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FOREWORD

INTRODUCTION

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RESEARCH

PRACTICAL TOOLS

MULTIMEDIA

PEOPLE POWERED HEALTH CO-PRODUCTION CATALOGUE

FOREWORD

At Nesta we're interested in testing radical solutions to social and economic challenges. We think co-production is potentially transformative and its power comes from re-framing the problem and re-establishing relationships to enable more holistic and people-centred approaches. Co-production can also tackle the lack of trust between some users and professionals, a dependency culture where people look to the state to solve their problems and a culture of expertise where professionals are trained to be the sole source of solutions. At its best, co-production can build people's capacity to live the life they want, in the community where they live.

This catalogue of co-production has been created as part of Nesta's People Powered Health programme run with the Innovation Unit. People Powered Health is a practical innovation programme, to explore how co-production can support people living with long term conditions. We're particularly interested in how to move co-production from the margins to the mainstream. Part of achieving that shift will involve a better understanding of what co-production can achieve and what it looks and feels like on the ground.

The catalogue, therefore, brings together some inspiring examples of collaborative public services in action, with a particular focus on health and social care. Each case study has been assessed against the Nesta and **nef** principles of co-production. This is done in the spirit of exploration rather than judgement – many of the case studies were never meant to represent co-production so it is no surprise they are stronger on some principles than others. The idea is to use these pioneering examples to increase our collective understanding of what co-production is and to raise our sights of what is possible.

To realise the potential of co-production we need to be able to explain it clearly and to build the evidence of what it can achieve. Our hope is that this catalogue contributes to these aims and stimulates some new ideas about how to use co-production to develop truly people powered public services.

Halima Khan

Director, Public Services Lab, Nesta

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INTRODUCTION

This catalogue was commissioned by Nesta to support the People Powered health programme sites and produced by **nef**. It brings together a range of case studies, resources and other information on co-production in health settings as well as in other sectors, in the UK and internationally. The purpose of the catalogue is to enable practitioners to reflect on their own practice and the extent to which that represents co-production; and to enable them to learn about co-production practice. The introduction is structured to help you to navigate the catalogue and provides some materials and questions for you to think about when you read through the case studies.

How to use this catalogue

The catalogue has been designed to present a range of successful and inspiring co-production activities. There are a number of ways to access the case studies.

The first page of the Case Studies section presents a brief summary of each case study so you can see what they are about at a glance. We have also used a visual ‘wedge’ to show the depth of co-production and the extent to which the case study is showing progress against the six principles of co-production.

At the beginning of each case study we have included some ‘Keywords’. These are words associated with existing professional practices being developed by the People Powered Health sites – for example, health trainers, self-management, time banks and navigators. At the end of each case study we recommend other examples of related practice that might also be of interest to you.

Though you can navigate by approaches that you are familiar with, we have sought with each case study to draw out key learning, opportunities for replication and broader relevance to co-production. Given sufficient time, reading the case studies in their entirety will help strengthen and deepen your understanding of co-production.

The **resource section** that covers the last three tabs is designed to provide a shortlist of the best websites, reports, evaluations, implementation guidance, short films and tools relevant to co-production, and the professional practices outlined by each of the keywords throughout the case studies. This is organised by the type of resource; Research and publications; Practical guidance and tools; Multimedia.

What co-production is and isn't

The following definition of co-production was developed by nef and Nesta, in partnership with the co-production practitioners' network:

“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.”

Along with this definition, it was also recognised that co-production is underpinned by six principles. These are common features of much co-produced support, and where all of them come together in one organisation they represent truly transformative co-production.

1. **Assets:** transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services.
2. **Capacity:** altering the delivery model of public services from a deficit approach to one that recognises and grows people's capabilities and actively supports them to put them to use at an individual and community level.
3. **Mutuality:** offering people a range of incentives to engage with, enabling them to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
4. **Networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
5. **Blur roles:** removing tightly defined boundaries between professionals and recipients, and between producers and consumers of services, by reconfiguring the ways in which services are developed and delivered.
6. **Catalysts:** enabling public service agencies to become facilitators rather than central providers themselves.

Many of these principles are distinct practices in their own right, and some – such as peer support and asset-based approaches – also have their own emerging evidence base. Although we will explore each of these principles within the catalogue, we recognise that it's only when they come together that the service is fully co-produced.

Another helpful way of thinking about what co-production means in practice is to be clear about what co-production is not. Co-production has emerged from a rich and diverse literature and practice; today it has parallels, for example, in asset-based community development. However, there has been some confusion between co-production and service-user design, user 'voice' initiatives and consultation exercises. Although co-production encompasses all of these things, it cannot be reduced to any one of these approaches. To fall back on a well-worn cliché, the whole is greater than the sum of its parts.

At its most basic, co-production of public services is about 'action', for example people (including professionals and people who use services) coming together and producing a service or an outcome through the medium of public services.

As the basic grid on page 5 depicts, voice-based initiatives involve people expressing opinions and ideas to planning processes, but ultimately still only recognise professionals as capable of doing the work needed to deliver a service. Voice-based initiatives may be able to design better services than those that don't engage with people, but ultimately they are not aimed at unlocking the practical skills and capacities of people who receive services.

It is also important to note here the difference between co-production and 'self-organised' provision of support. Co-production requires a contribution in terms of time and resources from public service professionals as well as people who 'use' services.

	PROFESSIONALS PLAN	CO-PLAN	COMMUNITIES PLAN
PROFESSIONALS DELIVER	TRADITIONAL SERVICES	CO-DESIGNED	
CO-DELIVERY	CO-DELIVERED	CO-PRODUCED	
COMMUNITIES DELIVER	CO-OPTED		SELF-ORGANISED

Grid adapted from *The Challenge of Co-production*, David Boyle and Michael Harris

The way in which time and resources are contributed may well look different from more traditional service provision but it is essential that this contribution is present. In this way co-production is not a cover by which it becomes possible to withdraw professionals entirely from services.

Achieving depth and transformation through co-production

The term co-production is being applied to many different practices, including user-involvement in decision making, partnership-working across organisations, personal budgets and service consultation. Some of the ways in which the term is being used detract from the full potential that co-production can achieve as an approach which can transform the capacity, equity, and impact of public services. The **depth** of co-production can fall along a scale from fairly tokenistic user-involvement all the way through to a complete transformation of power relationships within services.

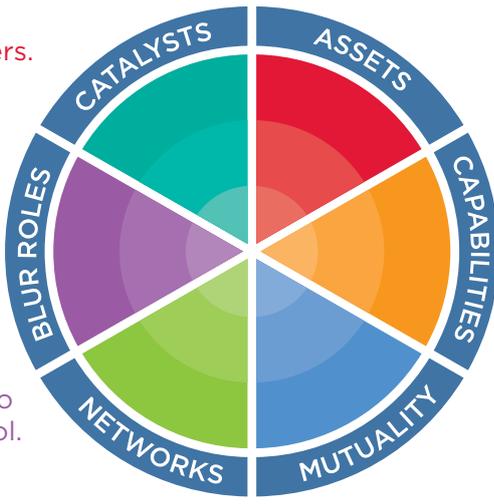
On the following pages we offer two ways of conceptualising co-production to help you determine a) the extent to which a service or project is being co-produced and b) the depth and transformative nature of co-production on a case-by-case basis.

We have also developed a series of critical learning questions that help you to reflect on your own practice; giving you the confidence to assess the current depth and extent of co-production in your service and to envisage how it might be developed even further. These questions appear on page 7 and are echoed in the case studies where relevant.

Recognising the extent of co-production

We have incorporated a visual representation of the six principles to make it easy to assess the extent to which co-production is taking place across them. This visual is based on an assessment tool, the co-production self-reflection tool, which sets out a series of policy and practice statements across the six principles. The case studies are reviewed to see to what extent they are engaging in all of the principles. Strength of engagement is indicated by depth of colour, so those areas where less activity is taking place will appear faded, and where no activity is taking place, the segment will be white. The self-reflection tool is included [here](#). The example on page 7 is one where a project or organisation exemplifies all the principles of co-production well. Where one or more of the principles are weak in the case study, we will point to how this could be developed in the text.

- Assets:** Transforming the perception of people from passive recipients to equal partners.
- Capabilities:** Building on what people can do and supporting them to put this to work.
- Mutuality:** Reciprocal relationships with mutual responsibilities and expectations.
- Networks:** Engaging a range of networks, inside and outside 'services' including peer support, to transfer knowledge.
- Blur roles:** Removing tightly defined boundaries between professionals and recipients to enable shared responsibility and control.
- Catalysts:** Shifting from 'delivering' services to supporting things to happen and catalysing other action.



Critical learning questions

This series of questions is intended to help you critically reflect on and assess the depth of co-production in the service you work in, and others you may come across. They have been adapted from the principles of co-production and colour coded to mirror the colouring of the visual tool. The questions are intended to support practitioners to direct their activities towards the most powerful application of co-production.

- 1. Assets**
Are people (and their families/carers) direct experiences, skills and aspirations integral to all services? Does all service design and delivery seek to build on and grow individual and community assets? Is progress against this tracked?
 - 2. Capabilities**
Are people's contributions vital to success? Does the activity and work required within the project get shaped to fit the skills and responsibilities of everyone involved? Is personal development a common expectation for everyone involved?
 - 3. Blur roles**
Do people have an active part in initiating, running, evaluating, directing and delivering projects? Do people work alongside professionals with their skills and opinions having equal weighting? Are people able to identify rewards that are valuable to them (not just money)?
 - 4. Networks**
Do projects see supporting peer networks that enable transfer of knowledge and skills as core work to be invested in? Do staff and people engage in activities that connect to local networks and activities beyond the remit of the service? Is growing networks outside the 'project' seen as a core activity?
- Mutuality**
Do people and staff know that it is their project? Do they each have an equal responsibility for it to run well? Is asking explicitly for and providing help from others is seen as positive and expected of staff and people? Are expectations of mutuality discussed when people become involved? Is a wide range of skills and experiences valued?
- 5. Catalysts**
The purpose of interactions is supporting people to live a good life. Do staff roles focus on connecting people to networks and resources to do this, removing

barriers where necessary and developing skills and confidence? Are people actively supported to do more?

Depth of co-production

Another useful typology of co-production has been developed by Catherine Needham and Sarah Carr. It suggests it is possible to understand co-production on three different levels; descriptive, intermediate and transformative. These descriptions represent a scale of how ambitious and transformative co-production can be.

1. Descriptive

At its least transformative, *co-production is used simply as a description of how all services already rely on some productive input from users*. This input may just involve compliance with legal or social norms such as taking medication, or not dropping litter. A descriptive approach to co-production simply describes the existing elements of public services that are co-produced, and therefore fails to acknowledge the potential for more effective use of the productive capacity of service users or communities.

2. Intermediate

Intermediate approaches to co-production *offer a way to acknowledge and support the contributions of service stakeholders, although without necessarily changing fundamental delivery systems*. Co-production may be used as a tool of recognition for the service users and their carers – acknowledging oft undervalued input and creating better feedback channels for people to shape services. The key difference between this and truly transformative co-production is that organisational cultures are unchanged. Indeed, this form of co-production is often led by a key member of staff, rather than being embraced by all members of staff equally.

3. Transformative

At its most transformative, *co-production requires a relocation of power and control*. New structures of delivery entrench co-production, and bring professionals and service users together to identify and manage opportunities to develop and deliver services. The culture of an organisation changes, embedding mutual trust and reciprocity between professionals and communities. The impact of public services is amplified as latent assets within the community, such as peer support, informal care networks, and faith and civil society groups, are supported to flourish.

We have used this typology in each case study to indicate where we think the examples are really transforming the service, and also where some of the principles could be developed further to really transform the service.

Acknowledgements

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If you have any questions on the case studies please contact joe.penny@neweconomics.org

CASE STUDIES

RICHMOND USERS INDEPENDENT LIVING SCHEME (RUILS)

[LINK](#)

A user-run and led organisation providing adult social care services in Richmond, London. RUILS helps from taking the first steps, to employing a Personal Assistant through to pooling personal budgets collectively with others.



KEYWORDS

Co-design | Personalisation | Information | Advice and Guidance

SERVICE USER NETWORK (SUN)

[LINK](#)

A support network developed for and by people who have long-standing emotional and behavioral problems (personality disorders) in Croydon. The SUN model sees the community as a doctor and aims to expand people's coping strategies by bringing peers together to support one another through a crisis.



KEYWORDS

Co-design | Self-help Groups | Care Planning

COMAS RECOVERY COACHING

[LINK](#)

Comas recovery coaching links a person with experience of recovery to someone in recovery from severe alcohol or drug problems. The coach is in recovery themselves, enabling them to offer insight and to understand the context of the individual they are mentoring.



KEYWORDS

Motivational Coaching | Experts by Experience

Patient Education in Groups

ECDP SOLUTIONS (FORMERLY ESSEX COALITION OF DISABLED PEOPLE)

[LINK](#)

A user-led organisation delivering, and influencing local authority policies about support planning and promoting the active involvement of people in their own support planning.



KEYWORDS

Care Planning | Personalisation | Personal Budgets

Shared Decision Making

SHARED LIVES PLUS (SL+)

LINK

SL+ organisations match vetted and trained Shared Lives carers with adults looking for practical and emotional help to live fulfilling lives in an ordinary family household. Participants are 'matched' to ensure compatibility and shared interests.

KEYWORD

Personalisation



KEYRING LIVING SUPPORT

LINK

KeyRing Living Support sets up a series of local networks which provide mutual support for independent living, and links into other local networks and resources.

KEYWORDS

Personalisation | Navigation | Information | Advice and Guidance



LOCAL AREA COORDINATION (LAC)

LINK

The LAC approach helps keep people strong, rather than waiting for a crisis before intervening. Rather than defining people by their needs and the services they use, LAC asks people what sort of lives they want to lead and then supports them to achieve their aspirations.

KEYWORDS

Information | Advice and Guidance | Prevention



NURSE FAMILY PARTNERSHIPS (NFP)

LINK

NFP pairs young first-time mothers in high-risk groups with nurses to improve the well-being of mothers and their children. By developing strong relationships, and providing effective support and coaching on a wide range of issues, NFPs have demonstrated impressive short-term and longitudinal results.

KEYWORDS

Prevention | Patient Mentoring | Well-being Coaching



Colour key: Assets Capabilities Mutuality Networks Blur roles Catalysts

PARTNERSHIPS FOR OLDER PEOPLE PROJECTS (POPPS)

[LINK](#)

POPPS aimed to promote the health, well-being and independence of older people, and prevent or delay their need for higher intensity or institutional care.

KEYWORDS

[Signposting Information](#) [Telephone Coaching](#)



FAMILIES AND SCHOOLS TOGETHER (FAST)

[LINK](#)

FAST is a programme with a strong assets focus that explicitly encourages reciprocity between participants. It is based on building relationships across family, schools and community and has addressed issues including teenage pregnancy and 'troubled' families.

KEYWORD

[Self-help Groups](#)



HOMELESS HEALTH PEER ADVOCACY (HHPA)

[LINK](#)

HHPA recognises the importance of using the lived experience of people who have been previously homeless in improving access to health services. Westminster PCT, in partnership with others, is recruiting, training and working with peer advocates to improve homeless people's experience of health services.

KEYWORDS

[Experts by Experience](#) [Information](#) [Advice and Guidance](#)
[Signposting Information](#)



FLEXICARE AT THE HOLY CROSS CENTRE TRUST (HCCT)

[LINK](#)

HCCT has extended an existing time bank at the Centre to incorporate the provision of a 'flexicare' service, which supports people to stay independent in their own homes by providing low-level care and support.

KEYWORDS

[Time Banking](#) [Prevention](#) [Personal Budgets](#)



Colour key: **Assets** **Capabilities** **Mutuality** **Networks** **Blur roles** **Catalysts**

HEADWAY EAST LONDON

[LINK](#)

Headway East London is a leading centre of support for people with an acquired brain injury (ABI). Everyone is encouraged to define meaningful roles and responsibilities that they can make their own; their skills, capabilities and interests are given space to flourish through professional and peer support.

KEYWORD

Time Banking



SKILLNET GROUP, KENT

[LINK](#)

The Skillnet Group supports people with and without learning difficulties to work together equally to make a difference. Their aim is to support people to make independent and informed choices about their lives, and work together with staff to develop projects and support networks which build on people's own interests, skills and capabilities.

KEYWORD

Personalisation



WAVERLEY CARE LIFE COACHING PROGRAMME

[LINK](#)

Waverley Care Life Coaching Programme provides support for people living with Hepatitis C and HIV, based on a life coaching model. The programme has demonstrated improvements in outcomes for participants across health and well-being measures.

KEYWORDS

Motivational Coaching Well-being Coaching



ROUTES OUT OF PRISON (ROOP)

[LINK](#)

RooP is a peer support project for returning prisoners. RooP offers participants access to life coaches who support them in linking to services in the community.

KEYWORD

Motivational Coaching



Colour key: Assets Capabilities Mutuality Networks Blur roles Catalysts

THE LEICESTERSHIRE & RUTLAND PROBATION SERVICE HEALTH TRAINERS

[LINK](#)

The Leicestershire & Rutland Probation Service Health Trainers is for ex-offenders and aims to improve take up of health services and promote behaviour change among the ex-offender community. The health trainers have personal experience of the criminal justice system.

KEYWORDS

- Social Prescribing
- Experts by Experience
- Health Trainers
- Information
- Advice and Guidance



THE BRADFORD HEALTH TRAINER AND SOCIAL PRESCRIBING SERVICE

[LINK](#)

BHTSP funds health trainers who spend time in local GP practices, supporting people to gain skills and employment, and find community-based solutions for a range of conditions.

KEYWORDS

- Social Prescribing
- Navigation
- Health Trainers



THE RECOVERY EDUCATION CENTRE (REC) NOTTINGHAMSHIRE

[LINK](#)

REC enables people to become experts in self-care and recognise their role and experience as equal to that of mental health professionals. There is a strong assets-based approach that has what people can do at its heart.

KEYWORDS

- Self-management
- Well-being Coaching



THE CHRONIC DISEASE SELF-MANAGEMENT PROGRAM (CDSM)

[LINK](#)

The Chronic Disease Self-Management Program (CDSM) was set up by Stanford University's School of Medicine, and is a community based self-management programme for people with a chronic illness. People with chronic conditions are involved in designing and delivering the training at all levels of the programme.

KEYWORDS

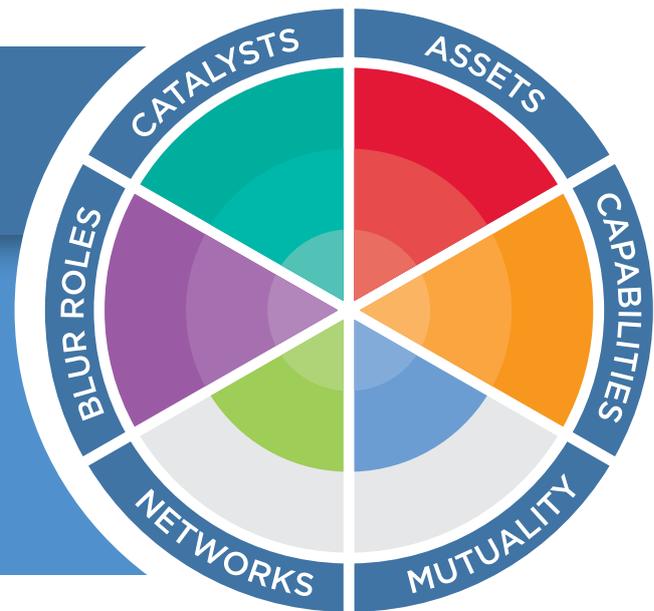
- Self-management
- Co-design



Colour key: Assets Capabilities Mutuality Networks Blur roles Catalysts

CASE STUDY 1

Richmond Users Independent Living Scheme (RUILS)



KEYWORDS

Co-design

Personalisation

Information

Advice and Guidance

SUMMARY

RUILS is a user-run and led organisation, providing adult social care services in Richmond, London. RUILS supports older people, and people with learning difficulties and mental health challenges, to live independent lives in their communities. They work in particular to ensure that people who receive direct payments and personal budgets get the best possible outcomes from the care they purchase. RUILS helps people in a range of different ways, from taking the first steps to employing a Personal Assistant, to getting involved in peer support networks, to pooling personal budgets collectively with others.

KEY LEARNING

- RUILS has developed a particular structure that enables people to make key strategic decisions that shape the development of the organisation at the highest levels. *Are service users able to make important organisational decisions in the service you work in?*
- RUILS provides services which bring people together to pool their skills, knowledge and resources. *Do the services you work for enable people to link up and support one another? Are people supported to collaborate with one another to improve their health or social care outcomes?*

MORE ABOUT RUILS

RUILS began life as a grass roots organisation lobbying for direct payments in adult social care. Today it is a well-organised charity and co-producer of services. It provides its users and their friends and families with opportunities to take an active part in how its services are run and led through its membership scheme. Although people can access RUILS' services without being a member, membership enables people to have a greater say in how the organisation is run. Currently, over 70 per cent of the board of directors is made up of service users.

There are three levels of membership. The first level, full membership, is available to older people, people with disabilities, people accessing mental health services, parents of disabled children and carers eligible for their own social care support. Full members have voting rights and can be elected onto the board of directors. The second level, associate membership, is available to non-disabled relatives, friends, advocates and close supporters of a full member or the RUILS organisation. Associate members do not have a right to vote but may serve as a co-opted Trustee. The final level, corporate membership, is available to all other user-led organisations working with similar groups in the Richmond area.

From this strongly user-oriented platform, RUILS provides a range of social care services for adults, focusing on groups that receive direct payments and personal budgets. These range from typical services which you might expect to find from an adult social care organisation, such as information and guidance, and advocacy and brokerage, to more developed and collective services such as the peer-to-peer support scheme and the pooling direct payments service.

The peer-to-peer support scheme was set up by RUILS as a way to better involve users in the running of services, and to tap into the skills, knowledge and expertise of their members which go beyond what members of staff can offer. In the peer-to-peer scheme, buddies act as one-to-one coaches, helping the person they support to overcome challenges and/or achieve a goal that is important to them. RUILS makes it clear that peer supporters are not there to take over or act as advocates; their role is facilitative.

RUILS also helps its users and members to pool their personal budgets. This enables people with personal budgets to increase their purchasing power, and also helps them to expand their social networks by bringing people together around activities that they enjoy. Pooling personal budgets is a good example of how a relatively individualistic policy can be made more cooperative, more co-produced and achieve better outcomes for people.

WHY IS THIS CO-PRODUCTION?

RUILS is a good example of how co-production can be embedded at both the organisational level and the service provision level. People who use the services, alongside their families and friends, are able to shape key strategic decisions through their membership, and are also supported to help deliver services through volunteering, peer support and collective purchasing. This ensures that distinctions between people who provide and receive services are blurred; the majority of key decision makers are themselves service users. RUILS also makes sure that non-members have their say in how the organisation and its services develop. Qualitative workshops and listening exercises are regularly held to inform member decision making and generate opportunities for personal development. Members are also encouraged to support one another and build mutual and reciprocal relationships, based on their skills and capabilities. This is clearly evident in the peer support and collective purchasing projects. RUILS is a good example of transformational co-production.

EVIDENCE OF IMPACT

To date there has been no formal evaluation of RUILS.

LINKS

<http://www.ruils.co.uk/>

RUILS publishes a number of practical and policy manuals, guides and reports. These can be found [here](#)

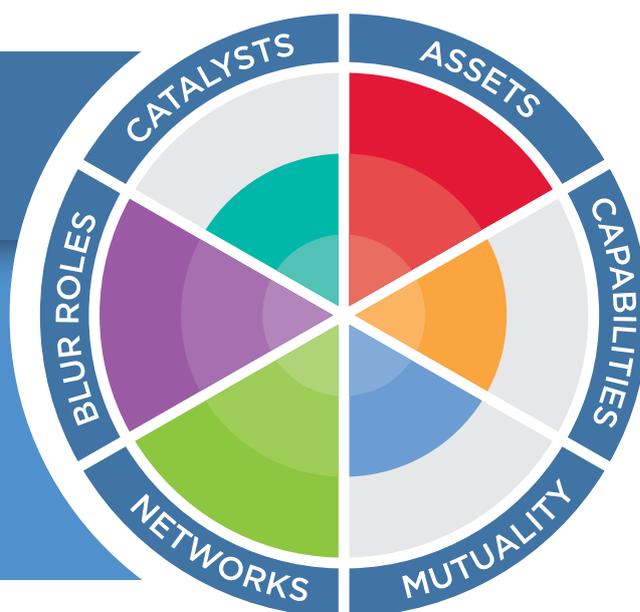
This [case study](#) from the NCVO describes the development of RUILS relationship with Richmond Council.

INTERESTED IN THIS APPROACH?

Then see also: [ecdip](#)

CASE STUDY 2

Service User Network (SUN)



KEYWORDS

Co-design

Self-help Groups

Care Planning

SUMMARY

SUN is a support network developed for and by people who have long-standing emotional and behavioral problems (personality disorders) in Croydon. SUN aims to help those who feel isolated and let down by mainstream services by bringing together people who share the same experiences to support one another in formal and informal ways. SUN members have the opportunity to:

- Attend social contact groups, meet new people and take part in leisure activities.
- Give support to, and receive support from, other members, learn new skills and find better ways of managing difficult experiences.
- Help influence the development of services in Croydon.
- At the heart of the SUN model is the idea of the community-as-a-doctor, and an aim to expand people's coping strategies by bringing peers together to support one another through a crisis.

KEY LEARNING

- Involving people in the design of services from the start is key to fostering a sense of collective ownership. *In what ways do people help design new services where you work? How could existing services begin to incorporate co-design techniques and methods?*
- Peer networks can provide additional and different capacity from professional support that is often more flexible and accessible to community members. *Do staff and people involved in the your activities see investing in peer and local networks as part of their core activity?*

MORE ABOUT SUN

The rationale behind SUN is that more support is needed for people experiencing periodical emotional and behavioral problems, and that service users themselves, or 'experts by experience', are best placed to offer this support. Too often people find themselves in periods of crisis which end in visits to A&E, where they receive little follow-up support and few attempts are made at finding alternative strategies for coping.

SUN uses peer-support networks to improve people's coping strategies, bringing together groups of people who have similar emotional and behavioral problems and who can help each other during times of crisis. This works because within a group crises rarely occur simultaneously, so there are always people on hand to help.

SUN is open to anyone with an emotional or behavioral problem, provided that they refer themselves to the service. Once they have decided to join, people create Crisis and Support Plans (CASPs) with a member of staff and other members of the group. These are tailored to the individual, but draw on everyone's common resources. The plans, held and owned by members of the group, provide a clear course of action for on call members of the group in the event of a crisis.

Whereas a typical crisis situation might see a person progressing from the cause of a crisis (relationship troubles, or an argument) to the crisis itself (self-harming) and on to A&E after that - with little, if any, support along the way - a member of SUN is supported from the outset. In times of crisis they know to follow the procedures set out in their CASP and will have access a member of SUN by telephone or in person.

Members of SUN meet in support groups held several times a week. These are facilitated by professionals, but the emphasis is very much on people learning from each other. Everyone's experiences and opinions are valued, making these sessions open and understanding. Support outside of the network is also encouraged as people exchange personal phone numbers. This brings an element of informality to the group, which experience shows can be very effective, and means members can access 'out-of-hours' support from their peers. Members have reported in evaluations that text messages from others during difficult times can make a big difference in how they feel. Knowing that there are people in the local area thinking about them when they are struggling is valued a great deal.

Because of SUN's formal and informal support people are better able to manage their crises, helping them to avoid harmful situations and reducing admittances to A&E.

WHY IS THIS CO-PRODUCTION?

SUN is designed and delivered in close partnership with its members. The continual development of the service is shaped through episodic forums where service procedures and rules are amended incrementally by members, enabling regular re-design of services. Members are also central to delivering the care provided through SUN. All members play their part in being there for each other in times of crisis, and in challenging people's responses to crises in the facilitated sessions. They can also receive training in how to facilitate the group sessions. There are now plans to roll out the SUN model to other areas and it is hoped that current members of the Croydon network will become paid members of staff in these networks. As such, the SUN model is moving towards **transformational** co-production.

EVIDENCE

- SUN has evidence to show that its model greatly decreases planned and unplanned hospital visits; from 725 to 596, and from 414 to 286.
- An audit looking at the impact of SUN on hospital bed day use after six months of members being a part of the network, showed a total decrease from 330 days to 162 days.
- A&E attendance was also down by 30 per cent for members after six months in the network.

LINKS

<http://www.hear-us.org/aboutthem/croydonsupportgroups/othersupportgroupssun.html>

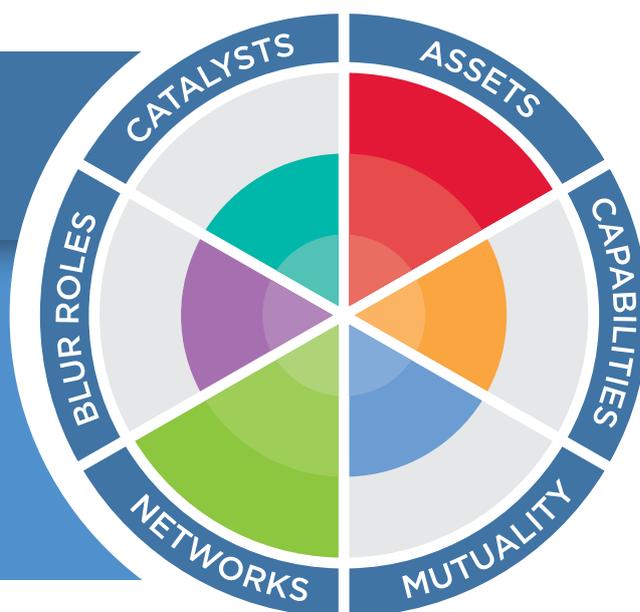
A useful overview with key contacts can be found [here](#).

INTERESTED IN THIS APPROACH?

Then see also: [Richmond Users Independent Living Scheme](#), [Flexicare HCCT](#)

CASE STUDY 3

Comas recovery coaching



KEYWORDS

Motivational Coaching

Experts by Experience

Patient Education in Groups

SUMMARY

“Coaching is based on the premise that human beings are capable of change, and that when we want to change, the key resource is within us. A coach does not change us. A coach helps us work out what change we want, and how to make change in our lives that will last. A recovery coach is not a therapist, advisor, counsellor or teacher. Their role is to help people in recovery learn about themselves and find their own answers.”

The recovery coach approach links a person with experience of recovery to someone in recovery from severe alcohol or drug problems. The recovery coach is in recovery themselves, enabling them to offer insight and to understand the context of the individual they are mentoring. The role of the recovery coach is to support the person with whom they are linked towards a ‘happy, fulfilled and sustained recovery’² in a way that is meaningful to the individual that they are supporting. The recovery coaching model is based on the learning from people in recovery that people want to find ways to occupy their time and think positively about the future, as well as learn to manage their addiction.³

KEY LEARNING

- Innovative approaches can be developed in partnership with people using services – in this example Comas learned from people recovering from addiction that ‘there was limited support for them to look at their whole life, beyond their addiction and that existing treatment programmes, once completed, could only provide limited ongoing support.’⁴ *How does your work invest in peer and community networks beyond your ‘service’ offer?*
- Comas has used accredited training as a way of recognising the contribution that people who are in recovery make to shaping the course. *How do you recognise and celebrate the contribution of people who use and support the service?*

MORE ABOUT RECOVERY COACHING

The recovery coach training has been piloted at Comas, a charity based in Edinburgh, Scotland, whose purpose is to 'liberate potential, connect people and empower communities'.⁵ The pilot was funded by the Self Management Fund with money from the Scottish Government. Comas also supports 'Circles of Care' and the Serenity Café as community-based recovery networks.

The recovery coach training evolved due to the close working between staff and people with experience of recovery in establishing the Serenity Café. From these relationships, insights into the benefits of sharing experience and self-management skills led to developing the coaching approach. The course was developed using an action learning approach with people in recovery helping to shape the content and the delivery. The Scottish Government then supported Comas to accredit the training with the Scottish Qualifications Agency, enabling participants to achieve valid qualifications, whilst contributing to their recovery community. The course is a thorough introduction to coaching, including self-reflection, applied coaching and exercises to demonstrate coaching in practice. The course is designed to be thorough but also to be accessible to people with no previous experience of coaching and 'possibly no recent learning experience'.⁶

The approach was also shaped in order to 'make the programme relevant to recovery from addiction itself, using a 'recovery capital' framework for the coach/client self assessment tools'.⁷ Recovery capital is described as 'the strength of internal and external resources that can be drawn upon to initiate and sustain recovery from severe alcohol or drug problems. These include: hope in recovery; supportive relationships; secure and stable housing; learning and personal growth; connections to a community; making a contribution to the community'.⁸

After initial piloting, the course has evolved into two modules. The first module is focused largely on self-coaching: 'self-awareness and self-management'; and the second module more specifically targeted on recovery coaching. This is because it became apparent that not everyone putting themselves forward for the training was necessarily ready to take on the role of coach. The self-coaching training is open to everyone and from this group people are identified who are ready to go onto the coaching component. The timescales and structure around how the training is delivered have been kept intentionally flexible in order to make it most accessible to the diverse people taking part. Different learning approaches are incorporated to ensure successful outcomes for people involved with different levels of learning or literacy and different experiences of recovery.

At Comas, the recovery coach training has been delivered to a mix of helping professionals and service users who were all learning about coaching approach together. Some professionals remarked on this being challenging, 'because of the [personal] information that they were sharing with the group'⁹ as part of the learning process. Comas learned from an early pilot to avoid engaging professionals in groups with their own clients; however, it was acknowledged that a joint learning approach could lead to a shared culture between staff and service users that embedded a common culture within the organisation.

Access and involvement in the recovery training has come largely through people's peer and personal networks, rather than formal referral mechanisms, as the coaching is embedded within a recovery community of social activities, learning programmes, positive relations with mutual aid Fellowships and links with other recovery initiatives.

WHY IS THIS CO-PRODUCTION?

Recovery coaches are ‘adding to the capacity of the community to help each other, and people coming forward for the coaching are able to access support in a flexible way that many services cannot manage. Coaching between peers is often during the hours that other services are closed, because this support is now available from within the community’.¹⁰ This approach actively and explicitly seeks to grow and sustain people’s social networks beyond their ‘condition’, recognising they have assets and the capacity to support others.

Delivering training to helping professionals and ‘service users’ together helped the professionals to recognise the variety of skills, experience and expertise that people in recovery can bring, and gave the training credibility. It also enabled some people in recovery to see that professionals can also have deep insights into the experience of recovery, drawing on their own life and professional experience.

It is clear that this approach is transformative in its approach to supporting people in recovery. However, it is only now beginning to explore how to work more closely with mainstream providers to influence culture and practice.

EVIDENCE OF IMPACT

Evaluations of the approach highlight that it is ‘essentially solution-focused as opposed to problem-focused’ and ‘gives people personal responsibility and ownership’.¹¹ Participants evaluating the scheme have commented that this is different from ‘the Fellowship (AA, NA or CA) and it was good to get a different perspective on things’.¹² Others identified that ‘it is a way of helping people to identify themselves, rather than a professional point out what is wrong’.¹³

People being coached by peers have been positive about the experience, identifying that recovery coaching ‘helps individuals with their focus; gives people an overall picture of where they are in their life; was a good opportunity to learn about themselves; was motivational but challenging; had a positive structure that was quick, simplified and broken down into small steps. The participants all highlighted that their coach’s awareness of recovery was a really important factor but [coaches] did not necessarily have to be in recovery themselves’.¹⁴

The Comas recovery coaching evaluation suggests that ‘those in early recovery seem to need the most experienced coaches (i.e. in longer-term recovery) as their lives are more complex, and emotions and thinking patterns are still very raw in the months after treatment. However, the approach has been found to be beneficial by people in early recovery and in longer-term recovery, whenever a person wants help to consider their well-being and their direction’.

The United Nations Office on Drugs and Crime (UNODC) have reported on ‘Sustained Recovery Management’ (UNODC, 2008) and included an evaluation of a recovering coaching and personal recovery planning project in Illinois.

<http://www.sdrconsortium.org/assets/files/DigestingTheEvidenceResearch.pdf>

LINKS

www.comas.org.uk

INTERESTED IN THIS APPROACH?

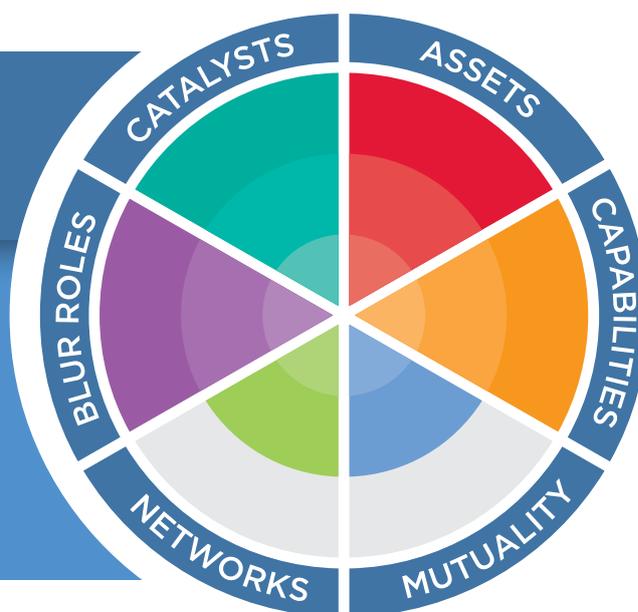
Then see also: **[the Waverly Care Life Coaching Programme, Homeless Health Peer Advocates \(HHPA\)](#)**

ENDNOTES

1. <http://www.comas.org.uk/index.php/recovery/recovery-coaching/102-peer-to-peer.html>
2. <http://www.comas.org.uk/index.php/recovery/recovery-coaching/102-peer-to-peer.html>
3. Self Management Fund - Special Report - Communities and Community Assets, March 2011.
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5. <http://www.comas.org.uk/index.php/our-vision.html>
6. 'The pilot.'
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8. <http://www.comas.org.uk/index.php/recovery/97-recovery-capital.html>
9. Recovery coaching feedback.
10. Self Management Fund - Special Report - Communities and Community Assets, March 2011.
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13. Ibid.
14. Ibid.

CASE STUDY 4

ecd p solutions (formerly Essex Coalition of Disabled People)



KEYWORDS

Care Planning

Personalisation

Co-design

Personal Budgets

Shared Decision Making

SUMMARY

ecd p solutions is an example of a user-led organisation delivering and influencing local authority policies about support planning. **ecd p** won an open tender in 2009 to complete 300 support plans for people qualifying for personal budgets each year at a cost of around £500 per completed plan (2009 prices). The organisation's approach promoted the active involvement of people themselves in their own support planning, to the extent that over 90 per cent of people need just one visit from a support planner. So far, every person who has used the support planning service has taken up a direct payment for all or part of their support package.¹ 'This compares well with the national average take-up of direct payments of 6.5 per cent in 2008-09'² and with figures in the Eastern region of approximately 17 per cent.

KEY LEARNING

- Interventions that devote time upfront to increasing people's skills, confidence and understanding are successfully increasing people's capacity to manage their own support. *Are people's own contributions vital to the success of your activity? Is personal development a common expectation for everyone involved?*

MORE ABOUT ECDP SOLUTIONS

ecd p solutions has a track record of enabling both the individual and collective voice of disabled people and also in directly delivering services including: self-directed support;

direct payment support; independent support planning; a personal assistant support service and a criminal records bureau administration service.³

On winning the contract to deliver support planning in Essex, **ecd**p brought users together and asked them what problems had previously arisen and what 'good' would look like to them. This provided the basis to develop a set of qualitative measures to use as Key Performance Indicators, which users are now involved in monitoring.⁴ **ecd**p works with all user groups in Essex, except adults with mental health support needs.

ecdp's approach to support planning is framed by them as an 'empowerment' approach. Their team (1.8 full-time equivalent, all with lived experience) provides 'a brief but intensive intervention' aimed at enabling the individual to develop the skills and confidence to negotiate the remainder of the support planning process themselves – in most cases without further face-to-face input from **ecd**p. **ecd**p support to them includes double-checking that there is sufficient information within the support plan to allow the local authority to make its decision.⁵

The average time taken to develop a support plan was just over nine hours. On average, around two hours of this was face-to-face contact with the individual, an hour-and-a-half on travelling to them and almost six hours spent on the writing of associated reports.⁶ Only one in six cases involved two or more home visits.⁷

WHY IS THIS CO-PRODUCTION?

The service was co-designed by the people who would be future recipients, due to the ability of **ecd**p to connect to networks of people with an experience of existing services.

People with an experience of support planning themselves have an active part in designing, running, evaluating and delivering the activity.

The service actively seeks to blur the boundaries between 'professionals' and 'service-users' by ensuring people with a lived experience are comfortable to share this insight with the people they are supporting. This has been identified as extremely valuable by people receiving support.

EVIDENCE OF IMPACT

In evaluating the **ecd**p approach to support planning, the Norah Fry Research Centre found that 'those in the ULO group [people receiving support planning from user led organisations] tended to know much more about what was happening, and could regularly find and talk about their own support plan.'⁸

Those who had been involved with ULO support planners described a range of positive characteristics, including their 'genuine' quality, the way they loosened the professional boundary and the fact that they acted in a more personal and relaxed way than their traditional local authority counterpart. These participants reported that they felt their lives actually mattered to the support planner as a result.⁹ On the whole, people using ULO services described the ULO as open and friendly, and its support planners as efficient, active, available, knowledgeable and professional.

The amount of time spent on support planning visits appeared to be less important to people than the availability and efficiency of the support planner. Where people were aware of the 'lived experience' of the support planner, they felt that it helped them, specifically because they felt the support planner would have personal knowledge and

information about personal budgets.¹⁰ Where individuals had a lifelong impairment, they reported it was important for support planners to draw on the expertise of both service users and family carers, and to enable them to think about ordinary life solutions to their support needs, rather than restricting themselves to service-led solutions. Those who had peer support from other disabled people fared better in the PB process.

LINKS

www.ecdp.org.uk

[Making Personalisation Happen: ULOs on SCIE TV, featuring ecdp](#)

INTERESTED IN THIS APPROACH?

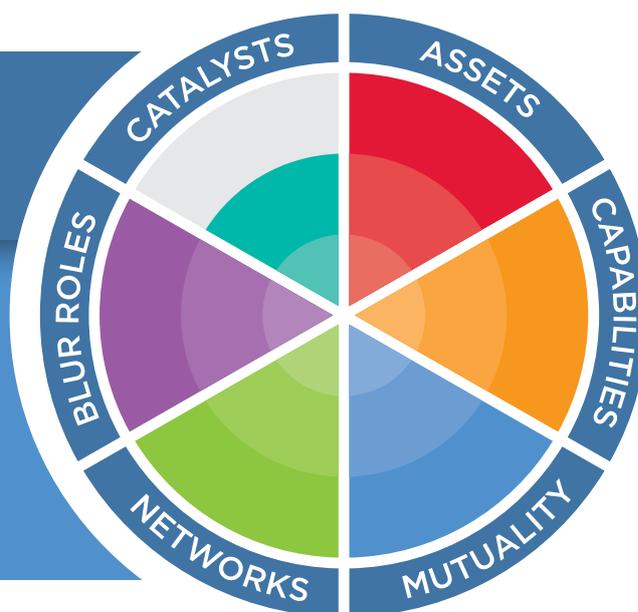
Then see also: [Richmond Users Independent Living Scheme](#)

ENDNOTES

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2. Practical Approaches to Improving Productivity through personalisation in adult social care, Rachel Ayling, Martin Cattermole, Dec 2010.
3. National Skills Academy, ULO's and Commissioning: 18 good practice learning recommendations, January 2011.
4. Ibid.
5. Final report from the support planning and brokerage demonstration project, May 2011.
6. Ibid.
7. Ibid.
8. Ibid.
9. Ibid.
10. Ibid.

CASE STUDY 5

Shared Lives



KEYWORDS

Personalisation

Patient Mentoring

Peer Support

SUMMARY

Local Shared Lives organisations match vetted and trained Shared Lives carers with adults looking for practical and emotional help to live fulfilling lives in an ordinary family household. Individuals and families in local communities provide support and often accommodation, for people who need some help to live the lives they choose. Participants are 'matched' to ensure compatibility and shared interests. Those supported by Shared Lives include older people, people with mental ill-health, people with physical and learning disabilities. Shared Lives can be used for long-term live-in arrangements, or the individual can visit the Shared Lives carer for day support or overnight breaks.

KEY LEARNING

- Shared Lives shows how a micro-service model that builds relationships within the community can be replicated at scale, across England. This is done through a network-based approach, with a comprehensive package of support, training and regulation for Shared Lives carers. *Does your approach think about scale, and how micro-service models might work for people?*
- Family, friends and the wider community can be engaged to contribute to a high quality, low-cost alternative to traditional care home and day care services. *Do you invest in mutual support networks as a core activity?*

MORE ABOUT SHARED LIVES

Shared Lives is about a household – family, couple or single person – including another individual in their family and community life. The majority of Shared Lives schemes are run by local authorities (86 per cent) but an increasing number are being run independently (14 per cent)¹ as councils outsource their social care provision. Increasing numbers of people fund their care using a direct payment.

Shared Lives carers are carefully selected and trained by regulated Shared Lives schemes, with the goal of enabling people to benefit from a highly personalised service which depends on achieving a good match between the individual requiring support and the Shared Lives carer who wishes to support them.² The national Shared Lives Plus network supports schemes and carers. Traditionally Shared Lives schemes focused on supporting adults with learning disabilities, but over recent years they have broadened to include older people, people with physical disabilities and people with mental health problems. The flexibility of the model means that the schemes can work in a variety of ways including:

- Providing a shorter-term arrangement for people with mental health problems recently discharged from hospital, which can also help prevent readmission.
- Providing day support and short breaks for people with dementia, as a small-scale, family-based alternative to large day centres or care homes.
- Providing respite to unpaid family carers, an arrangement which can also help with long-term succession planning for older family carers.³

Whilst there is flexibility in the application of the Shared Lives approach, there are a number of constants that distinguish the Shared Lives approach:

- The recruitment and approval process for Shared Lives carers is thorough and does not just look at the individual applicant(s) but at the whole family and its place in the community.
- Arrangements are subject to a careful matching process and support agreements which ensure that the individual has maximum choice and control.
- Arrangements provide committed and consistent relationships where all participants are seen as having something to contribute. Relationships can be lifelong.
- People living in Shared Lives households are more able to be active citizens, contributing to the life of their local community and all have the opportunity to be part of the Shared Lives carer's family and social networks.⁴

Because Shared Lives is regulated as a community rather than a residential care service, it enables the supported person to maximise their benefits. This ensures that the person retains a larger amount of their income than if they were in residential care and this increases their choices and opportunities to use their money as they wish.⁵

Payment levels to Shared Lives carers comprise the following:

- Rent, which is paid direct to the Shared Lives carer, usually funded by housing benefit.
- Food and utilities costs, which are usually an agreed fixed amount, paid direct to the carer by the person.
- Care and support needs and management costs for the scheme which are funded from the Community Care budget increasingly via a personal budget or direct payment.

Shared Lives carers are classed as self-employed. Payment levels to Shared Lives carers are usually decided according to the level of support required: carers are not paid by the hour. There are specific (favourable) tax arrangements for Shared Lives carers.⁶

WHY IS THIS CO-PRODUCTION?

Shared Lives mixes paid and unpaid caring contributions. It shows how the assets within the core economy – people’s time, skills and empathy – can be used to support the delivery of services. Relationships are reciprocal ensuring everyone involved is valued as an individual and makes a contribution to the life of the household and their community. By supporting people to live in a community setting, the wider networks of the community are engaged in providing support and friendships.

The approach is transformational; by working in the way it does, some local authorities are shifting their models of support from traditional supported housing options into community settings, enabling greater access for individuals into informal support networks and wider community and civil society activities.

EVIDENCE OF IMPACT

Shared Lives is a cost effective way of supporting people to continue living in the community. Shared Lives schemes deliver savings of between £35 and £640 a week per person in comparison to traditional services. A scheme supporting 85 people could recoup £13 million for an initial investment of £620,000.⁷ The Care Quality Commission (CQC) in England rated 57 per cent of schemes as good, 38 per cent as excellent and none poor. Thirty-eight per cent is nearly double the percentages of other forms of regulated care.⁸

People involved in Shared Lives have identified benefits including: increased control and choice for ‘users’; developed ‘user’ confidence, self-esteem, skills and independence; developing stronger reciprocal relationships with others, widening social networks and integrating better into local communities; improved physical and emotional well-being; reduced likelihood of abuse; increased community awareness and involvement.⁹

There is evidence that Shared Lives is highly valued by service users and commissioners. Its focus on the individual and their relationships, it helps councils give service users more choice and control and develop the capacity of the whole community to support its more vulnerable members.¹⁰

LINKS

<http://www.sharedlivesplus.org.uk/>

A Business case for Shared Lives (2009) – NAAPS/ Improvement and Efficiency South East

A Shared Life of My choice (2011) – Shared Lives Plus. (www.SharedLivesPlus.org.uk)

Cuts or Putting People First (2010) – NAAPS (www.SharedLivesPlus.org.uk)

Supporting Micromarket development: A practical guide for local authorities (2009) – NAAPS/ DoH

<http://www.youtube.com/user/sharedcarenetwork>

INTERESTED IN THIS APPROACH?

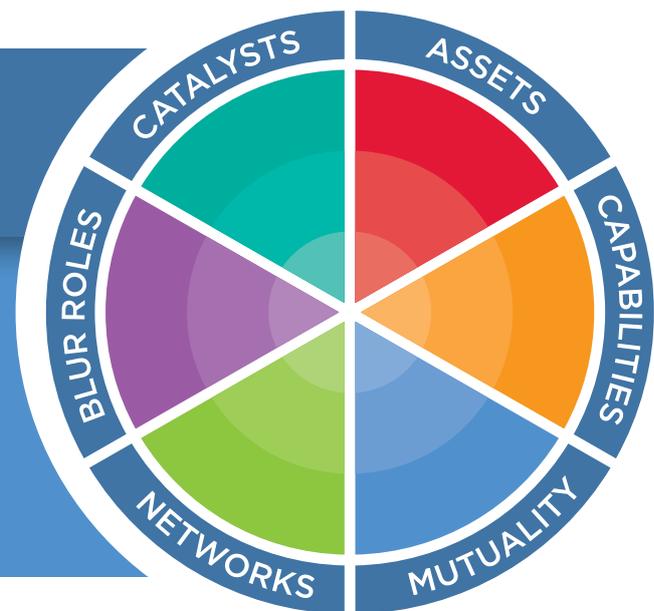
Then see also: [KeyRing](#), [LAC](#)

ENDNOTES

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2. Ibid.
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7. Ibid.
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9. Slay, J. (2011) Budgets and Beyond: A review of the literature on personalisation and a framework for understanding co-production in the 'Budgets and Beyond' project, new economics foundation and the Social Care Institute for Excellence.
10. www.communitycare.co.uk

CASE STUDY 6

KeyRing Living Support



KEY WORDS

Personalisation

Navigation

Information

Advice and Guidance

SUMMARY

KeyRing is a supported living service for vulnerable adults. There are 899 members in over 105 networks nationally. The biggest is in Oldham. The approach is to set up a series of local networks, of which each has nine adult members and one volunteer (the navigator), all living independently, usually within a 10-15 minute walk of each other. The networks provide mutual support for independent living and links people into other local networks and resources.

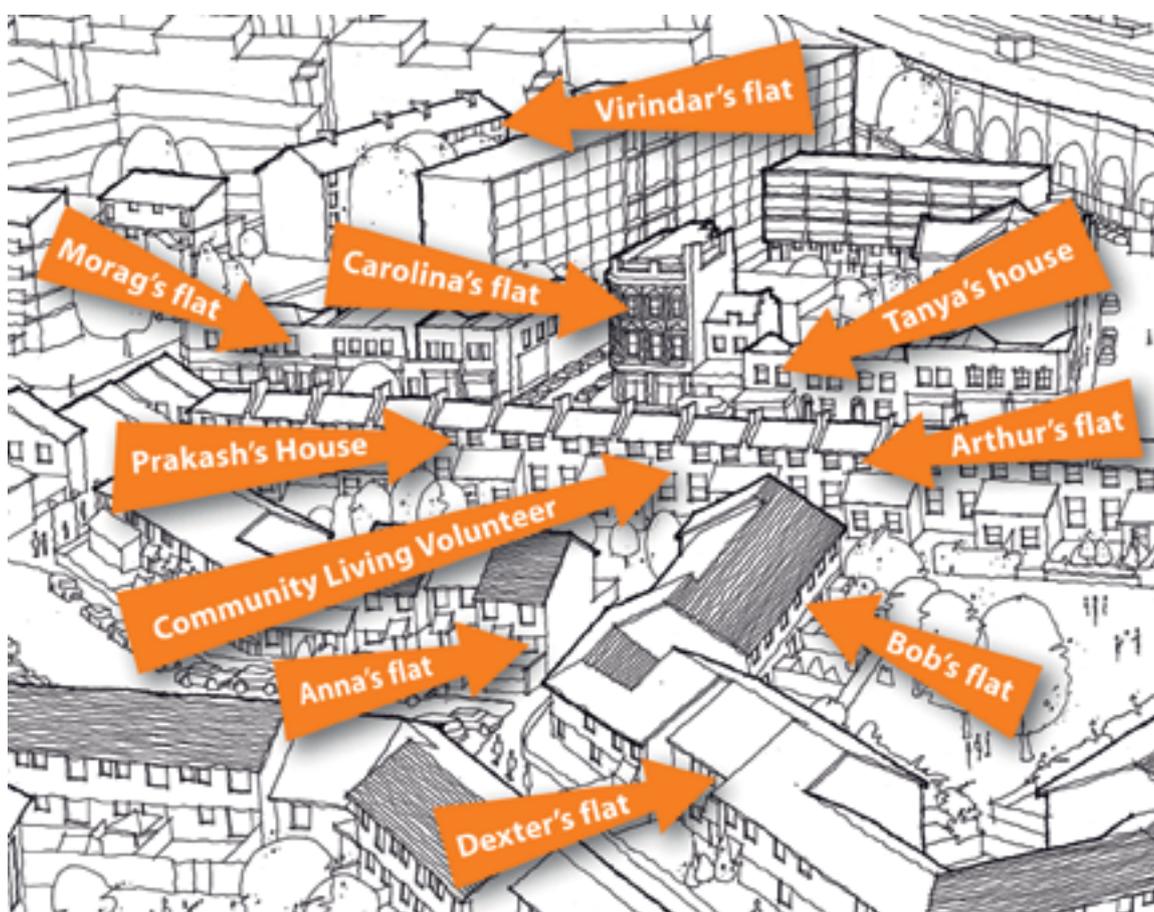
KEY LEARNING

- Peer support networks improve outcomes for people and increase the scope and effectiveness of services. *How could the people you work with be brought together with the explicit intention of helping, and learning from, each other?*
- Peer support networks need careful nurturing, so the 'navigator' role is critical in signposting people to formal and informal support. *Does your service make use of service 'navigators'? Do they look beyond the service to help people link up with informal, community networks, resources and assets?*
- Local communities are an often-neglected resource. *Does your service treat patients in isolation from their families, friends and local communities? What might a community asset mapping exercise tell you about the 'under the radar' resources that you and the people you work with might be able to tap into?*

MORE ABOUT KEYRING

KeyRing's support is based on people living in their own homes, but sharing their skills and talents with each other and with their communities. It is about helping people to live independently by building networks of interdependence with other KeyRing members and the broader community. Building these networks is the role of the community living volunteer. KeyRing networks draw on community development philosophies, which emphasise the importance of social networks to good living.

Volunteers are much like good neighbours who help people out when challenges arise; such as helping to read and pay bills, or organising necessary housing maintenance. But volunteers also help members make links with each other and with the wider community. One of the first things that members of a new network start to work on is a personal and community map which highlights people's networks of friends and acquaintances and draw out formal resources and amenities, and informal networks and assets within the community. Because the volunteer lives in the community, they know what's going on and are able to help members make the most of where they live. Community connections are very important to KeyRing. KeyRing members campaigned for streetlights, have saved lives and run neighbourhood improvement campaigns.



Once networks have matured, the support becomes more mutual within the network, and the volunteer role is reduced as members turn to each other. The volunteer is often perceived as a peer by members: in the 2008 floods in Gloucester, the local network volunteer's flat was flooded and all the members arrived to help clear the water and debris away.

WHY IS THIS CO-PRODUCTION?

Elements of transformational co-production are evident across the service. It is a members' organisation developed and driven by and for the members. At least two members are involved in the recruitment of new KeyRing staff and members are trustees on the board. This helps to blur the boundaries between people *receiving* a service and people *providing* a service. Mutual support is an explicit component of membership. Critically the networks developed are not simply for vulnerable adults, but instead informally incorporate a wide range of people from the local community. Assets and resources from within the membership base and beyond are carefully identified, in some cases nurtured, and then mobilised to maximise the networks scope and impact.

EVIDENCE OF IMPACT

KeyRing's business case has shown that it can:

- Reduce costs in a sustainable way.
- Effectively meet the needs of people with a range of complex needs, from diverse backgrounds.
- Help the shift towards personalisation in care services.

LINKS

<http://www.keyring.org/Home>

KeyRing also offer a free DVD explaining how what they do works. You can order a copy [here](#)

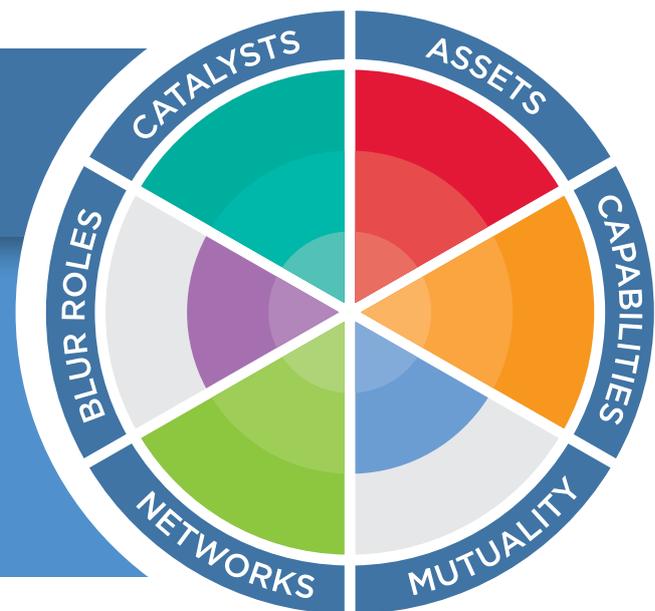
This document demonstrates KeyRing's ability to save costs <http://www.keyring.org/DocumentDownload.axd?documentresourceid=19>

INTERESTED IN THIS APPROACH?

Then see also: [Shared Lives](#), [LAC](#)

CASE STUDY 7

Local Area Coordination (LAC)



KEY WORDS

Peer Support

Information

Advice and Guidance

SUMMARY

Local Area Coordination (LAC) is an approach to supporting people with disabilities to live good lives in their communities. Rather than defining people by their needs and the services they use, LAC asks people what sort of lives they want to lead and then supports them to achieve their aspirations. It does this through Local Area Coordinators, who act as a single point of contact for people with disabilities and their families in a defined area; enabling them to develop their own skills and capabilities; helping them to tap into existing local resources and networks, and, where it does not exist, building community inclusivity and capacity. In so doing, the LAC approach helps keep people strong, rather than waiting for a crisis before intervening.

KEY LEARNING

- The LAC approach can be seen as an advanced form of the navigator model; it does not just simplify a complicated system, it transforms the system. *How is navigation conceived of where you work?*
- Despite working with people with complex needs, LAC refuses to treat people as passive beneficiaries of services. Everyone is seen as capable. *How do you work to identify and build on people's existing capabilities?*
- The LAC model fully utilises local capacity, resources and assets to improve outcomes for the people it supports. *How much do you know about the resources and assets in the local communities where you work? Have you considered how asset mapping exercises might help in identifying under the radar activity that can be informally accessed?*

MORE ABOUT LAC

The LAC model was first developed and implemented in Western Australia in 1988. Since then, reflecting its success, the approach has been adopted across Australasia, in Canada, Ireland, Scotland and England.

The approach works by employing Local Area Coordinators, who act as single points of contact in a defined local area, supporting between 50-60 individuals and their families in their local communities.

A key part of the Coordinator's role is to get to know the people (individuals and their families) with whom they are working, and the communities within which they live, very well. This is because the Coordinator's job is to enable people to make the most of their individual skills and capabilities and the resources and assets within their community. If these capabilities, resources and assets are weak, the Coordinator will seek to develop them.

Another key element of the Coordinator's role is to build and develop personal and community networks. These networks support people through difficult times, provide practical responses to their needs and help them to achieve their aspirations.

LAC actually helps people to move away from seeing formal services as being the inevitable first port of call, by developing informal and more personal forms of support over which they have a much greater degree of control and ownership.

In England the most developed model of LAC is being implemented in Middlesbrough. Here, the approach is very similar to its Australian predecessor; the same principles and ways of working are all adhered to. However, whereas in Australia LAC is focused around people with disabilities, in Middlesbrough, everyone is eligible for at least some support – even though most support is still given to people with disabilities and older people. This has meant that a broad range of people with low-level needs have been able to access help to prevent problems from escalating down the line and adding strain to children and adult social care services.

This universality of coverage has also meant that certain people have been supported, who are not picked up by traditional services because their specific service needs are not seen as being high enough, but who nonetheless experience multiple low-level challenges which cumulatively make their lives very difficult.

WHY IS THIS CO-PRODUCTION?

The LAC model is a strong example of co-production for a number of reasons. The philosophy behind it is explicitly assets-based; personal and community assets are drawn upon, developed and made an integral part of the service. The role of the coordinator is very important in this. Much of the success of the model can be attributed to the relationships that coordinators forge with the people they work with. Time and effort goes into making sure that the coordinators get to know people and their local areas well. This means they are trusted, and are seen to be allies of the people, not of the service they represent. LAC also encourages the development and strengthening of networks of reciprocal relationships between the individual and their families, friends and the wider community.

EVIDENCE OF IMPACT

Australian evaluations of the LAC programme demonstrated:

- High levels of user-satisfaction: users, families and the coordinators all scored the service highly in surveys conducted.
- Responsive and flexible service provision: the service has proven a strong ability to adapt with the changing needs of the service 'users'.
- Good value for money: "the LAC model provides value-for-money outcomes not matched by any other areas of disability service delivery (in Australia)... LAC provides more support to more people, with a high level of satisfaction, at a cost that is more likely to be able to be afforded by (the Australian) Government."¹

Significantly, "evaluations of the LAC service in Australia have demonstrated a 30 per cent reduction in costs as part of a move towards a preventative service with much lower levels of acute interventions and much higher levels of participation and enthusiasm from the people who use the service."² This is costed on the basis that the LAC model keeps people from using costly, specialised state services by using more light touch and informal forms of support.

In Middlesbrough, although the programme has been running for much less time, and therefore the results are still tentative, similar conclusions are being drawn. Conversations with service users in particular have been very encouraging.

LINKS

For a more detailed summary of the LAC model and why it is a good example of co-production, see Nesta and **nef's** report *Public Services Inside Out*

For the most authoritative evaluation of LAC in Western Australia see the [Review of the Local Area Coordination Program Western Australia \(2003\)](#).

For more [information](#) on LAC in Middlesbrough.

INTERESTED IN THIS APPROACH?

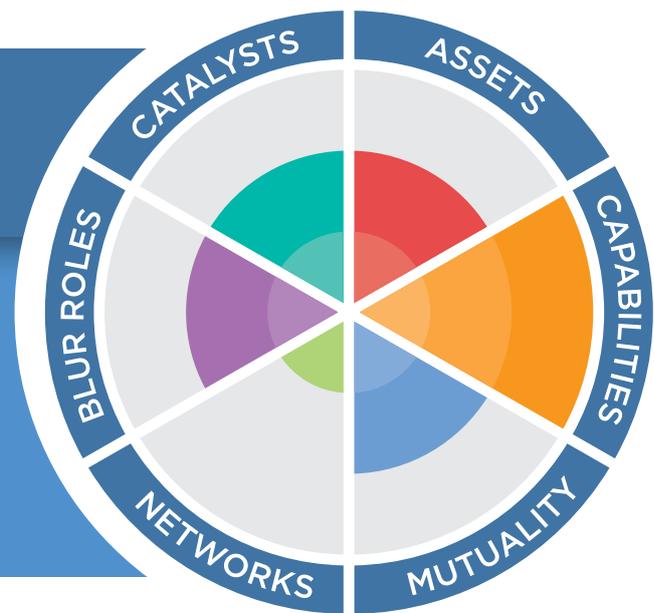
Then see also: [Shared Lives](#), [KeyRing](#)

ENDNOTES

1. Review of the Local Area Coordination Program Western Australia (2003) http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_per_cent28id_369_ver_1.0.2_per_cent29.pdf
2. Right Here, Right Now http://www.nesta.org.uk/library/documents/coproduction_right_here_right_now.pdf

CASE STUDY 8

Nurse Family Partnerships (NFP)



KEY WORDS

Patient Mentoring

Well-being Coaching

SUMMARY

Nurse Family Partnership (NFP) is an evidence-based community health model which pairs young first-time mothers in high-risk groups with nurses, to improve the well-being of mothers and their children. By developing strong relationships between nurses, mothers and infants, and providing effective support and coaching on issues ranging from feeding, nutrition and literacy, to sexual health, employment and safety, NFPs have demonstrated impressive short-term and longitudinal results. These include:

- Improved pre-natal care and health.
- Reduced instances of child neglect and abuse.
- Improved self-sufficiency and economic activity amongst mothers.
- Higher rates of literacy.
- Lower rates of obesity.
- Fewer interactions with the criminal justice system.
- Better grades in school and a higher chance of graduation.
- The model's success has seen it spread throughout the USA with high-level government backing. In 2006 the model was also trialled in the UK, where it continues under the slightly different name - Family Nurse Partnership.

KEY LEARNING

- The professional's focus is to encourage and support people to take control over their own lives, giving them greater self-esteem and agency. *Do you generally do things for people? Or with them? How could you work to help others develop their own capabilities and agency?*

MORE ABOUT NFP

Nurse Family Partnerships were developed in the 1970s by David Olds – specialist in paediatrics and preventative medicine – who was struck by the avoidable risks facing children born into deprived communities whilst working in an inner-city day care centre. He realised that if children from these backgrounds were to have a better chance in life, more attention needed to be paid to their health and development from the outset. This, he believed, required a change in their home environment, and crucially in the social, emotional and economic context of the expectant mother's life.

The NFP is grounded in three complementary theories based on years of developmental research; ecological theory, emphasising the links between behaviour and social context; self-efficacy theory, concerning a person's belief that they can change their lives; and, attachment theory, which looks at the importance of long term, sustained human relationships.

Underpinned by these theories, the NFP model partners young first-time mothers-to-be with trained visiting nurses. Nurses are given specialist training in motivational interviewing and behaviour change methodology. The nurses' role is to build lasting therapeutic relationships with the mothers, and between the mother and child. This is done through a structured curriculum of home visits, where nurses help the mother build on her existing capabilities, develop new skills and improve their confidence.

Ideally these visits begin early in the second trimester, on a weekly basis for a month and then every other week until the child is born. Home visits then take place weekly for six weeks, fortnightly up unto the age of 20 months, and monthly thereafter until the child's second birthday.

“During pregnancy the programme addresses modifiable risks for poor birth outcomes and child neurodevelopment impairment such as prenatal exposure to tobacco, alcohol, illicit substances, inadequate maternal diet and low take-up of antenatal care that might address obstetric complications. Following the birth, the focus is more on developing sensitive, competent care of the child to avoid abuse and neglect or injuries, while fostering secure attachment bonds.

In the USA, the NFP programme assigns 25 mothers to each nurse, with a part-time supervisor supporting teams of four nurses at a time. Teams of four nurses meet regularly with their supervisors to reflect on their practice and seek out areas to improve their work and the lives of the mothers they are working with. Team meetings are also designed to help nurses deal with the emotional strain of working with mothers and children in difficult situations.

WHY IS THIS CO-PRODUCTION?

The Nurse Family Partnership programme draws on a number of the principles of co-production, and these can be seen to be instrumental to its impact. In particular, because NFP is grounded in self-efficacy theory and attachment theory, it stresses the importance of individual agency and relationships. The NFP model recognises mothers as agents of change in their own lives, and the future lives of their child. With this in mind, much of the training provided by nurses concerns building on the mothers' existing capabilities and developing new skills. Therapeutic relationships, which are at the core of the NFP model, are about sustained, two-way engagement, trust and support. Nurses work with the mothers to facilitate a process of change; they do not for work them, dictating terms and providing answers.

Perhaps one of the only areas where the NFP model could be developed from a co-production perspective is in relation to peer support. Currently there is little emphasis

placed on the potential benefits of bringing young mothers together in support networks to amplify the support provided by nurses. Although this may be happening in certain cases, it is not an explicitly recognised element of the model. 'Graduates' of the NFP could, for example, be offered pathways into providing additional support for other local expectant mothers.

KEY LEARNING

The NFP is one of the most rigorously evidenced social programmes in child development. Short-term and long-term outcomes include:

- Enhanced cognitive functioning and fewer behavioural difficulties amongst children.
- Children at age 15 had fewer sexual partners, fewer arrests, convictions and parole violations, and were less likely to run away from home.
- Parents provide safer homes and more stimulating parenting.
- Reduced prevalence of child abuse and neglect.
- Reduced welfare dependency, increased economic activity amongst mothers.
- Fewer future pregnancies and greater spacing between future births.
- Every \$1 invested provides between \$2.50 – \$5.70 in savings across criminal justice, education, welfare and health.
- After programme costs, the benefits per child are estimated at \$17,180.
- Preventative cost savings associated with parents include, 20 per cent reduction in months on welfare, and 83 per cent increase in employment for the mother by the child's fourth birthday.

LINKS

<http://www.nursefamilypartnership.org/>

Barnes, J. *et al.* (n.d.) *Nurse Family Partnership Programme: First year pilot sites implementation in England*, Birkbeck, University of London: London.

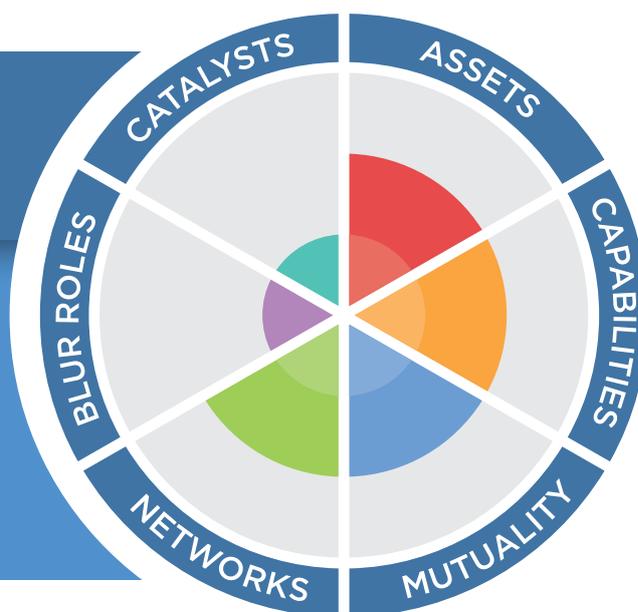
For more information on NFP in the UK: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118530

INTERESTED IN THIS APPROACH?

Then see also: [LAC](#), [FAST](#)

CASE STUDY 9

Partnerships for Older People Projects



KEY WORDS

Peer Support

Experts by Experience

Signposting

Information

SUMMARY

The POPPs programme, financed by the Department of Health between 2006 and 2009, funded activities aimed at promoting the health and well-being and independence of older people, and preventing or delaying their need for higher intensity or institutional care. Twenty-nine local authorities were involved. One-hundred and forty-six core local services were established for people needing significant support, such as people (and their carers) with long-term conditions. A further 530 small 'upstream' projects commissioned from the third sector were described as low-level preventative programmes and were open to all older people. Over 260,000 people used the services of POPP projects over the three years.^{1,2} The overwhelming majority of the POPP projects have been sustained, with only 3 per cent being closed at the end of the pilot phase.³

KEY LEARNING

- Activity that mobilises local community networks can generate additional capacity and communicate with groups that services find 'hard to reach'. *Does your service design and delivery seek to build on and grow individual and community assets?*

MORE ABOUT POPPS

All local projects involved older people in their design and management, although to varying degrees, including as members of steering or programme boards, in staff recruitment panels, as volunteers or in the evaluation.⁴

The Camden Networkers in London received POPPs funding of £773,000 per year over two years for services to support Community Interventions for Older People with Mental Health Problems. In this project, older people are encouraged to participate within the community by being trained as volunteer networkers. The older people who are targeted to become volunteers networkers are particularly those with direct (or indirect) experience of mental health issues. Alongside their lived experience they are trained to understand mental health issues with the aid of resource packs and act as 'sign-posters', providing support for older people affected by both functional and organic mental health problems.⁵

The volunteers 'promote information on healthy living; mental health and social care issues to their peers, passing information by word of mouth to create a 'network' of information. They also undertake some practical help such as making phone calls to people with memory problems to remind them about hospital appointments and medication'.⁶

Following the end of the POPPs pilots the Networkers scheme has continued, being delivered by the Retired Senior Volunteers Programme (RSVP). The project currently has 96 volunteers, a large number of whom have themselves experienced mental health difficulties. The project responds to a real need in the community by helping vulnerable, isolated older people to access health services that they might not otherwise be able to.⁷

The Networkers scheme has been highlighted by the Audit Commission as a 'Green Flag' (exceptional performance or innovation that others can learn from) highlighting that: *'The Partnership is supporting people well, through helping them to help others. Networkers are generally over 65 but some younger older people are also volunteers. They have reached over 1,000 other older people through their work, helping them to access services at an early stage'*.⁸

WHY IS THIS CO-PRODUCTION?

This scheme supports people to use their own skills and experience (of mental health) to support others, and provides training to support them to grow their capacity to do this. It also seeks to grow people's local informal social networks. Older people themselves provide support and information on living in Camden with a mental health condition, which blurs the boundaries between professional and lived experience. Whilst the service is listed within local resource directories for people facing mental health problems, it is unclear the extent to which the scheme is connected into the local health services and how, if at all, it has altered mainstream professional practice.

EVIDENCE OF IMPACT

The evidence from POPPs showed that for every extra £1 spent on the POPP services, there was approximately a £1.20 additional benefit in savings on emergency bed days. Overnight hospital stays were reduced by 47 per cent and use of Accident and Emergency Departments by 29 per cent. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person.⁹ Evidence also showed that for users receiving 'well-being or emotional' interventions, a category that included befriending, fewer reported being depressed/anxious following the intervention: 58 per cent before and 63 per cent after the intervention.¹⁰ Looking at quality of life improvements as a result of better mental health – using evidence from some of the POPPs pilots – their monetary value would be around £300 per person per year.¹¹

LINKS

<http://www.csv-rsvp.org.uk/site/disability.htm>

<http://www.youtube.com/user/departmentofhealth> and search for POPPs

INTERESTED IN THIS APPROACH?

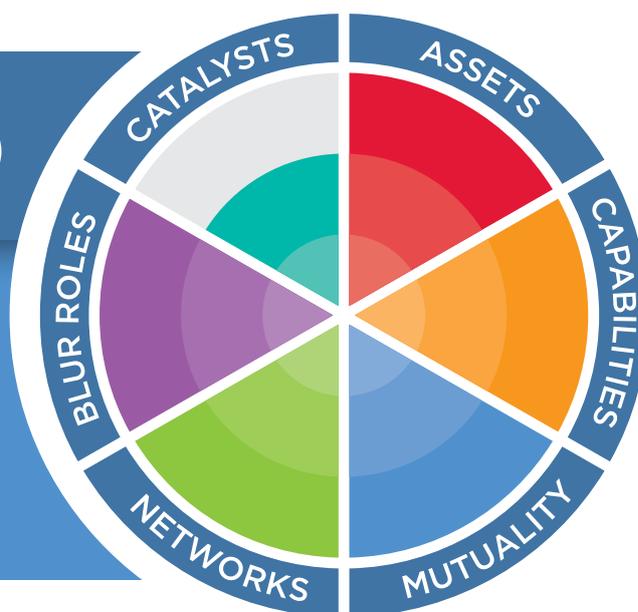
Then see also: [Comas Recovery Coaching](#), [flexicare](#)

ENDNOTES

1. The National Evaluation of Partnerships for Older People Projects: Executive Summary, PSSRU.
2. Ibid.
3. Ibid.
4. Ibid.
5. CIP, Partnerships for Older People Projects: An outline of innovation and service elements, June 2007.
6. Ibid.
7. <http://www.csv-rsvp.org.uk/site/disability.htm>
8. <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/areaassessment/pages/localpriority.aspx?region=51&area=325&priority=4542>
9. Ibid.
10. Knapp, M., Bauer, A., Perkins, M. and Snell, T. (2010) 'Building Community Capacity: making an economic case.' PSSRO, 2010. Discussion paper 2772.
11. Ibid.

CASE STUDY 10

Families and Schools Together (FAST)



KEY WORDS

Peer Support

Group Coaching

SUMMARY

FAST is an eight week group programme facilitated by multiple agencies and peers to support families who need a bit of extra help. It has been tested in a range of settings: with first-time teenage parents, young people on the verge of exclusion, and families at risk of becoming involved with social care services. It is based on building relationships across the social ecology of family, schools and community. FAST is a values-based programme with a strong assets focus that explicitly encourages reciprocity between participants.

KEY LEARNING

- **Reciprocity can be explicitly built into models:** in FAST, there are explicit expectations set of people's contributions and everyone is encouraged to support each other and the programme after they leave. *Do you work to celebrate people's capabilities? Are the service users you work with expected to make use of their skills and opportunities identified for them to give back?*
- Programmes can be **successfully replicated** and **scaled up** across geographical and sector boundaries: the FAST model clearly distinguishes between critical components of the model, and aspects that can be tailored to local context. *If you are thinking about taking inspiration from case studies in this catalogue, ask yourself; which parts of the process are central to the model, and which parts would benefit from being more tailored to local conditions?*

MORE ABOUT FAST

FAST has been designed as a values-based programme that is built on a set of strong principles, as well as a certain number of fixed processes. The programme is outcomes-oriented, ensuring enough flexibility to focus on helping families achieve the best life chances possible for their child – rather than fixating on specific targets or outputs.

There are two clear stages to the programme: the first part sees professionals and participants working closely for an initial eight week period, whilst the second stage, lasting two years, is peer-led. Individuals are referred into the programme by schools, children's centres, or health clinics.

Stage 1: up to 40 participants, with their whole family, will come together in groups of ten families for 2.5 hours per week with professionals, and are usually based in a community space, such as a school. This group includes parents, nurses, social workers, youth workers, teachers and community leaders. Participants will have been recruited in one-to-one meetings with a team member in advance of the first session, ensuring that they go into the initial multi-family group sessions knowing someone else, and feeling more comfortable.

The focus of each meeting is to build up participants' skills through experiential learning, peer support and coaching techniques. If, for example, the desired outcome of a FAST programme is to develop responsive parenting, then the process will involve training up the parent to do what would have once been the role of 'qualified' therapists. Sessions can initiate circle conversations and peer sharing with other parents, and participants will receive coaching from professionals in one-to-one quality time, or might be trained in responsive behaviour tools and techniques to use with their children.

As the families meet, the concept of reciprocity is encouraged among the group. For example, they eat together as families each week, and the cooking is done by one family member of the group each week (funds for the food are provided). There is also a family lottery each week (which is fixed for everyone to win at some point). Those who 'win' reciprocate by making the following week's meal and so each person is encouraged to contribute and take an active role in sustaining the group dynamics.

All members of the team (parents and professionals alike) are trained to take part in the programme. Parents who served as team members are rewarded by getting credits towards work-based learning, coaching and activities outside the programme.

Stage 2: after the initial eight week intensive programme, FAST shifts to become participant-led. Most of the professional members retreat from the project, offering back up support as needed. Parents, for example, would continue to meet in small groups of eight to ten, for two years, or as long as they find useful. Over 86 per cent of parents state that they meet friends through the project that helps to maintain their involvement for years later. Research shows that FAST parent graduates become community volunteers and leaders, developing local capacity and social capital.

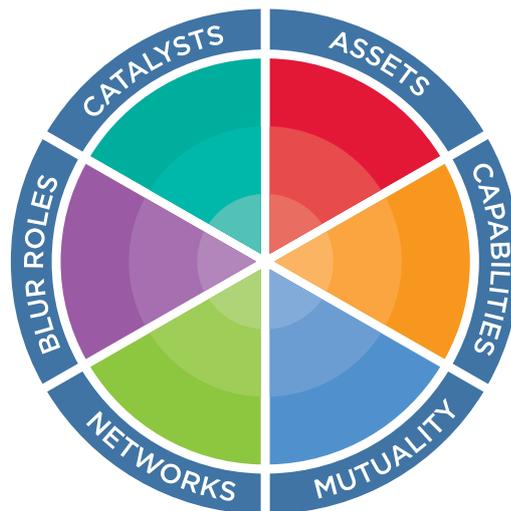
One of the challenges they have faced has been the existence of power differentials between professional and peer groups, and so particular attention is now paid to those people whose voices might not usually be heard: for example, teenage parents, or low-income parents from a range of socially excluded backgrounds. The power differentials between parents and professionals are actively considered in FAST to increase the equality of all voices at the table.

FAST was first developed in 1988, by Dr. Lynn McDonald, now Professor of Social Work at Middlesex University, London. Since then, over 200,000 people have participated in FAST in 14 countries. It can be sponsored by community groups, schools, local authorities and prisons. The FAST model has been implemented across the US, Canada, the UK and Australia, among other countries. Careful thought has gone into the replication of the model and a clear approach has been determined to help the

programme reach an international level of scale and keep the core components in place, whilst also leaving scope for new groups and communities to make it their own. This has been achieved by keeping 40 per cent of the model consistent as a core process, while 60 per cent is flexible and adaptable at a local level.

WHY IS THIS CO-PRODUCTION?

The FAST model is a great example of the ways in which the experience and resources of parents and professionals can be pooled to improve outcomes for children. The longer-term benefits of the model are achieved through the effective use of peer support. A clear recognition of the barriers that can exist between parents and professionals has led to activities which break down these barriers. People's skills are built up through experiential learning, and the role of the professional is to facilitate and support the groups. In this example, all of the principles of co-production are embedded in the approach, making it a good example of transformational co-production.



EVIDENCE OF IMPACT

Four published RCT trials have demonstrated a reduction in children's behaviour problems, school failure and drop out, drug abuse, delinquency and special educational referrals.

FAST is listed as an evidence-based intervention by United Nations (UNODC), UK and US governments. Save the Children UK is sponsoring the scale-up of FAST in 400 primary schools by 2014.

LINKS

<http://www.mdx.ac.uk/aboutus/Schools/hssc/mh-sw/research/fast.aspx>

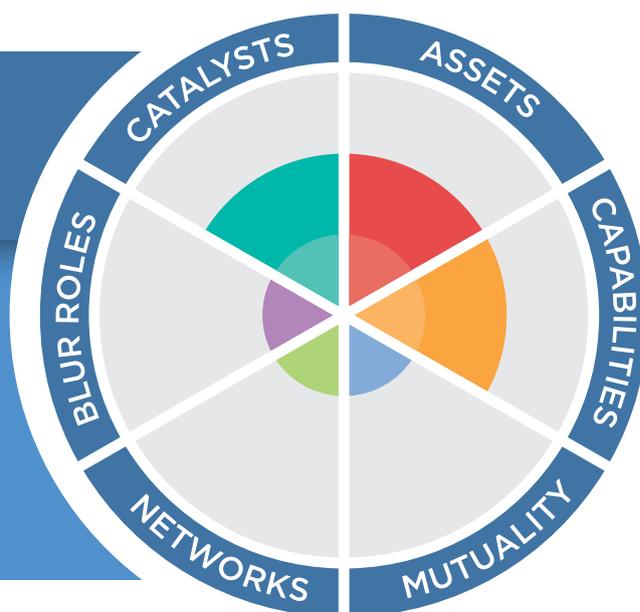
The Save the Children Website has a short film and number of [introductory reports](#) to the FAST model.

INTERESTED IN THIS APPROACH?

Then see also: [Nurse Family Partnerships \(NFPs\)](#), [Comas Recovery Coaching](#)

CASE STUDY 11

Homeless Health Peer Advocacy (HHPA)



KEY WORDS

Peer Support

Experts by Experience

Information

Advice and Guidance

Signposting Information

SUMMARY

Since July 2010 Westminster Primary Care Trust, in partnership with Groundswell UK, have been recruiting, training and working with peer advocates to improve homeless people's experience of health services. Westminster PCT has recognised the importance of using the lived experience of people who have been previously homeless in improving access to health services; in doing so they have helped improve health outcomes for this group and reduced health inequalities.¹

KEY LEARNING

- Lived experience is central to the model: Westminster PCT recognised that they did not have the full expertise to help homeless people access health care services, and so explored the concept of experts by experience. *Does your service maximise the resource of the lived experience of its participants? Is the knowledge of service users valued alongside professional expertise?*
- Feeding back into public services: one aim is to improve health practitioner understanding of, and sensitivity to, the particular health needs and health attitudes of the long-term homeless. HHPA provides a continual feedback loop into the health services. *Could the work that you do change wider attitudes and thinking in the sector(s) you work in? What feedback loops could you initiate to scale-up your impact or effect broader culture change?*

MORE ABOUT HHPA

The HHPA project uses peer approaches to improve homeless people's access to health services. It is based around the activities of health advocates, all of whom have personal experience of being homeless. Groundswell UK, who set up the project, currently have 11 advocates (three paid, eight volunteers) working in Westminster and Hammersmith. In 2012, the scheme will expand into Camden.

As part of HHPA, advocates undergo intensive training and mentoring by a health or social care professional. They also have access to a small progression fund, which they could apply to for funding for further qualifications, or to purchase some smart clothes for interviews. The advocates also get insight into hospital and primary care services by working alongside nurses, GP's, administration staff and clinicians, and can also access bursaries to spend on further training. Often they have particular interest in careers in the health and social care sector, and working as an advocate can be a route to career development, thereby building up their own skills and opportunities for employment.

Advocates are also encouraged to give health providers an insight into the challenges faced by homeless people that may be overlooked by those with no direct experience of homelessness themselves.

"We speak the same language as the service users, and I believe we take some pressure off the keyworkers. I wish this service had been around when I was on the streets."

Dennis, Health Peer Advocate.

Advocates visit hostels and day centres for the homeless, sometimes also approaching rough sleepers directly, giving them hands-on help and advice on how to get medical treatment. Typically, advocates support a homeless person in identifying local health services, including GPs, dentists and opticians, and may help with making appointments, getting to the venues, and filling out forms.

A strong focus of the role is on building up trust and relationships with individuals, and time is spent chatting in informal settings to gain this.

WHY IS THIS CO-PRODUCTION?

The scheme has been set up to explicitly recognise and use the skills and lived experience of people who have been homeless themselves. The model supports people to access services, rather than doing it for them. It values and supports advocates to develop their own skills through health and social care training, and some homeless people who have been supported have gone on to be advocates themselves. In this way it is a good example of intermediate co-production.

The model could be developed to further embed transformational co-production by:

- Explicitly embedding reciprocity: giving those who have benefited from more structured pathways to 'give back' by volunteering or referring others to the service or forming peer support networks; like in the **Service User Network** case.
- The model could also explore how advocates and participants could focus on increasing awareness of supporting homeless people within the local health infrastructure (GPs, dentists etc.) and by identifying how some of the boundaries and barriers between health staff and homeless people could be eroded; see for example **ecdpsolutions**.

EVIDENCE OF IMPACT

Early indications of the project show that it is improving homeless people's willingness to engage with health services, and their experience of them. This has the potential to reduce usage of A&E services, though this has not yet been formally evaluated.

Since starting the project, five advocates have moved into paid employment with Groundswell. In just one year, advocates have supported over 70 individuals and attended over 370 appointments.

Evidence of the value of other similar peer-outreach programmes shows that they improve outcomes and reduce health inequalities.

LINKS

Groundswell has produced a homeless health peer toolkit which provides guidance on the 'How To' of Peer Health research, education, promotion and advocacy, and also includes advice on peer recruitment, training and incentives.

INTERESTED IN THIS APPROACH?

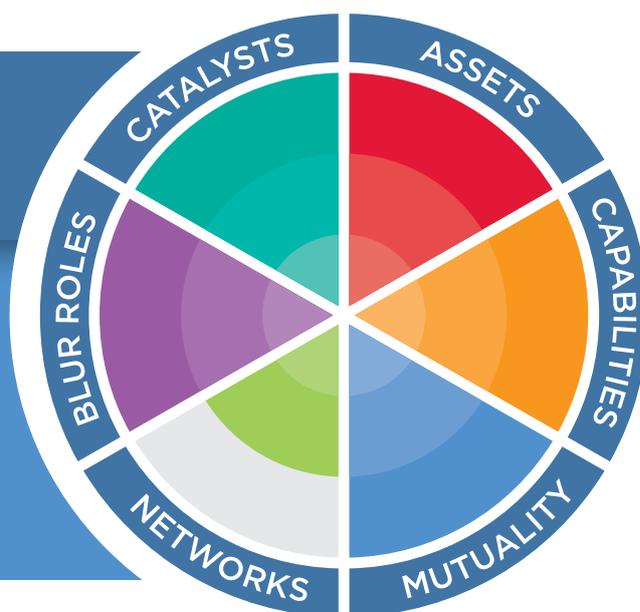
Then see also: [Comas Recovery Coaching](#)

ENDNOTES

1. <http://www.london.nhs.uk/what-we-do/promoting-innovation/examples-of-innovation-in-london/less-health-peer-advocates>

CASE STUDY 12

Flexicare at the Holy Cross Centre Trust (HCCT)



KEY WORDS

Time Banks

Personal Budgets

SUMMARY

The Holy Cross Centre Trust (HCCT) in Camden provides day services for people with mental health conditions. HCCT has extended an existing time bank at the Centre to incorporate the provision of a 'flexicare' service, which supports people to stay independent in their own homes by providing low-level care and support.

KEY LEARNING

- Everyone can contribute and earn time credits and part of the well-being impact of time banking is in giving as well as receiving. *Are 'service users' where you work encouraged and supported to develop their skills and give something back?*
- Personalisation isn't just about giving people a budget: a new take on time can broaden the capacity of services, and enable people to complement their finances with time credits. *Has your service considered which resources and assets could be bought in to complement personal budgets and increase the capacity and variety of your activities?*

MORE ABOUT FLEXICARE

The flexicare service was originally set up in 1996, and over the last two years has been adapted to include the exchange of time credits. Since then it has grown to support around 15 people, many of whom are paying for their support through a mixture of time credits, and personal budgets, or their own funds. 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. By being active and giving support to others in this way, people using the flexicare service are improving their own well-being and strengthening their local networks. Support varies from person to person, and can involve supporting someone to go to the hospital, companionship, or reminding someone to take their medication. Using this funding model, HCCT are able to build the capacity and variety 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.

There are a number of challenges when setting up a model like flexicare. Ensuring that the quality of care provision is high is vital. HCCT have worked with trainee social care staff who are able to apply their skills and earn credits for their work. Bringing in the trainees to the flexicare service ensures a certain quality and consistency of support for people. One of the challenges is that it can be difficult to encourage and embed genuine reciprocity between members and staff, and to remember that everyone has something they can give.

WHY IS THIS CO-PRODUCTION?

Members of the time bank, including those usually seen as 'users' or 'beneficiaries' of the service, are able to support each other through the time bank. Their active involvement is critical to building up the capacity of the service, and its ability to offer flexible, personalised, social care support. People are directly involved in the running of activities and can offer to exchange their time helping others to earn credits for themselves.

The activities created through the time bank don't replace services, but can complement and extend existing provision, building the vital social networks and capacity that support people within their communities. It also brings a crucial preventative focus to services. Flexicare is a good example of transformational co-production; it has embedded new structures of delivery by bringing professionals and service users together to identify and manage opportunities to develop and deliver services. The culture of the organisation has greatly changed in the last decade with mutual trust and reciprocity between professionals and communities key to their success.

EVIDENCE OF IMPACT

HCCT has had a number of evaluations of its services, including the time bank, and the flexicare service. These have shown that;

- HCCT relies on the time and commitment of over 500 time bank members, which, valued at the London Living wage, totals £137,119 over one year alone.
- **nef** determined that more than £2 million of social value was generated for the state in 2009/2010 by the mental health day service provided by the Consortium. Nearly half (or just over £1 million) of this value comes from cost savings associated with the mental health and employability outcomes of service users. The social return on investment of the HCCT time bank is approximately £5.75 for every £1 invested.

- Other studies have shown reduced GP visits and reduced hospital re-admissions
- Common outcomes associated with time banking in public services include: improved social networks, improved intergenerational relations, improved psychological well-being, increased access to public services, improved employability, increased social inclusion for typically marginalised groups, improved confidence and self-esteem for individuals, increased sense of belonging, greater community cohesion and reduced stigma and discrimination.

Other studies showing the impact of time banking and care banking include:

- More than Money: literature review. This report reviews the literature on time banking and summarises the key evidence on outcomes and cost effectiveness. It also signposts to other relevant case studies and evaluations.
- The Reach Service Exchange Network: a US-based care bank that adapts the model of time banking and tailors it for health and well-being support. The model is currently in development, and should have an evaluation published towards the end of the project.

LINKS

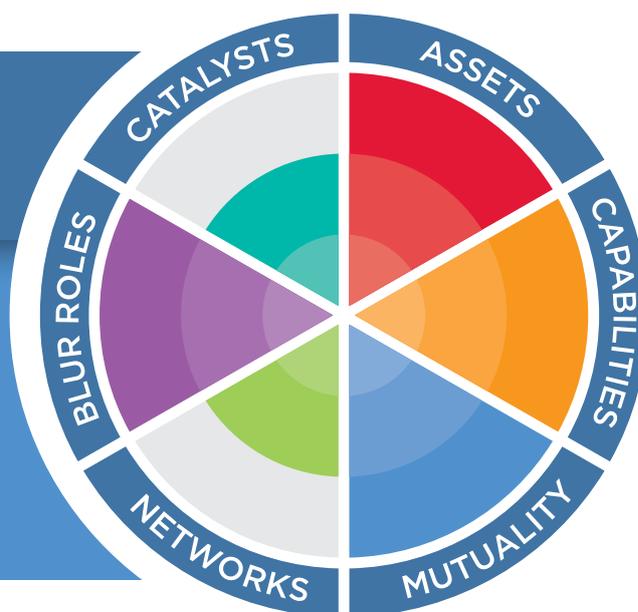
Website: <http://www.hcct.org.uk/what-we-do/projects/flexicare/>

INTERESTED IN THIS APPROACH?

Then see also: [Richmond Users Independent Living Scheme](#)

CASE STUDY 13

Headway East London



KEY WORDS

Time Banks

Peer Support

SUMMARY

Headway East London is a leading centre of support for people with an acquired brain injury (ABI). Unlike many traditional providers of similar services, Headway East London ensures that people take on a leading role in shaping their own care and developing and running the centre. Everyone is encouraged to define meaningful roles and responsibilities that they can make their own; their skills, capabilities and interests are given space to flourish through professional and peer support. Headway also hosts the Timber Wharf Timebank.

KEY LEARNING

- Headway East London emphasizes that everyone has an important and valuable role to play in the organisation and works hard to identify and bring out people's skills, capabilities and interests. *What are the skills, capabilities and interests of your service users? How could you help nurture these and simultaneously add capacity to the service?*
- Headway East London enables everyone to take on meaningful responsibilities in the development and running of the centre, ensuring that people are given the freedom to define these responsibilities for themselves. *Have you considered asking service users how they could help, or what they would like to do for others?*

MORE ABOUT THE APPROACH

In 1997, frustrated by the lack of long-term support for people living with long-term acquired brain injuries (ABIs) in Hackney, East London, a group of professionals and people directly affected by ABI came together to open Headway East London, a one-of-a-kind centre offering specialist therapies and services for people with ABIs. But Headway East London is more than a provider of professional services; it is also a community of people with shared values. At Headway East London it is recognised that everyone, from the staff and patients, to their families and the wider community, has something to contribute. Every week around 170 people visit headway. About 120 of these have an ABI, and 50 do not. Some are paid professionals, and others are unpaid – family members, friends and volunteers. Everyone is encouraged to take on roles and responsibilities that they can feel proud of and which contribute to the development and the running of the centre. This ethos is embedded within the organisation through the services that it provides, including its occupational services and the [Volunteering Programme](#).

Headway runs personalised occupational programmes, supporting people with an ABI into meaningful occupations of their choosing. Unlike many other traditional occupational programmes, Headway's programmes do not have fixed ideas about what people with ABIs can or should be able to do. They do not dictate what sort of training people need, nor what what ambitions people should have. As Firoza Choudhury, a member of the one of Headway's occupational therapy programmes, explains:

“The aim of the programme is to create real occupations for people who find the competitive market inaccessible. In the long term, the projects aim to help other excluded people, as well as those with brain injuries... The teams are given flexible support, but they are ultimately responsible for developing and running their own project... I have been working on a project to shoot films with two other members for the past year. It started when Ben (the Programme Manager) explained that the programme was an opportunity to have a working role in something we were interested in and promised to support us in any way he could. I'd had no previous experience of filming, but was really keen to give it a go and learn something new. Since then we've had some training and advice by external experts, but mainly we have been teaching ourselves through trial and error and input from Ben to learn how to shoot, edit and get the lighting right etc.”

WHY IS THIS CO-PRODUCTION?

Headway East London exemplifies many key elements of co-production. In particular, they value the people that they work with as active contributing members of the centre, and are adept at identifying and building upon people's skills and capabilities. People at Headway are supported in a tailored way, recognizing what they are interested in, to shape how the centre and the services on offer are designed and delivered. This in turn helps to blur professional boundaries and foster a palpable sense of community. It is a good example of transformational co-production.

EVIDENCE OF IMPACT

To date there have been no formal evaluations of Headway East London.

LINKS

<http://www.headwayeastlondon.org/>

INTERESTED IN THIS APPROACH?

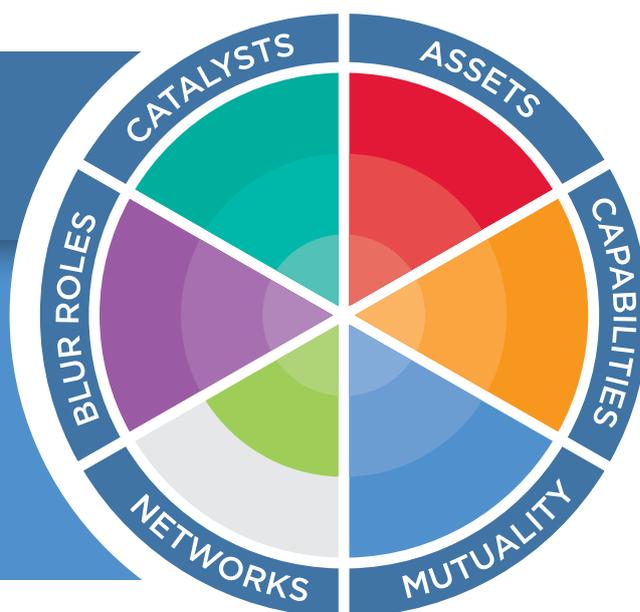
Then see also: **Skillnet**

ENDNOTES

1. In This Together Report.

CASE STUDY 14

Skillnet Group, Kent



KEY WORDS

Personalisation

SUMMARY

The Skillnet Group, based in Kent, supports people with and without learning difficulties, to work together equally to make a difference. Co-production is at the heart of their work, and has been developed in a number of ways, including in the attitudes and culture of the organisation and the processes which staff follow. Their aim is to support people to make independent and informed choices about their lives, and they work together with staff to develop projects and support networks which build on people's own interests, skills and capabilities.

KEY LEARNING

- Skillnet shows how co-production can be embedded from board level down to practical delivery within an organisation. *What might be the potential impact on your service of involving people in strategic decision making activities, project delivery or commissioning? What might need to change to make sure everyone is able to participate in a meaningful way?*
- Skillnet uses a huge range of resources, including the expertise, time and energy of people they support, and many of the networks, buildings and businesses locally. *What local resources are there that could enhance the capacity and impact of your service? Are your staff aware of these resources? Are staff encouraged to use and actively engage with the community?*

MORE ABOUT SKILLNET

The Skillnet Group was co-founded by Jo Kidd, her husband, and a group of people with learning difficulties in 2002. They have grown a wide membership and have a range of income sources, including from people with personal budgets and some who are 'self funders'.

People are supported in the way that suits them best. Those with learning difficulties are involved in planning and developing projects and support approaches from the outset. Individuals can choose from a 'menu' of different options (which are always evolving in response to people's interests) or can choose to develop something new themselves, with support, or with others. These activities are many and varied, but include: Speaking up citizens groups, co-developing training courses on environmental and ethical issues, and supporting people to set up their own businesses.

One of their projects is called Risky Business, an arts and drama group and emerging social firm, where people are paid for their work and performances. Meetings are held each Friday in Sittingbourne, Kent. There are three members of staff (two of whom have learning difficulties themselves), and around 15 group members who have come for the morning. They are currently working on sketch performances to be shown at national conferences for which they are being paid. Another, the 'Swale Mates' community connecting project, is a peer mentoring and befriending scheme that works with members of the local community.

Skillnet's staff roles are central to the way that support is co-produced. Staff are encouraged to build up people's capabilities, and actively develop links and opportunities with the local area to bring in broader community assets, such as local businesses and sports centres.

Many of the people Skillnet supports have got first-hand experience of being supported themselves, and their personal insight and experience is a valuable asset when it comes to developing the ideas and values of Skillnet.

Skillnet has experienced some challenges in the way they work, most notably in convincing commissioners that their approach to integrating with other aspects of the local community is 'safe' for people, and that people are able to take on active and meaningful roles as citizens, activists and employees. Another common challenge is that some parents and families find it difficult to 'let go' and support people to play a more active role in their local community.

There are a number of ways in which Skillnet has developed its organisation and processes to further embed co-production. Some of these include:

- Having a values-led philosophy which helps them focus on how they work with people, rather than focussing on specific interventions or services.
- The Skillnet board includes members of staff, people who are supported, and members of the local community, all of whom contribute to shaping the direction of the organisation.
- All activities are co-led or delivered by people who receive support, and staff. This goes from planning activities through to chairing meetings, writing up notes, deciding on priorities and delivering practical projects.

WHY IS THIS CO-PRODUCTION?

The Skillnet Group shows how co-production can be applied to personalised and self-directed support. The role of Skillnet is focussed on supporting people to become independent of services, brokering relationships between people and the community. They have a specific focus on supporting people to 'do' things, whether that's enterprise, employment, dramatic arts or training, and the relationships and involvement of people and staff are equal and reciprocal from board level to practical projects. Within this context it is a good example of transformational co-production.

EVIDENCE OF IMPACT

Skillnet has not had an evaluation done on their activities, but have a number of powerful case studies in video form on their website, which can be found [here](#). Their own observation of the benefits brought through co-production includes many people they support being moved away from formal care or acute support, a reduced demand on services, and some people being supported to enter employment.

LINKS

[Think Local Act Personal \(TLAP\) co-production resources page](#) and [provider blueprint](#), which is focussed on personalisation, with some aspects covering co-production.

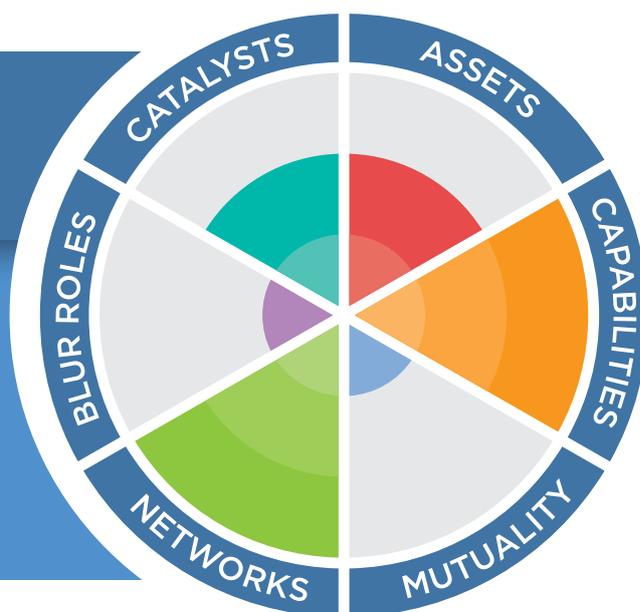
[Tricia Nicoll's co-production self-reflection tool](#): A useful resource for providers to use and reflect on their own practice, and on how they could deepen and develop co-production.

INTERESTED IN THIS APPROACH?

Then see also: [KeyRing](#), [Headway](#)

CASE STUDY 15

Waverley Care Life Coaching Programme



KEY WORDS

Motivational Coaching

Well-being Coaching

Peer Support

SUMMARY

Waverley Care, based in Scotland, has developed a programme of support for people living with Hepatitis C and HIV, based on a life coaching model. The programme has strong aspects of co-production, and has demonstrated improvements in outcomes for participants across health and well-being measures.

KEY LEARNING

- Models that explicitly build in peer support and mentoring from the start of the programme mean that a stronger, more sustainable, support network outside of services can be created. *Could peer support be embedded into the service you work in? Could it transform how elements of the service are delivered?*
- Many of the six principles of co-production are core components of the life coaching programme content. Integrating these values into self-management programmes helps to maintain a focus on building co-production from the bottom up, as well as the top down. *What work could you do to develop a co-productive ethos amongst staff and service users?*

MORE ABOUT THE LIFE COACHING PROGRAMME

The life coaching programme is a one off intervention which lasts seven weeks, and consists of seven coaching sessions each taking 2.5 hours. It sits within the Waverley Care self-management programme. In 2010, Waverley Care was funded by Scotland's Long Term Conditions Alliance to develop the life coaching programme, and an initial pilot with eight participants was taken forward.

The programme is designed to support individuals build up their knowledge, expertise, awareness and capacity to manage their own condition. The programme content covers a range of areas, including:

- An introduction to self-management.
- Action planning techniques and goal-setting techniques.
- The impact of positive and negative thinking.
- Managing emotions and depression.
- Working on abilities and strengths.
- Building your support network.
- Relationship building with healthcare professionals.
- Peer support and starting your peer group support.
- Self-assessment and appraisal.

The programme is designed to equip participants with more effective thinking and behavioural skills and to improve confidence and self-esteem using techniques to deal with difficult emotions and problems such as depression, pain and social isolation. A crucial focus is on building up participants' own resources and capabilities, and doing so within a supportive and enabling peer context.

The programme links peers together and encourages them to develop their own peer support networks. The programme coordinator also supports the development of peer mentors and peer support groups. Peer mentors are trained and supported, and some participate in PSMP accredited facilitation training alongside the coordinator.

The programme coordinator facilitates the training and coaching, alongside at least one other person who has lived experience of the condition. The programme coordinator role is particularly focussed on supporting the peer coaches in their own roles.

WHY IS THIS CO-PRODUCTION?

The programme places a real emphasis on supporting people to build up their own skills and capabilities, and to continue identifying support through social networks and peer groups. The focus of the coordinator in the programme is to facilitate peer mentors and self-organised support to develop from the coaching programme, and their role is positioned very much as a facilitator and enabler.

The approach could be even further deepened to encourage formal and informal reciprocity between peers and staff and begin to impact on the 'patient/clinician' interaction. It could also formalise the assets approach, which might involve mapping local individual and community resources and helping people to link in to these for support. This would move it from intermediate to transformational co-production.

EVIDENCE OF IMPACT

The Hep C/HIV coaching model was evaluated and a short summary can be found [here](#). Recent evidence showed the programme has resulted in a 34 per cent decrease in demand on NHS services, and a 63 per cent decrease in missing work due to poor health. Forty-nine per cent of participants had improved emotional and mental health.

LINKS

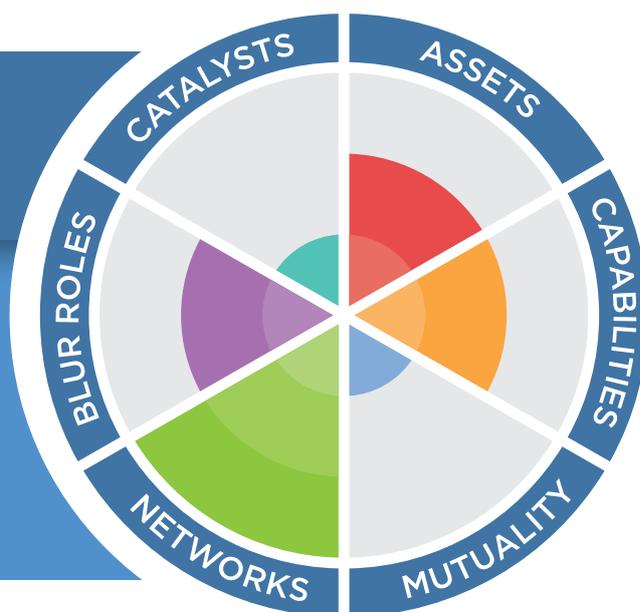
<http://www.waverleycare.org/content/selfmanagementprogramme/216/>

INTERESTED IN THIS APPROACH?

Then see also: [Homeless Health Peer Advocates \(HHPA\)](#), [RooP](#), [Comas Recovery Coaching](#)

CASE STUDY 16

Routes out of Prison (Roop)



KEY WORDS

Motivational Coaching

Peer Support

SUMMARY

Roop is a peer support project for prisoners returning to Glasgow, Lanarkshire, North Strathclyde and South West Scotland Community Justice Authority areas after serving a sentence of between three months and four years. Roop offers participants access to life coaches who support them to link to services in the community.

KEY LEARNING

- The value of blurring roles: Roop uses Community Life Coaches with direct experience of being in prison to create supportive peer-to-peer relationships in which there is not a clear professional-user division. *Is people's lived experience seen as an asset and actively used in the delivery of your services?*
- The credibility of peer support: an evaluation of Roop found that peer-led services gave the programme credibility with participants and for them to engage with other public services as well. *Do the services you work for actively enable people to link up and support one another? How can your organisation give maximum credibility to 'non-traditional' types of support?*

MORE ABOUT THE PROJECT

Roop was established by the Wise Group, Families Outside and the Scottish Prison Service (SPS) in August 2006, and received two years of funding from the Scottish Government to deliver the service in three prisons and four Community Justice Authority areas. In 2008, Apex Scotland joined the Partnership and the Project secured further funding from the Big Lottery Fund. By 2011, Roop was operational in seven prisons.

As RooP is a peer support project, many of RooP's Community Life Coaches have personal experience of offending or addictions – currently 70 per cent of the 16 trained coaches.

RooP offers a 'through the gate' support service whereby Community-based Life Coaches meet with the client at least twice in the prison before they are released to establish a working relationship and an outline plan of action. The Life Coach then aims to 'walk the journey' with the client, by accompanying them to subsequent appointments and explaining the purpose and processes of other services with which RooP partners. The Coach will also advocate on their behalf and provide practical assistance, emotional support, praise and encouragement. In this sense, RooP provides a 'bridging model' of support from the prison into the community. The most common support needs identified by RooP participants relate to addictions, homelessness and unemployment; 70 per cent reported being out of work for 12 months and 56 per cent were unemployed for over two years.

Once their support needs have been addressed and the participant is 'job ready', they are supported by one of RooP's Employment Consultants, who will help them find employment, training or education.

WHY IS THIS CO-PRODUCTION?

RooP uses the coaching model in a peer-to-peer context, thereby transforming the perception of prisoners returning to communities in Scotland from that of passive recipients to active participants. The aim is to empower individuals to make good decisions on release from prison, rather than to dictate such decisions and this encourages a greater degree of shared responsibility for outcomes. Participants benefit from the insight offered by peers who are steps ahead on their own journey.

There is scope for the co-production model to be extended from intermediate to more transformational co-production by;

- **Looking for ways to increase engagement with communities:** RooP could become more transformative by encouraging participants to develop connections within the local communities to which they return. This will mean building upon the trust and mutuality that the peer-to-peer coaching already encourages. The **KeyRing** and **LAC** models both offer interesting insights into how connections with wider communities can be made.
- **Developing more formal partnerships with other statutory services:** this is a dimension highlighted in RooP's September 2011 Evaluation. Partnering more formally with public services at a national and local level could catalyse change by encouraging the blurring of boundaries between professionals and clients within statutory services, rather than just with the life coaches.

EVIDENCE OF IMPACT

- Between August 2010 and January 2011, RooP helped 81 homeless participants find accommodation, supported 88 people in accessing health or addiction services. One-hundred and twenty-three people accessed the financial benefits they are entitled to, and 17 people were assisted in taking steps to tackle their debts.
- Nearly a fifth of the 293 participants achieved clear employment, training or education related outcomes, with 5 per cent of RooP clients securing employment.

- Interviewees felt that the peer support element of the Project gave RooP credibility with participants, encouraged engagement with the service and motivated people to make positive changes to their lives.
- The Wise Group has produced an [evaluation of RooP](#) which provides useful evidence for the success of the intervention, as well as recommendations for improvements.

LINKS

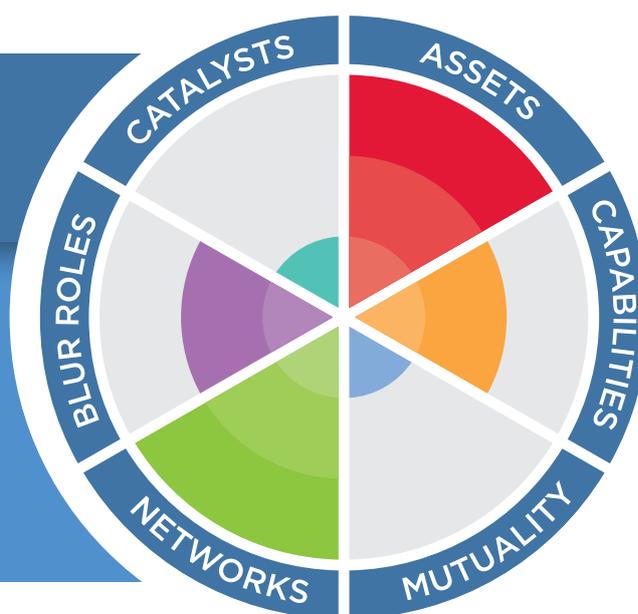
www.thewisegroup.co.uk

INTERESTED IN THIS APPROACH?

Then see also: [Comas Recovery Coaching](#), [LRPT](#), [LAC](#)

CASE STUDY 17

The Leicestershire and Rutland Probation Service Health Trainers (LRPT)



KEY WORDS

Social Prescribing

Experts by Experience

Peer Support

Health Trainers

Information

Advice and Guidance

SUMMARY

The LRPT set up a health trainer model for ex-offenders, funded by the local PCT, in 2010. The initiative aims to improve take up of health services and promote behaviour change among the ex-offender community. The health trainers have personal experience of the criminal justice system, and some had previously been involved in peer mentoring schemes.

KEY LEARNING

- Identify experts by experience and recognise the value they bring. *What forms of knowledge do you privilege? How could you better tap into user expertise to improve your work?*

MORE ABOUT THE LRPT HEALTH TRAINER MODEL

The health trainer model followed by LRPT is very similar to other health trainer schemes, but has a greater focus on the value of lived experience and peer support; the trainers are often former offenders themselves who are experts by experience and can empathise and act as a role model with the people they support.

Individuals are referred to the health trainer in a deliberately informal process, usually through an initial phone call, so that people aren't deterred by an over-complicated process. The trainers also run drop-in sessions at a range of community venues to promote their work and can receive self-referrals from people through this route.

The services provided by the health trainers usually fall into three main categories:

- **Signposting/advice:** this includes activities such as support to register with dentists and GPs, and providing information about local health and well-being services.
- **Individual health planning:** most of these plans focus on healthy eating and fitness, smoking cessation, employment, training or education, and general health support. Activities can involve awareness raising, as well as more tailored support such as building up skills in budgeting, shopping for healthy food, and cooking.
- **General health promotion work:** this can include drop-in sessions, as well as other community events to promote positive health and well-being activity.

The recruited health trainers are trained in two qualifications to enable them to take on their role. These are a Level 2 Award in Understanding Health Improvement, and a City and Guilds Level 3 Certificate for Health Trainers. This training is critical as two of the four key components of the qualifications develop co-production within their approach. These are:

- To maintain relationships with the local community.
- To support individuals to increase their capacity to improve their own health and well-being.

Typical activities conducted by the health trainer include developing individual health plans, and providing up to eight one-to-one sessions with people focussed on specific aspects of their health, such as smoking and diet.

The staffing structure of the health trainer model used by LRPT is organised as follows; one manager, four health trainers, three health champions (unpaid) and one part-time administrator. Unlike many other health trainer models, the focus on using the lived expertise of former offenders and resourcing the programme with volunteer health champions builds the capacity of the programme, and helps erode the distinction between peers and professionals.

WHY IS THIS CO-PRODUCTION?

It is important to view the health trainer role within the wider set of activities promoted by the LRPT, which include peer support and peer mentoring programmes, and a pro-social modelling approach. The model recognises the value of having local knowledge and personal experience of being an offender and the trainer model does not sit alone in their approach to supporting ex-offenders.

The LTPT model is particularly strong on recognising people as assets, and using peer support and experience. Working with peers enables the distinctions between the 'professionals' and 'patients' to be broken down. The model could develop from **intermediate** to transformational co-production by:

- Actively developing peer support among participants, perhaps through a buddying or mentoring scheme with previous programme participants.
- Actively linking participants into other local networks and resources (beyond health services), including community networks such as faith groups, or local gyms and leisure centres; see for example **KeyRing** or **LAC**.
- Breaking down the boundaries between health staff and the participants so that clinicians can begin to build on the strengths of the model in their own work.

EVIDENCE OF IMPACT

The Leicestershire pilot has had an [evaluation](#) completed. The evaluation shows that almost all staff and participants in the programme stated that they felt it was the trainer's own lived experience of the criminal justice system which made their support so effective. This was because there was a higher level of empathy from the health trainer, the language used was more familiar, and their own positive role modelling was inspiring to participants.

The value of the health trainer project was estimated against a cost per referral, which was £397 per person, and used the QALY. The total cost of the service was £106,503. Positive results were recorded for GP registration, smoking cessation, healthy eating and exercise.

LINKS

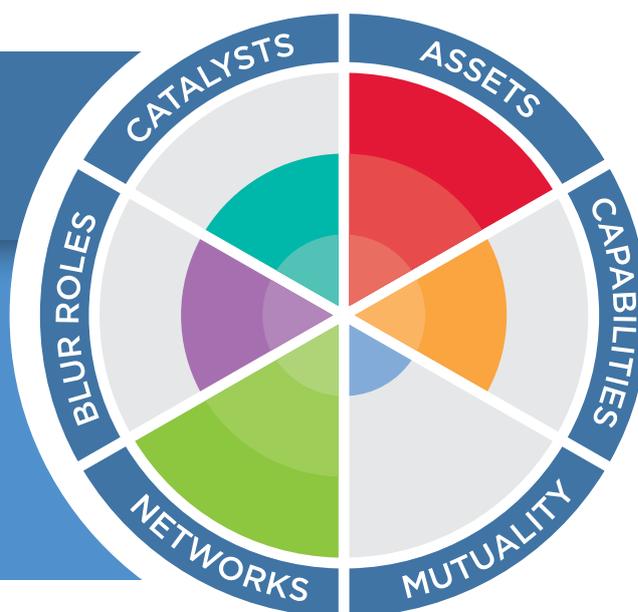
<http://www.icpr.org.uk/media/31870/ICPR%20evaluation%20of%20health%20trainer%20service%20final%20report%20August%202011.pdf>

INTERESTED IN THIS APPROACH?

Then see also: [Homeless Health Peer Advocates](#), [Comas Recovery Coaching](#)

CASE STUDY 18

The Bradford Health Trainer and Social Prescribing Service



KEY WORDS

Social Prescribing

Navigation

Health Trainers

SUMMARY

GP commissioners in Bradford fund a number of health trainers who spend time in local GP practices, supporting people who are referred to them to find non-medical opportunities and solutions to a range of diverse conditions. The role of the health trainer is to support participants to gain skills and employment, and find community-based support.

KEY LEARNING

- A key part of the trainer role is to actively engage with local community networks and assets: this builds up a strong base of local knowledge, and means people can be supported to engage with these individuals and organisations in a way which provides more consistent and long-term support. *What is the relationship between your service and the wider community? How could you make the most of local assets, resources and networks to amplify success?*
- The focus of the health trainer is not on doing things for the person, but on helping people build up the knowledge, skills and confidence to access community services and support independently, in the long term. *How would you describe the relationships you have with patients? Do you find yourself doing things for them? What could they do for themselves, and how could you support them in this?*

MORE ABOUT BRADFORD'S SOCIAL PRESCRIBING SERVICE

The Bradford Health Trainer and Social Prescribing Service has been operating since early 2006 and is one of the most developed in the UK. Bradford's South and West GP alliance invested an initial £131,000 to fund the service until mid-2011, following its successful roll-out across the area. This has employed six health trainers, equivalent to 4.5 FTE. Each trainer spends between half a day and a day in the practice, and most trainers work across at least two practices.

A key part of the health trainer role is dedicated to establishing relationships with local community groups and organisations so that they can effectively signpost and link people in to them. Typical activities that people are referred to include local support groups, health and well-being activities such as gyms and classes, or support agencies such as dentists, or housing agencies.

The process of referring-in and receiving support is fairly straightforward. Individuals can be referred to the trainers if they fulfil certain criteria. In Bradford, these criteria include mild mental health problems, social isolation, problems with housing, employment or support, or challenges in managing a disability or long-term illness. People can also self-refer in. Their first appointment with the trainer can last up to an hour, and most participants see the trainer between one and six times, giving much more time and support than GPs and clinical staff can provide. The trainer's support is focussed on listening to the person's concerns, supporting them to identify coping techniques and particular activities or methods that might help, and possibly helping them develop a personal health action plan.

Eighty-four per cent of participants in Bradford who participated in an evaluation were referred in to the health trainer to focus on improving their general health and well-being, and some for more specific problems, such as diet, alcohol and smoking.

An evaluation of the model was conducted between January and September 2010, and it showed that following referral to the trainer, patients were able to:

- Return to work after an illness.
- Improve their personal relationships.
- Get involved in local activities.
- Engage in more physical activity, at home and through local classes.
- Engage with local support groups.
- Improve coping mechanisms for anxiety.

Some challenges have arisen in the development of the Bradford model. One is the nature of referrals. Some individuals who were referred had severe mental health conditions which the trainers felt unable to deal with. Some of these referrals are sent back to the GP, and trainers used the Health Trainer handbook to maintain clarity on what the remit and competencies set out for the trainers are.

During the evaluation of the pilot, some trainers also discussed wanting greater clinical supervision in the same way as psychological well-being workers. There are also some challenges in how to work with the 'hardest to reach' groups, who may not yet be registered with the GP.

WHY IS THIS CO-PRODUCTION?

Health trainer and social prescribing models can vary quite widely. The Bradford example is particularly strong in focussing the role of the trainer on building links and developing support networks for people within their community, and using these assets to sustain longer-term support for the individual. The trainer also supports people to build up their skills and capabilities, and their confidence in continuing these activities independently, away from services.

Transformative co-production could be developed by explicitly nurturing peer support between participants (see for example **KeyRing**), and working with participants as health champions or mentors to other new patients. The model might also develop its approach by supporting the clinical staff and GPs in the health trainer approach, developing the skills and capabilities needed to support wider culture change and to really make the model transformative.

EVIDENCE OF IMPACT

Evidence from the Bradford evaluation indicated that the service was a low cost way of improving the method and range of what primary care can offer patients. Fifty-one per cent of patients seen were referred to a community-based service for on-going support and 87 per cent made changes which enabled them to cope better and improve their health.

Another recent study on the impact of social prescribing, showed that short and medium-term outcomes for social prescribing include:

- Increased awareness of skills, activities and behaviours that improve and protect mental well-being.
- Increased uptake of leisure, education, volunteering, sporting and other activities.
- Increased levels of social contact and social support.
- Reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression.
- Reduced waiting lists for counsellors and psychological services.
- Reduced levels of frequent attendance (defined as more than 12 visits to GP per year).

LINKS

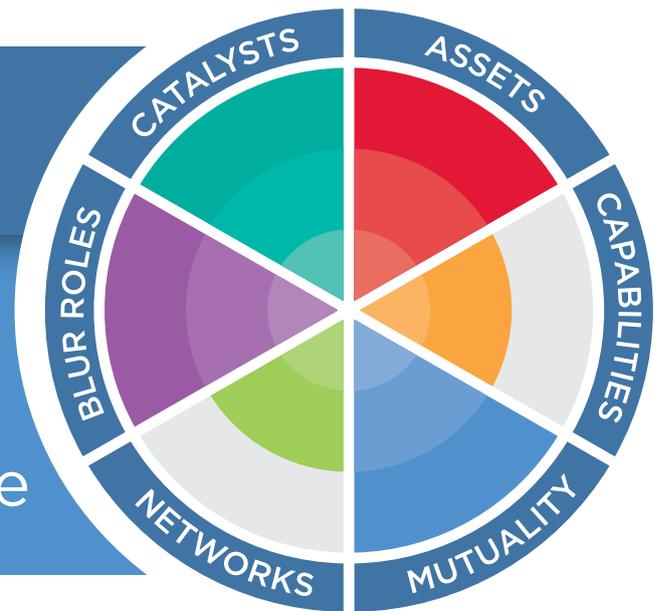
[http://www.bdct.nhs.uk/our-community-health-services/specialist-services/heath-trainer/Social Prescribing for Mental Health: a guide to commissioning and delivery](http://www.bdct.nhs.uk/our-community-health-services/specialist-services/heath-trainer/Social%20Prescribing%20for%20Mental%20Health%3A%20a%20guide%20to%20commissioning%20and%20delivery): this report includes an overview of some of the key evidence, and guidance on indicators and measures to evaluate social prescribing.

INTERESTED IN THIS APPROACH?

Then see also: **KeyRing**, **LRPT**, **LAC**

CASE STUDY 19

The Recovery Education Centre (REC) Nottinghamshire



KEY WORDS

Self-management

Well-being Coaching

SUMMARY

The recovery movement is an international approach to self-efficacy and empowerment in mental health, enabling people to become experts in self-care and recognising their role and experience as equal to that of mental health professionals. One organisation pioneering the co-production of self-care is the Recovery Education Centre in Nottinghamshire. Education is seen as the basis for recovery and there is a strong assets-based approach that has what people can do at its heart.

KEY LEARNING

- Embedding equal ownership into the day-to-day running of a service: the centre is an example of how the entire culture of an organisation can be developed alongside people who are 'service users', and how every aspect from strategic decision making and governance down to daily activities can be co-produced. *How can you blur roles to enable shared responsibility and control?*

MORE ABOUT RECOVERY

Nottingham's centre is driven by an ambition to:

- Provide a base for recovery support and resources.
- Promote an educational and coaching model in supporting people to become experts in self-care.
- Break down barriers between 'us' and 'them' by offering training sessions run for and by people with lived experience of mental health conditions and professionals.

Peer support is a strong feature of the movement and explicitly recognises the value of every participant's knowledge and experience. The course is not only open to those who have a mental health condition, but caregivers, family members, friends, and people working in mental health services.

The centre's courses are focussed on recovery, and improving the individual's well-being. Participants are seen and treated as equals, and play a strong role alongside staff running and leading courses at the centre. Partnership is at the heart of the approach.

Valuable lessons can be learnt from the US experience of recovery education. For example, changes to everyday management of centres in the US has promoted a range of positive changes. Small changes have included: using positive language; having high expectations of people's capabilities; encouraging people to help as well as be helped; celebrating and rewarding accomplishments; changing forms and procedures to support recovery rather than stability; making an effort to ensure everyone is able to hold a valued role within the community; taking steps to avoid writing about people who are supported, instead enabling them to draft up their own ideas, recovery plans, and notes. The US experience has shown how organisational policies are often driven by values, and the 'Policy and procedure manual' is a good example of how these can be developed to support (rather than inhibit) co-production in recovery.

Nottinghamshire is one of four demonstration sites for Recovery Education in the UK that build on the US experience, and are developing solutions to ten challenges which are identified as common:

1. Changing the nature of day-to-day interactions and the quality of experience.
2. Delivering comprehensive user-led education and training programmes.
3. Establishing a 'Recovery Education Centre' to drive the programmes forward.
4. Ensuring organisational commitment, creating the 'culture'.
5. Increasing personalisation and choice.
6. Changing processes for risk assessment and management.
7. Redefining service-user involvement.
8. Transforming the workforce.
9. Supporting staff in their recovery journeys.
10. Increasing opportunities for building life 'beyond illness'.

<http://www.nottinghamshirehealthcare.nhs.uk/aboutus/latest-news/piloting-the-way-for-recovery/>

WHY IS THIS CO-PRODUCTION?

The demonstration site in Nottinghamshire explicitly states that it is focussed on "*The transformation of services into positive, strengths-based, recovery focused facilities, working in partnership with local communities.*"

The service explicitly tries to link people into the community and find networks and roles that will support them outside 'services'. Family and friends of individuals are seen as crucial partners in the recovery process. 'Working in partnership as equals replaces 'service-user involvement' as an ideal'

The Trust's strategy sets out that a key focus for teams is to build relationships with

neighbourhoods and communities, involving wider family/personal networks in care planning, goals and outcomes that are user-defined. Positive risk taking, building up skills and identifying new opportunities, actively developing peer support as a critical feature of services are also supported.

The involvement strategy set out by the Trust seeks to ensure that people with experience of using services are involved in governance, staff inductions and training, decision making, and evaluation and research. People also play a practical role such as co-delivering the recovery training programme.

It could be further developed by:

- Thinking about how to apply the principles of co-production in crisis situations: some useful analysis of how this change was affected at the META recovery centre in the US can be found [here](#).
- Another inspiring case study of an organisation's transformation towards the recovery model can be found [here](#).

EVIDENCE OF IMPACT

There has yet to be a formal evaluation of the centre.

LINKS

recoveryeducationcentre@nottshc.nhs.uk

The [Recovery strategy](#) provides an insight into the thinking behind the Nottinghamshire centre.

INTERESTED IN THIS APPROACH?

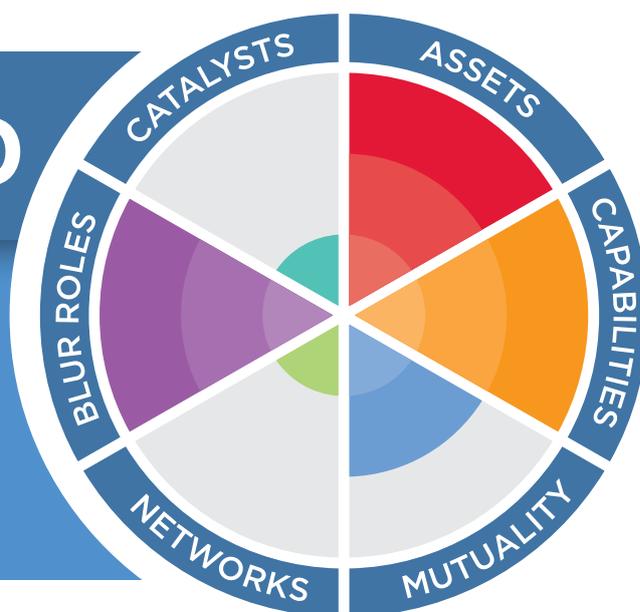
Then see also: [SUN](#), [Comas Recovery Coaching](#), [Bradford Health Trainers](#)

ENDNOTES

1. <http://www.nottinghamshirehealthcare.nhs.uk/aboutus/latest-news/piloting-the-way-for-recovery/>

CASE STUDY 20

The Chronic Disease Self-Management Program (CDSM)



KEY WORDS

Self-management

Co-design

Peer Support

SUMMARY

The Chronic Disease Self-Management (CDSM) Program was set up by Stanford University's School of Medicine, and is a community based self-management programme for people with a chronic illness. The approach is based on a participative and reciprocal process, mutual and community-based support. This makes it one of the best examples of how self-management can achieve transformational co-production. People with chronic conditions are involved in designing and delivering the training at all levels of the programme.

KEY LEARNING

- The success of this programme is in the participative process at the heart of the course, and the focus on building skills and capabilities within an environment of mutual support. *Does your organisation focus on building up the skills and abilities of people who access services? How could this be built into the core of the service?*
- Lived experience of chronic disease is central to the success of the programme and trainers usually have personal experience of this. *Does your service make use of experts by experience? How could you integrate different forms of knowledge into the design and delivery of services?*

MORE ABOUT CDSM

The CDSM programme was started in 1996 by Stanford University's Patient Education Research Center. People with chronic conditions attend six sessions each for 2.5 hours, usually based in community settings such as community centres, libraries or churches. People with a range of chronic conditions can attend the same course. The focus of the programme is on managing health conditions and supporting people to maintain fulfilling lives, and enabling them to play an active role in community life.

There are several aspects of Stanford's CDSM programme which incorporate a much deeper level of co-production than many other self-management or expert patient programmes.

The content and design of the course was developed collaboratively by professionals and those who had personal experience of living with a chronic condition, and the content is shaped by the areas of support which are most important to people living with chronic conditions. Subjects covered include coping techniques for problems such as pain and isolation, use of medication, effective communication and nutrition.

The workshops are led by two trained professionals who usually have experience of living with a chronic condition themselves. A strong emphasis is also placed on building up peer support within the group and using methods which increase confidence and self-efficacy in participants own skills and abilities. Efforts are also made to help people build skills and share their experiences.

The programme is usually run by a programme coordinator who recruits and supervises trainers and can be anything from ¼ to 1 FTE. Master trainers lead the training of 'Trained Leaders', who run the courses on a day-to-day basis. Master trainers are professionals, many of whom also have personal experience of a chronic condition, or as a carer. Two trained leaders run the six week workshops. They are usually peers with chronic condition(s) themselves and it is recommended that they receive a small salary for teaching the programme.

Crucially, the programme highlights that *'It is the process in which the program is taught that makes it effective. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.'*

Recent developments in the programme have piloted online training courses, on which more information can be found [here](#).

Some of the key challenges in setting up the programme include recognising and rewarding the valued input of Trained Leaders, and ensuring the course is tailored to the community or group of people it hopes to train. The programme has adapted to respond to these challenges, and recommends paying trained leaders a small stipend for their work, recognising their efforts with events, adequate support and training, and ensuring that their role does not become extended into the programme coordinator's. The programme also advises seeking advice from a range of community members on how to tailor it to local circumstances, and advocates employing people from the community the programme is intended to benefit.

WHY IS THIS CO-PRODUCTION?

Assets: the lived experience and expertise of those with a chronic condition is recognised and incorporated into the design and the delivery of the course. Community resources (usually buildings rather than people) are also central to the programme.

Building up skills and capabilities: peers are trained and supported as course leaders and participants are trained to build up their confidence, self-efficacy, knowledge and condition self-management skills throughout the course.

Peer support: the courses are intended to foster mutual support between participants during the course.

Facilitating rather than delivering: the intention of the course is to equip people living with chronic conditions with the skills to live a positive and fulfilling life.

Though this is a relatively strong example of co-production, it could still be further deepened. For example, it could be more explicit in developing peer support networks or buddying programmes among participants, and perhaps encourage these to be maintained beyond the duration of the course. It could also look at ways in which other community resources, local networks, and health and well-being resources could be used to support people. The idea of reciprocity between and among trainers and participants could also be developed a bit more, perhaps by asking people who have participated if they want to 'give back'.

EVIDENCE OF IMPACT

The US CDSM programme has had an RCT evaluation of over 1,000 people who had heart disease, lung disease, stroke or arthritis. The RCT explored the impact of the programme on health status, health care utilisation, self-efficacy, self-management, use of community resources and communication with their physician. The RCT showed that patients who took the programme demonstrated:

- Improvements in exercise, cognitive symptom management, self-reported general health, health distress, fatigue and disability.
- Reductions in days in hospital, reduced outpatient visits and hospitalisations.
- The RCT data indicated a cost saving ratio of 1:4 over three years.

LINKS

Website: [The Stanford Patient Education Centre](#).

Contact: betterchoices@selfmanage.org

[CDSM Implementation manual](#)

A toolkit for patient education: <http://patienteducation.stanford.edu/>

INTERESTED IN THIS APPROACH?

Then see also: [The Recovery Education Centre](#), [Bradford Health Trainers](#)

RESEARCH AND PUBLICATIONS

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More than Money: platforms for exchange and reciprocity in public services

Boyle, D. 2011

This paper proposes and develops a typology for reciprocal exchange systems, such as time banks, service credits, rewards points, local economic exchanges and backed exchanges, based on objectives.

It takes as its starting point the key aims of the different systems, making a two-fold distinction between social and economic aims and forms of exchange.

It is very much designed with public services in mind and aims to clarify the roles that different exchange systems could play to support the delivery of public outcomes.

More than Money: a literature review of the evidence base on reciprocal exchange systems

Slay, J. 2011

This literature review brings together the existing evidence of impact, outcomes and cost that exist across reciprocal exchange systems, including: time banks, complementary currencies and peer-to-peer platforms for collaborative consumption. The review makes a distinction between social forms of reciprocal exchange, designed to meet social objectives and incentive pro-social behaviour, and economic forms of reciprocal exchange, which are designed primarily to circulate and meet economic ends. The literature review draws mainly from evidence of reciprocal exchange in public services, and is especially useful for those interested in time banking and time credit schemes.

Co-production: an emerging evidence base for adult social care transformation

Needham, C. and Carr, S. 2009

This SCIE research briefing outlines the role of co-production in adult social care services. The evidence highlights that:

- Different types of co-production in social care can fit on a scale from 'descriptive' models, to truly 'transformative' models.
- Descriptive models in social care understand that care services cannot be produced without input from the people who use services, but are concerned with little more than service-user compliance - whether by choice or imposition.
- Intermediate models involve a much fuller recognition and valuing of the many people who together co-produce care outcomes, with an emphasis on mutual respect.
- Transformative models of co-production have the potential to create new relationships between the people who use services and staff. These models reposition service users as experts and ask what assets they can contribute to collaborative relationships which will transform provision. They take 'a whole life focus' which incorporates broader quality of life issues, rather than just clinical or service issues.

The paper concludes that the transformative approach can come closest to fulfilling the demands of the 'Putting people first' adult social care transformation agenda.

Co-production with Older People Guide

National Development Team for inclusion (NDTi)

This paper sets out seven principles to help local authorities and their partners, including local communities, work together and improve older people’s influence at all levels of service commissioning and delivery. Use this resource to provoke thinking about what underpins successful collaboration with older people for a range of purposes. Includes helpful diagrams about how the seven principles can be translated into practical steps, and case studies from social care.

LAC: Review of the Local Area Coordination Program, Western Australia

Disability Services Commission 2003

In 2002 an LAC review was commissioned to analyse the value for money case for the service; this report, based on detailed consultations with multiple stakeholders, summarizes its main findings. These include:

- High levels of user-satisfaction: users, families and the coordinators all scored the service highly in surveys conducted. These were further backed up by in-depth conversations.
- Responsive and flexible service provision: the service has proven a strong ability to adapt with the changing needs of the service users.
- Good value for money and has demonstrated a 30 per cent reduction in costs.

Peer support/peer provided services underlying processes, benefits, and critical ingredients

Solomon, P. 2004

Outlines different types of peer support and peer provided services and includes evidence of the benefits.

The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial

Kennedy, A. et al. 2006

This lay-led self-care support group is a useful example of peer education in groups, and was used to teach self-care skills. Patients receiving immediate course access reported considerably greater self-efficacy and energy at six-month follow-up. The study concluded that lay-led self-care support groups are effective in improving self-efficacy and energy levels among patients with long-term conditions, and are likely to be cost effective over six months. Read this if you are seeking to build upon your evidence base.

Cost effectiveness of the Expert Patients Programme (EPP) for patients with chronic conditions

Richardson, G. 2008

A study of an EPP based on the US Chronic Disease Self-Management Program (CDSMP) – a lay-led self-care group involving six weekly sessions to teach self-care support skills applied to two community settings in England. The research found a reduced cost of around £27 per patient and concluded that this form of EPP is very likely to provide a cost effective alternative to usual care for people with long-term conditions. Useful as evidence of cost effectiveness.

A synthesis of published research on mentoring and befriending

Phillip, K. and Spratt, J. 2007

Reviews the evidence base for volunteer and peer forms of befriending and mentoring. Focuses on interventions with young people who are socially excluded, experiencing mental health problems, and stresses that results vary widely as many different kinds of intervention are included under the banner of mentoring. The most successful models reviewed were those that were essentially ‘youth driven’ and characterised by qualities such as trust, mutual respect, reciprocity, challenge and support. Useful as a wide-ranging overview of the literature in the field.

Peer Educators lead the Way: How London Borough of Lambeth lowered teenage pregnancy rates and improved sex education

Tatam, J. 2011

This case study points to the success of co-production in the delivery of health education. The Lambeth Peer Educators project (which began in 2003) is described in terms of its objectives, outcomes, performance indicators and costs.

Learning points are also helpfully drawn from the study, and the ways in which the programme recognises that young people have a special knowledge, augmented by some training and then put back into the community, are highlighted.

The peer employment training approach of Recovery Innovations in Arizona

Needham, C. 2010

Recovery Innovations is an Arizona-based NGO which provides services to adults with serious mental illness and substance use issues. Its work is associated with a 56 per cent reduction in hospitalisations, a 36 per cent reduction in seclusion and a 48 per cent reduction in restraints.

Needham highlights:

- The need for specific, tailored jobs for peers, along with a career training ladder so that peers can progress to more senior positions.
- That peer support must not remain peripheral.
- If peer support is to be effective a cultural shift is required, so that the peers are not seen as amateurs working alongside the 'real' staff.

Building community capacity: making an economic case

Knapp, M. et al. 2010

Develops economic analysis of community capacity-building initiatives, such as time banks. With regards to time banks it notes that they have the potential to generate savings at local and national levels, improve skills and participant employability and reduce people's reliance on paid and unpaid support - particularly in relation to health and care support. As a conservative estimate, the authors estimate that the £450 annual cost per participant of running a time bank generates over £1,300 of economic benefit per person in return.

All you need is love? Assessing time banks as a tool for sustainable economic development

Callison, S. 2003

Focuses on the economic impact of time banks on the finances of participants, in the case of Gorbals Time Bank in Glasgow. It was shown that in many cases time banks can improve the financial situation of its members, but that DWP welfare and benefits legislation risked dampening its effects. Useful as part of the time-banking rationale and evidence base.

Keeping the GP Away: An evaluation of the Rushey Green Time Bank

Garcia, I. 2002

This paper presents the findings of an in-depth qualitative evaluation of the Rushey Green Time Bank in London, based on interviews with 24 time bank participants, and surveys of practice staff about their experiences of the scheme. It finds that the community time bank approach helps to:

- Engage patients as partners in the business of delivering health.
- Use hidden resources in the community and increase organisational capacity (greater number and diversity of services).
- Enable health centres to supply a broader view of health.
- Develop mutual support, which can make a difference to the way people experience the NHS.

Useful as evidence for time banking's efficacy as an approach, but also as an example of qualitative evaluation.

The new wealth of time: how time banking helps people build better public services

new economics foundation (nef) 2008

This report introduces a useful typology of time banking and develops the case for time banking

as part of the new paradigm for public services. It includes a case study section on the use of time banks in improving mental health.

Community Connections Time Bank: impact of the time bank on its membership

Visiting Nurse Service of New York 2009

The Community Connections Time Bank is a time bank run through the Visiting Nurse Service of New York. This short document summarises the main findings from a survey designed to gauge what impact the time bank has on the lives of active elderly participants. Some key findings include:

- One in two self-reporting improved physical health.
- Almost 75 per cent self-reporting improved mental well-being.
- Improved access to health and other community information and services.
- Larger and closer social networks.
- Improved quality of life.

Interestingly, the greatest benefits were felt amongst those who are often most marginalised; those on lower incomes and those for whom English is not a first language.

The Impact of Time Banks in the UK

Swift, H. (n.d.)

This paper was written for the Royal Borough of Windsor and Maidenhead and provides a useful overview of the literature on the impact of time banks in the UK. It looks at the benefits for individuals, communities, local economies and organisations and institutions, drawing on key authors and organisations, as well as the main evaluations to date.

Spending time locally: The benefits of time banks for local economies

Gregory, L. 2009

Explores the potential role of time banks in rebuilding and sustaining local economies, focusing on how time banks can a) reduce people’s dependency on financial resources and b) interact and contribute to local economies.

Spending time, building communities: Evaluating time banks and mutual volunteering as a tool to tackle social exclusion

Seyfang, G. 2001

This report presents the findings from the first national survey of time banks. The paper shows that time banking has the potential to bring together a range of diverse participants and improve their quality of life by building social networks. The author argues that with increased funding and policy focus, time banks could transform volunteering and social action.

With a little help from my friends: evaluating time banks as a tool for community self-help

Seyfang, G. 2003

Presents findings from the first national evaluation of the impacts and potential of time banks in the UK, drawing upon national surveys and an in-depth case study of Rushey Green Time Bank. It finds that time banks: “remove the stigma attached to being a recipient of charitable assistance”; “make volunteering a more attractive prospect for groups who would not normally get involved”; and “change the relationships between giver and receiver into reciprocal ones of mutual respect”.

Time Banking and Health: the role of a Community Currency Organisation in enhancing well-being

Lasker, J. et al. 2011

Based on a survey of 160 members of a hospital-affiliated time bank, this examines the physical and mental health benefits of membership. The paper argues that a sense of belonging and development of social capital is key to improved physical and mental well-being and that time banking can be particularly valuable in promoting health and belonging among older and lower-income individuals, as well as those who live alone.

Health coaching to facilitate the promotion of healthy behaviour and achievement of health-related goals

Palmer, S. 2003

Useful as an introductory piece on health coaching. Gives a tentative definition of the process, and briefly discusses its role in supporting people to move from Health Inhibiting Thinking (HIT) to Health Enhancing Thinking (HET) - a process that can have a wide appeal across generations.

Health Coaching: What is it? Psychological strategies for lifestyle change

Gale, J. (n.d)

A PowerPoint presentation giving an accessible, but detailed overview of health coaching and its benefits in comparison to traditional approaches to health behaviour change. Includes helpful charts and diagrams on the role of health coaching, the skills required and effective goal-setting, among others.

The impact of life coaching on goal attainment, metacognition and mental health

Grant, A. 2003

A study of a group life coaching programme facilitated by an external coach, which found that participants' levels of depression, anxiety and stress were significantly reduced, while their level of insight and goal attainment increased. The results indicate that solution-focused, cognitive-behavioural life coaching can facilitate goal attainment, improve mental health and enhance general life experience. Useful as part of the evidence base for coaching in health settings.

The Evidence for Coaching in Leadership and Healthcare

Moore, M. 2009

Review of the evidence base for coaching produced for the International Coaching Federation annual conference by the co-director of the Institute of Coaching. Presents evidence of the impact coaching can have on quality of life, stress and anxiety, but also for cancer survivors, patients with diabetes, and those with clinical depression. Useful as a bullet-pointed overview of research and evidence.

Coaching Your Patient Into the Driver's Seat

Frates and Moore (n.d)

A guide to coaching designed to teach healthcare professionals to move from the 'expert approach' to the 'coach approach' which empowers the patient. Includes a useful table (p.8) which summarises research papers on coaching, covering cardiac disease, diabetes, asthma and cancer pain.

'Thanks for the Petunias' - A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions

NHS Year of Care 2011

Describes the benefits of partnering with non-traditional providers to improve the health and well-being of people with long-term health conditions. Makes the case for commissioning social activities such as exercise and cooking at the level of commissioning consortiums, and in GP surgeries. In particular, shows how such activities, when well commissioned, can be a route to enhancing self-management and user-involvement. The paper can be helpful in providing a rationale for social prescribing, and for exploring the range of models for NHS providers and non-traditional providers partnering with each other.

Moving on up

Mental Health Foundation 2009

This report outlines the evidence in favour of social prescribing in both primary and secondary care settings. GPs are becoming gradually more receptive to prescribing exercise for mental health conditions. Suggest improvements and 'lesson learned' in running exercise referral schemes. Useful as a rationale for a specific kind of social prescribing, and more generally for understanding the processes that make the commissioning of such schemes productive.

Patient self-management of chronic disease in primary care

Bodenheimer, T. et al. 2002

Evidence from controlled clinical trials suggesting that programs teaching self-management support are more effective than information-only patient education in improving clinical outcomes, and self-management education improves outcomes and can reduce costs. Useful in providing evidence and rationale for using self-management.

Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams

Glasgow, R. et al. 2002

Presents evidence that implementing self-management support in the context of the Chronic Care Model improves care for both diabetes and heart failure patients. Lessons learned, keys to success, and directions for future research and practice are discussed.

Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial

Lorig, K. et al. 1999

A study assessing the effectiveness (in terms of changes in health behaviours, health status and health service utilisation) of a self-management programme with a heterogeneous group of chronic disease patients. Suggests that programmes can feasibly be designed to meet the needs of a range of diverse conditions, providing they are all chronic conditions, and can reduce hospitalisation levels. Improvements were noted in self-reported health, weekly minutes of exercise and communication with physicians.

A Systematic Review of Internet-based Self-Management Interventions for Youth with Health Conditions

Stinson, J. et al. 2009

Offers the beginnings of an evidence base that self-management interventions delivered via the internet improve selected outcomes in certain childhood illnesses. Reviews literature relating to a range of Internet-based interventions varying in their degree of interactivity. Suggests perceived useability as a prime factor in the efficacy of an intervention, and the importance of navigation and search tools, as well as feedback features. Useful as a summary of the literature on this specific area of self-management.

Personalisation, productivity and efficiency

Social Care Institute for Excellence (SCIE) 2010

This report examines the potential for personalisation, particularly the mechanism of self-directed support and personal budgets, to result in cost efficiencies and improved productivity as well as improved care and support, resulting in better outcomes for people's lives. It provides an overview of some emerging evidence on efficiency from the implementation of personalisation so far, to inform the next stage of delivery. Read this to gain a sense of the early findings relating to this emergent area in social care.

Budgets and Beyond: what co-production can offer personalisation

Slay, J. (2011)

Explores the potential for co-production to improve outcomes for those individuals (along with their families and support networks) who are intended to benefit from the move towards greater personalisation of care and support services, including people who have personal budgets or are self-funders. Includes the findings of a wide ranging literature review, and outlines a framework for exploring what co-production might offer personalisation.

Personal Health Budgets (Review)

The Health Foundation 2010

This research scan collates more than 60 articles on personal health and social care budgets in the UK and internationally. Useful if you want a brief synopsis of the evidence surrounding personal budgets with an international perspective.

Personal budgets – checking the results

Putting People First 2010

Considers emerging approaches to developing outcome-based performance measures and describes the key features of best practice when checking results. Use this if you want a rationale, and a foundation, for measuring the outcomes of personalisation.

Good practice in care planning

NHS National Treatment Agency for Substance Misuse 2007

Includes a useful section on factors influencing good performance which, while targeted at drug treatment, are useful in defining the critical ingredients of successful care planning. These include:

- Responsiveness to service user needs.
- Working with local forums and meetings.
- Good systems for recording, sharing and monitoring care plans.
- Regular audits.
- Local commitment to care planning.
- Care plan simplicity.

Making shared decision a reality: No decision about me, without me

The King's Fund 2011

Evidence for the benefits of shared decision making and practical support in implementing it. Includes insight into patient decision aids, the use of health coaching, advice on recording and implementing decisions and a discussion of incentives for improving clinical decision making.

Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status

Joosten, E. et al. 2009

The link given here is for a National Institute for Health Research summary of the study, which used randomised control trials to assess the impact of shared decision making on healthcare. The paper concluded that the evidence for the efficacy of SDM is strongest with regard to the treatment of patients with chronic health conditions making long-term treatment decisions.

Shared decision making interventions for people with mental health conditions

Duncan, E., Best, C. and Hagen, S. The Cochrane Collaboration 2010

Assesses the effects of provider, consumer or carer-directed shared decision making interventions for people of all ages with mental health conditions, on a range of outcomes including patient satisfaction, clinical outcomes, and health service outcomes. This is useful as an analysis of the possible roles played by SDS in the care of people with mental health conditions, and of the factors that affect its effectiveness.

Shared decision making for in-patients with schizophrenia

Hamann, J. et al. 2006

Randomised controlled trial comparing a SDM program with routine care, showing that the intervention studied was feasible for most of the patients and did not take up more of the doctors' time. Concludes that sharing medical decisions with acutely ill in-patients with schizophrenia is in many cases possible and improves important treatment patterns. This might help in destigmatising this group of patients and improving schizophrenia-related health outcomes. Use this if you are seeking to build upon your evidence-base for SDM.

NHS Diabetes Year of Care

Outlines collaborative care approaches to caring for people with diabetes and the necessary training for practitioners learning to use care planning. The page gives a helpful analysis of the benefits of the Year of Care approach – for people with long-term health conditions, commissioners, practitioners and chief executives – as well as tables summarising a range of measurements for monitoring and evaluation.

Preventing loneliness and social isolation: interventions and outcomes

Windle, K. et al. 2011

Research presents the use of 'Wayfinders' or 'Community Navigators' as one of four key interventions that can be used to tackle social isolation. The study found that people who used befriending or Community Navigator services reported they were less lonely and socially isolated following the intervention, and noted positive changes to health outcomes such as depressive symptoms, physical health, health-related quality of life and mortality. These interventions were also assessed as cost-effective when compared with 'usual care'. Useful as part of the evidence base.

LAC: Local Area Coordination: Family, friends, community - a good life

Government of Western Australia 2010

Outlines the vision and principles of the LAC Programme in Western Australia - an intervention which has strong and positive evidence base. Helpfully provides the role description for a Local Area Coordinator, and gives examples to illustrate seven key aspects of the position. Useful in highlighting the means by which the LAC programme made the role of navigator truly transformative.

LAC: Review of the Local Area Coordination (LAC) Program, Western Australia

Disability Services Commission 2003

In 2002 an LAC review was commissioned to analyse the value for money case for the service; this report, based on detailed consultations with multiple stakeholders, summarises its main findings. These include:

- High levels of user-satisfaction: users, families and the coordinators all scored the service highly in surveys conducted. These were further backed up by in-depth conversations.
- Responsive and flexible service provision: the service has proven a strong ability to adapt with the changing needs of the service users.
- Good value for money: demonstrated a 30 per cent reduction in costs.

LAC: Local Area Coordination Consultation Project

Disability Services Commission 2010

A review of LAC based on over 100 conversations with people with disabilities, their families and carers. Contains useful sections on the ingredients for a successful working relationship between LAC and client (pp.20-21) and client-suggested improvements (pp.28-29). Also includes an overview of questions asked during the consultation which is a useful resource for designing qualitative evaluations.

Turning Point: Connected Care

Connected Care is Turning Point's model for community-led commissioning. It aims to bring the voice of the community to the design and delivery of all health, housing, education and social service delivery. The website includes information about the ten projects Turning Point are running across the UK, videos explaining the rationale and evidence for Connected Care, an outline of the model's seven step process, and access to useful publications such as Explaining Connected Care.

Lay patient navigator program implementation for equal access to cancer care and clinical trials: essential steps and initial challenges

Steinberg, M. et al. 2006

Study of the use of patient navigators to address barriers to cancer care, particularly for ethnic minority patients and those from low-income backgrounds. Preliminary assessments suggest the programme was effective in reducing barriers to care in the pilot in South Los Angeles. Stresses the importance of careful initial planning, including input from a community advisory committee, in ensuring smooth programme implementation.

PRACTICAL GUIDANCE AND TOOLS

The Co-production Self-Assessment Audit Tool

new economics foundation (nef) 2011

This short self-assessment tool has been designed to help practitioners critically assess how deeply they have developed co-production. The framework encourages self-reflection around the six co-production principles:

- Assets
- Capacity
- Mutuality
- Networks
- Blurring roles
- Catalysts

Using these six principles, you can score yourself or your organisation to identify areas for improvement, barriers to better working and points to celebrate. It is also very useful as a means to assess progress towards co-production over time.

Co-production - how are you doing? A self-reflection tool

Inclusion North and Tricia Nicoll Consulting 2011

This tool uses Edgar Cahn’s four key principles of co-production and helps practitioners to score their work across the four areas as red, amber or green. Questions are asked to provoke changes towards deeper and more transformative practice of co-production. This is an easy-access, user-friendly resource and works well for self-reflection at multiple levels of an organisation/project.

The Integrated Resource Framework (IRF) Co-production learning template

This learning template was put together for the Integrated Resource Framework (IRF) program in Scotland, a program set up in 2008 to address a perceived lack of shared resources available to guide informed and evidenced decision making by care partners. It is designed to help people reflect upon their practice by asking a number of questions that can guide people in thinking through how they might effectively structure learning from their work. It is particularly useful as a guide to questions that might be asked when writing up case studies on co-production.

Conversations about inclusive and sustainable communities: six practices for creative engagement

O'Brien, J. and Towell, D. 2011

The six practices presented in this guide offer practitioners helpful insights into how to begin conversations with citizens that develop mutual understanding and a shared desire to act together. The six practices will be useful for those trying to:

- Discover more about local people’s perspectives.
- Bring together diverse groups to co-produce knowledge and generate new, shared insights.
- Identify local assets which are often overlooked, but which often prove key to success.
- Balance broad-based engagement with in-depth understanding.

A glass half-full: how an asset approach can improve community health and well-being

Improvement and Development Agency (IDeA) 2011

Explains the asset-based approach and describes how this can help tackle health inequalities. Read this for advice on asset-mapping as well as other techniques to support an asset-based approach - such as appreciative inquiry, participatory appraisal and open space technology. It is very strong on practical examples and case studies.

Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success

Heisler, M. 2006

Outlines seven peer support models, including case studies and information on costs and reimbursements. The selected models cover support strategies that include professional-led group visits, peer mentors, reciprocal peer partnerships, and email- or web-based exchanges. Particularly useful for developing front line practice.

Homelessness and health: resources to support peer activity

This toolkit is an extremely useful resource providing pointers and 'how to' guidance in setting up peer health research, education, promotion and advocacy including ideas on recruitment, training, on-going support and evidencing the impact. The learning is relevant for all peer programmes, and it is a valuable, practical guide, particularly for programme coordinators and front line staff.

Social prescribing for mental health - a guide to commissioning and delivery

Care Services Improvement Partnership

A review of different forms of social prescribing with helpful notes on the evidence base and rationale for each approach. Includes computerised therapy, books on prescription, arts and creativity, ecotherapy, learning, volunteering, social enterprise and supported employment, each with an angle on mental illness. Presents a model and flowchart for social prescribing in practice (pp.33-34). Case studies are also given.

Partnering in Self-Management Support: a toolkit for clinicians

The New Health Partnerships Initiative 2009

A toolkit intended to give clinicians an introduction to a set of activities that can help them change their practice to support patients and families in the day-to-day management of chronic conditions. Provides useful practical advice and techniques to help clinicians:

- Build better relationships with patients.
- Engage in more collaborative conversations.
- Plan and problem-solve with patients.
- Involve family members meaningfully.
- Build patient skills and monitor progress together.

Adult Advance Care Planning Toolkit

NHS South Central 2011

An easy to use tool with short summaries of how adult advance care planning (ACP) operates and downloadable PDFs of example ACP forms and factsheets. Useful as a pool of information regarding ACP and as an example of an interactive tool for both professionals and service users.

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Co-production Practitioners' Network

The Co-production Practitioners Network website is a dedicated network, run by the new economics foundation (**nef**), with and for practitioners of co-production. The website currently hosts an online community of over 500 practitioners from public, third sector and academic backgrounds, working in areas as diverse as health, social care, criminal justice, housing, and education. The website enables people to link up with and support one another, share ideas and case studies, and ask questions. The website also serves as a useful first port of call for people who are new to co-production, with a regularly updated blog, events page and bibliography of key articles and reports.

Centre for Innovation in Health Management

CIMH is a network of doctors, public sector managers, organisational change consultants and academics facilitated by the University of Leeds. It aims to bring people together to build connections and alter the ingrained patterns of behaviour across the whole healthcare system. CIMH helps people working in such systems understand that it is their individual and collective actions and attitudes that shape outcomes, and the website includes a helpful list of resources including links to articles and publications on change management, impact value, leadership, partnerships and social enterprise – all in the arena of health management. In particular, their report on 'Co-producing Health: an enquiry into what works' is an excellent discussion of some of the successes and challenges of co-production in the health sector.

Governance International

Governance International provides solutions and tools aimed at transforming public services in the context of Open Government co-production. Particularly useful for case studies.

Time Banking UK

Time Banking UK is the national umbrella charity linking and supporting time banks across the country by providing inspiration, guidance and mutual help. The Time Banking UK website is a good first port of call for those keen to learn more about time banking, its different models and how they can be set up. The website, which is currently under redevelopment, also hosts the UK's time banking network, bringing together interested and committed organisations; for individuals, the website acts as the UK's time bank directory – enabling people to locate a time bank close to where they live. Finally, there are a number of interesting reports, case studies and short videos hosted on the site.

Spice

Spice is a social enterprise that develops agency time banking systems for communities and public services. It works to transform communities by engaging and empowering the many rather than the few in housing, schools, localities and international contexts. Includes links to evidence of the impact of time banking, media coverage and new models for development.

[Camden Shares](#)

This is useful as an example of a website acting to resource and facilitate time banking. Individuals, groups and organisations can offer their time and resources, and also request support, time and resources in return. The website includes case studies of [successful trades](#) and a [video case study](#).

[About Health Coaching](#)

Health Change Australia (HCA)

Focuses on the HCA model for health coaching which is being used in Australia alongside other chronic disease prevention and self-management (CCPSM) models. The download section includes an audio file summarising the theory behind the HCA model, a chart comparing Health, Tele-Health, Life and Wellness Coaching, and a diagram showing where health coaching fits within the wider health change spectrum.

[Health Trainers England](#)

NHS England website that draws together information about health trainers from across the country. Information is broken down by region and includes case studies and evaluation. There are also broadly applicable resources on the role of a health trainer in various settings (including Primary Health Care, communities and pharmacies), job descriptions, community engagement training and Data Collection & Reporting Systems (DCRS).

[The Well-being Project](#)

Provides a basic outline of the literature on social prescribing, and the evidence for its benefits. The Well-being Project runs several social prescribing programmes which serve as useful examples of social prescribing in practice.

[The Health Foundation: Self Management Support Resource Centre](#)

A collection of resources helpful in reviewing the evidence for self-management support, suggesting strategic improvements (see 'Co-creating Health: Second Annual Evaluation Report' 2010) and in providing tools that include a self-care toolkit, and an introductory PowerPoint presentation designed to support those who want to present the case for self-management to colleagues.

[In Control](#)

In Control is a national charity aiming to create *'a fairer society where everyone needing additional support has the right, responsibility and freedom to control that support.'* The [resources](#) section of the website contains procedures, guidelines and templates for personalisation, SDS and personal budgets; 'easy read' resources; factsheets; and research, including evaluations and case studies.

[Think Local Act Personal Partnership](#)

The TLAP Partnership is comprised of over 30 national and umbrella organisations representing the broad interest in personalisation and community-based support. The website has a resource section that can be browsed by topic and includes information on and examples of co-production commissioning, user-led organisations, personal budgets and SDS. Use this to source clearly-labeled resources - both reports and practical guides - with a focus on personalisation, as broadly defined.

[Measuring the results](#)

This page on the TLAP website gives a series of reports which consider emerging approaches to developing outcome-based performance measures in social care, and highlights the effectiveness of specific methods such as SDS and personal budgets.

[Leeds Directory](#)

The website directs people towards local resources they might use to help them stay independent. Provides a centralised route to social prescribing, community networks and self-help groups.

Stories of Co-production

new economics foundation (nef) and Feedback Films 2011

A useful introduction to co-production, set around three case studies of successful co-production in different contexts. Skillnet is a social enterprise working with people with learning difficulties and taking their views seriously, Headway East London runs a 'Discovery' programme to support people with acquired brain injuries to explore occupational roles, and Wells Blue School has developed an innovative programme entitled 'Learning to Lead' to enable students to take ownership of activities and seek change in their school and community.

Running time: 7:55 mins.

The Story of Co-Design

Think Public 2009

Co-design made simple and accessible in a fun short film using the analogy of residents of 'panda island', co-designing a panda bus service. Covers the difference between co-design and other forms of expert service design, and the value of co-design in terms of user satisfaction and sustainability.

Running time: 3:48

Rushey Green Time Bank

Explains the rationale for setting up Rushey Green Time Bank which is based in a doctor's surgery in Catford, London. Useful way to introduce interested parties to the benefits of time banking more generally, with helpful specific examples of it in practice.

Running time: 8:48

How Coaching Works

Coach Meg and Wellcoaches 2008

A fun, simple animation outlining the coaching process. Useful as an interesting introduction to the coaching approach, and as a visual representation of the aims of coaching.

Running time: 3:47

Nesta...



FOREWORD

INTRODUCTION

CASE STUDIES

RESEARCH

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