully understand the opportunities that involvement in co-production may bring. Of course, the other side is that we in local government need to be open to suggestions that may be presented by the community and service users. Not all suggestions will be great ones, but some will be gems, and you need to be willing to listen to them when they come along.

Bureaucracy is a real turn off – avoiding this wherever possible will remove barriers, and the perception of barriers, to small community groups getting involved in co-production activities, such as co-commissioning.

We know it's not that simple – the challenges

While there are many opportunities to adopting the co-production approach, it would be remiss to present it as an easy solution to a series of complex problems – we know that it's not so simple and that actually taking co-production forward is challenging. There are a series of things that local government and citizens will have to confront and work through in order for the co-production approach to flourish. These are not insurmountable challenges, but they are challenges that will take thought and consideration to work through.

Changing culture and mindset

An essential part of being able to take this agenda forward will be done through a change in culture and mindset – of local government officers and members, and within communities themselves. Councils have to create an environment where decisions are made differently and where new possibilities are explored. In this new culture officers and politicians will be encouraged to float new ideas, experiment, take risks and be open to learning from anything that does go wrong.

Communities will also have to adapt to this new landscape; the future will be much more about giving as well as taking from the state. In this new environment, citizens will have to take more responsibility for themselves and their surrounds – co-production is central to this. For some communities this will mean a huge shift in mindset, although for many others, it is already something with which they have significant experience. In either case, councillors and local leaders will be central in taking communities with them on this journey, and encouraging this new mindset to flourish.

Risk and accountability

We know that councils feel cautious about the new environment, and tend to be risk averse. In a recent LGiU survey, 50 percent of respondents described their council as 'risk averse' or 'very risk averse' and nearly 85 percent agreed that increased community participation will create new risks for the organisation.

This survey also asked council to rate types of community involvement in order of importance; 91 percent of councils said that co-production of services was very important or important. This came top of the list for what will be important to authorities over the next five years. However, when also asked how much risk they were willing to take in getting the community involved in specific services, respondents showed a low level of appetite for taking risk in adult services.

This suggests that although councils understand that co-production will be important moving forward, they are not necessarily yet prepared to take risks with aspects of health and social care services. Moving forward, this will have to change and councils will have to be prepared to take risks by letting the community get more involved in services.

Local authorities will have to be prepared to take risks, but also understand that with this, they will also have to be prepared for some services to fail. Plans will have to be thought through on how this will be dealt with, as the co-production approach also raises questions about the nature of accountability. If more and more citizens will be responsible for aspects of their own care alongside professionals, if and when things go wrong (and let's be realistic – sometimes they will), lines of accountability will have to be clear.

New skills

There is no doubt that the co-production approach will require a different skill set for communities. Local authorities will have to be mindful that communities will have different capacities to undertake co-production; some capacity building may have to form part of the process, which will require resource. Councillors too may need different skills, including facilitation and deliberation. They will also need to be prepared to manage competing community priorities and manage expectations.

Particularly in relation to personalisation and social care staff, a significant challenge will to be to understand what the implications of personalisation are on the way that they work, how they deal with service users and what this will mean for their role in the future.

The future

The future delivery of health and social care services is changing; it has to transform in order to meet the needs of future generations. There are some big questions that still need to be confronted – not least, future funding. But there are steps that local authorities, councillors and communities can take now in order to start this transformation process. Co-production is one of these steps; and working through the challenges and opportunities above will enable councils to move forward.

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LGiU
LOCAL GOVERNMENT INFORMATION UNIT

Governance International

2nd Floor, 3 Brindley Place
Birmingham, B1 2JB
United Kingdom

Phone: (0044) (0)121 698 8743
Fax: (0044) (0)121 698 8600
E-Mail: info@govint.org
Web: www.govint.org
Twitter: @govint_org

Incorporated in England & Wales as Company Limited by Guarantee No. 04488214.
VAT No. GB 100 4403 89

Local Government Information Unit (LGiU)

22 Upper Woburn Place
London, WC1H 0TB

Phone: 020 7554 2800
Fax: 020 7554 2801
Email: info@lgiu.org.uk
Web: www.lgiu.org.uk
Twitter: @LGiU