A Toolkit for Co-production

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Agreement number: 2015-1-UK01-KA204-013821

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Co-funded by the
Erasmus+ Programme
of the European Union

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Learning Outcomes

By the end of this module practitioners, commissioners and individuals responsible for developing services will understand what co-production is and how it differs from traditional forms of service user involvement and engagement. They will be able to describe the key principles and benefits of co-production.

Learners will develop their own toolkit of exercises and guidelines to use co-production principles in the context of their organisation and their role.

What is co-production?

Co-production is about the active contribution of service users to the provision of services they receive from the state or another organisation. In other words, this is more than involvement but individualised service delivery based on information exchange and shared decision making. Central to co-production is partnership; it is about a new way of working, a new set of relationships between organisations and consumers, service providers and service users, clinicians and patients.

It is important to recognise that co-production is not the same as peer-only support networks or self-organised support. The strength of co-production is in the equal participation of every ‘expert’; be that ‘experts by experience’ or experts with professional, clinical or technical expertise.

An understanding of the 6 main principles, as outlined in this section of the tool kit, is key to understanding and implementing co-production. However, it is equally important in developing an understanding of co-production to consider the power balance between people (patients or service users) and professionals delivering services. Both the key principles and the sharing of power must combine to make co-production successful.

1. **An asset based approach**

This requires a shift in understanding and attitude from service providers, seeing service users firstly as people with a range of different experiences, strengths and talents who can be active participants in their own care. It comes from a starting position that accepts that people have the ability to take control of their own lives and care and can effect change. It is an approach that moves from people being passive recipients of services or care to being actively involved in designing, creating and delivering services.

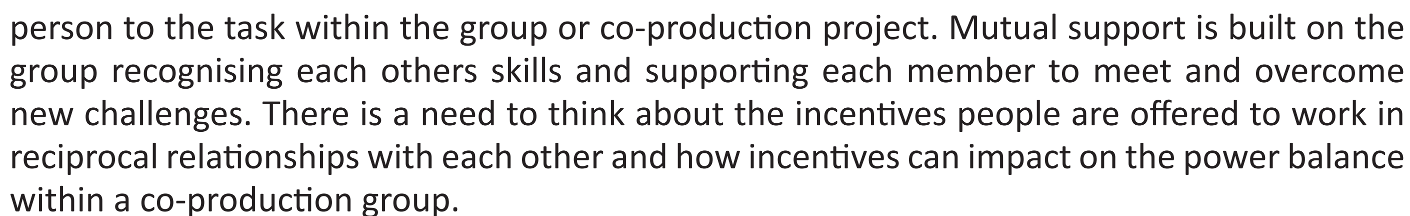
approach recognises the assets of everyone affected by this strategy, the unique insight of people using service through to staff working day to day on the wards who will implement the strategy.

2. **Building on people’s existing capabilities**

This involves changing models of participation, service delivery and care to not only recognise each individual’s capabilities but also to provide opportunities for growth and personal development. Support should be offered to all members of the community to access such opportunities for learning and growth. It is important to support people to actively maintain roles within their community, involving families, schools and educational institutions and employers. In mental health settings this means that practitioners should take time to find out about people’s life skills and background beyond their experience of mental ill health and value these experiences, helping people to rebuild their life around their personal preferences and skills.

3. **Mutuality and reciprocity**

Central to this element of co-production theory is the idea that for everyone involved there are mutual responsibilities and expectations. This does not mean that everyone had exactly the same role but that individual skill and talents are recognised and built on, fitting the



person to the task within the group or co-production project. Mutual support is built on the group recognising each others skills and supporting each member to meet and overcome new challenges. There is a need to think about the incentives people are offered to work in reciprocal relationships with each other and how incentives can impact on the power balance within a co-production group.

4. **Peer Support Networks**

The development of peer support networks can be extended within co-production to look at wider support networks and how to include the whole community and use the resources available to all through connecting with wider social and community networks. Using personal and peer support networks do not replace support from professionals but are used alongside this support to enhance recovery, complement service user and provider relationships and as a way of transferring knowledge.

5. **Blurring distinctions**

This element may perhaps seem the most challenging, especially to traditional services which are based around medical models of managing long term health conditions and disability. It requires professionals and services to reconsider how they deliver care and identify new ways of working which supports individuals rather than does to them. As Zoe Reed states In her article Co-production – A slippery yet essential concept in health (NESTA, 2012), 'Service systems that support the co–production delivery approach require clinicians to be comfortable at communicating in group settings and thinking about how to lever and ensure rather than do to. Clinicians and managers need to be constantly thinking who else could be delivering different parts of the healthcare system – people who could benefit from the sense of value and worth they themselves get from delivering it'.

6. **Facilitating rather than delivering**

This puts 'support' at the centre of services, encouraging services and practitioners to think about how they can support individuals to lead a life beyond illness rather than just deliver care or treatment to people. It links to the other key elements in that facilitating requires the service and practitioner to recognise the individuals' capacity for change using their own skills, abilities and resources and supports them to build networks and community based resources. By facilitating recovery rather than delivering treatment services begin to take an asset based approach seeing service users as individuals who actively participate in their own care and recovery.

Co-production Toolkit

The following pages contain a range of exercises, guidelines and tools designed to help clinicians and support workers and also services to develop co-production within their individual practice and own organisation. The tools can be used to improve day to day practice and enable a more individualised, person centred approach or within a specific co-production project. They are designed to be used by individuals but also by groups, especially groups brought together on a co-production project who may not have worked together before.

Some of the tools are reflective, asking the group or individual to assess their own progress on the way to developing co-production approaches. Others are designed around the 6 key principles of co-production, so groups and individuals can build skills in these specific areas. Described in more detail earlier in this document these principles are:

- Assets
- Capacity
- Mutuality
- Networks
- Shared Roles
- Catalysts

Armsteins Ladder of Participation

Purpose of the tool

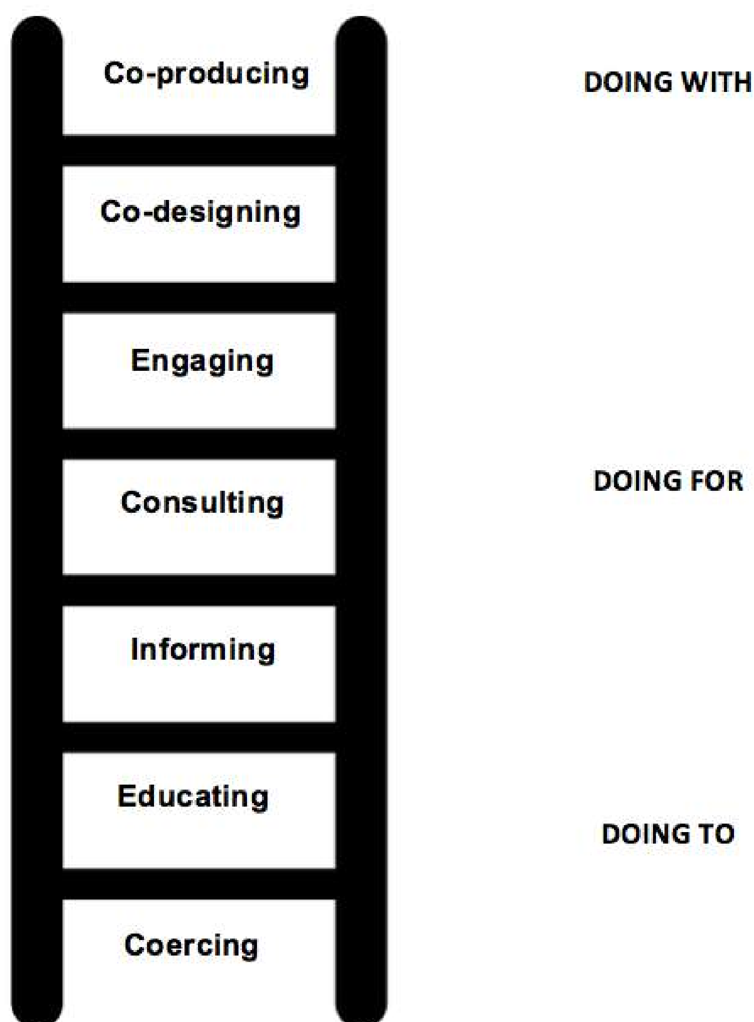
This exercise provides a model to help practitioners consider where they are in their journey towards working with individuals in a co-productive way. It uses Armsteins Ladder of Participation to encourage reflection on personal practice and to highlight how working co-productively may mean getting a better outcome.

You will need

Armsteins Ladder of Participation (see below), exercise sheet

The Exercise

Examine the ladder of participation shown below, thinking about how the various headings relate to your day to day work. Concentrate particularly on doing to, doing for and doing with.



Now think of specific examples in your individual practice when you have worked in the ways described – doing to, doing with and doing for – and complete the exercise sheet below.

Doing to

What I did

Where does this fit on the Ladder of Participation?

What outcomes did it achieve?

How might you have achieved a better outcome?

Doing for

What I did

Where does this fit on the Ladder of Participation?

What outcomes did it achieve?

How might you have achieved a better outcome?

Doing with

What I did

Where does this fit on the Ladder of Participation?

What outcomes did it achieve?

How might you have achieved a better outcome?

Personal Reflection

In my own practise do I tend to do to, for or with?

How can I ensure my day to day practise moves up the ladder towards ‘doing with’?

What skills do I need to develop to enable me to move my practise up the ladder? How can I access support to gain these skills?

Adaptation

This exercise can be adapted to examine where a service or project is on the ladder of participation by substituting the phrase ‘what I did’ with ‘what we do’ or ‘what we are doing’.

Co-production Readiness Assessment

Purpose of the tool

The readiness assessment check list provides organisations with a simple to use checklist based on all key aspects of co-production and gives organisations/projects an opportunity to recognise existing good practice and identify priority areas for improvement or action going forward.

You will need

- The checklist
- A willingness to honestly reflect on current practice
- An open mind

The Exercise

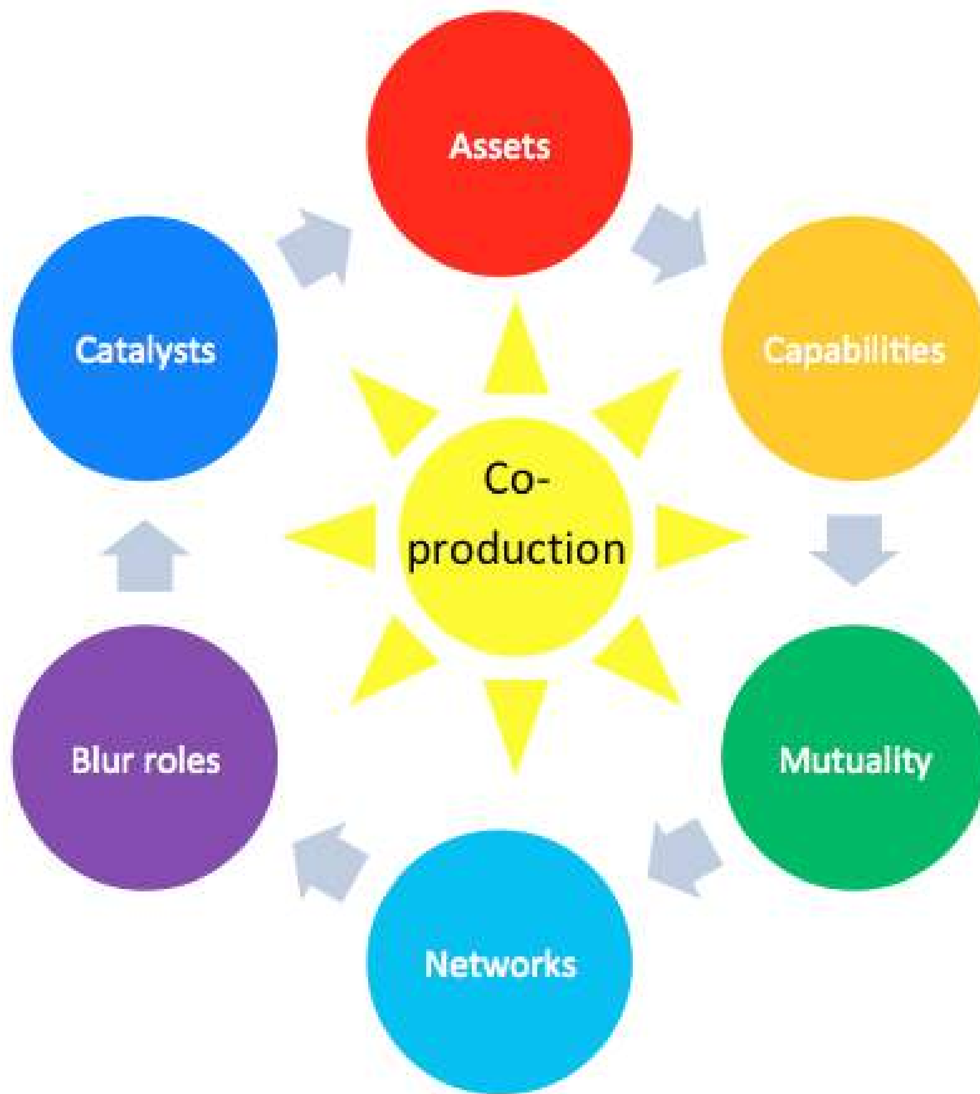
These questions will help you reflect on the level of co-production in the service you work in, your project and others you may come across. Before beginning a cycle of co-production or a co-production project take some time to consider your answers, you may wish to involve others in asking these questions.

Consider the questions then use the diagram to map out your answers against each of the key principles of co-production.

Examine the diagram and identify elements which have gaps or less satisfactory answers. Use the action plan template to set SMART (Specific, Measureable, Realistic, Agreed, Timed) goals to improve fidelity to the key principles of co-production.

Adaptation

The diagram can be used with groups, with a facilitator encouraging discussion against each principle using the questions as a prompt to discussion. The discussion could be recorded using graphic facilitations methods. This exercise works well for examine individual practice with slight changes to the questions.



ASSETS

Are people's (and their families/carers) direct experiences, skills and aspirations central to this project/all services?

Does all service design and delivery seek to build on and grow individual and community assets?

Is progress against this tracked?

CAPABILTIES

Are everyone's contributions vital to success, including service users?

Does the activity and work required within the project match the skills and responsibilities of everyone involved?

Is personal development a common expectation for everyone involved?

MUTUALITY

Does everyone know that it is their project not just the organisation’s?

Do they each have an equal responsibility for it to run well?

Is asking explicitly for and providing help from others seen as positive and expected of everyone involved?

Are expectations of mutuality discussed when people become involved?

Is a wide range of skills and experiences valued?

NETWORKS

Does this project/organisation see supporting peer networks that enable transfer of knowledge and skills as core work ?

Do staff and people engage in activities that connect to local networks and activities beyond the remit of the service/project?

Is growing networks outside the ‘project’ seen as a core activity?

BLUR ROLES

Does everyone involved have an active part in initiating, running, evaluating, directing and delivering the project/services?

Do people work alongside professionals with their skills and opinions having equal weighting?

Are people are able to identify rewards that are valuable to them (not just money)?

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?

ACTION PLAN

Key Element	What will we do	Who will do it	By When	How will we know its worked
Assets				
Capabilities				
Mutuality				
Networks				
Blur Roles				
Catalysts				

Co-production Circle of Support

Purpose of the tool

Completing this exercise prior to starting a co-production project or cycle will help you to identify the key stakeholders and their level of involvement in the project. The exercise can be used flexibly at different points as your project or service progresses to ensure all the necessary stakeholders are identified and involved at the most appropriate level. Once this exercise is complete you can then use it to plan engagement and contact strategies that best match the person and the level of participation in your project or service provision.

You will need

Circle of support exercise sheet

The exercise

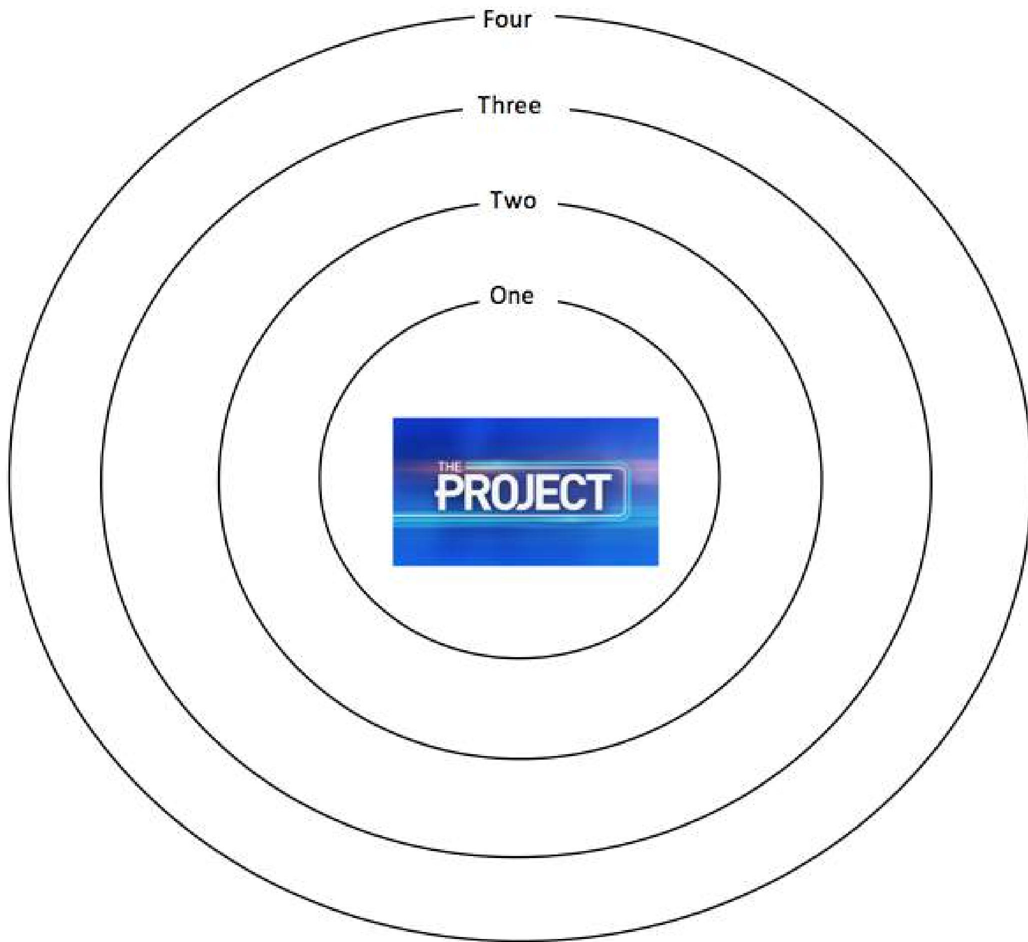
This exercise is similar to stakeholder analysis, however as well as identifying key stakeholders you must also consider how they are involved in your project or service. Think about each person and name them, don't write down job titles or generic groups of people. Then think are they truly involved equally in co-producing the service, outcome or project or is there another role for them? Place crosses on the circle of support for each person and where you think they best fit and list them in the grid below.

'Co-producers' relates to all stakeholders who are responsible for the outcome and give their time, skills and expertise to the project.

'Participants' relates to those who will receive the benefit of the service or project or help deliver it but who do not initially develop it; these people may become co-producers as time progresses.

'Involved' relates to those who may need to be informed about your project and who may wish to give feedback for example commissioners or managers but who are not actively participating in the project or co-producing it.

'Consulted' relates to stakeholders whose opinions you wish to take account of but who are not actively receiving the service or benefit from the project.



Circle One – Co-producers	Circle Two - Participants	Circle Three - Involved	Circle Four - Consulted

One Page Profiles

Purpose of the tool

A one page profile is a useful tool both for individual practitioners working with service users and for teams working in a co-production methodology. Completing and sharing a one page profile helps to build key elements of co-production:

- It blurs distinctions by having the same level of personal information sharing across the whole team or group
- It creates reciprocity and mutuality by creating a shared understanding of each individuals support needs
- It takes an assets based approach by asking each individual to highlight what others identify as their skills
- It builds on existing capabilities by highlighting what is important to each individual
- It builds a network of peers as each individual is sharing similar information, no one individual is asked to provide more or less information than the other

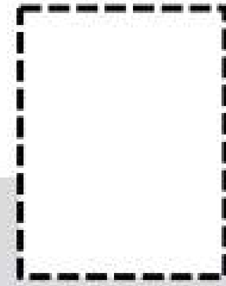
You will need

Sufficient one page profile forms for every individual involved in your project or service.

Adaptation

The template is just an outline suggestion; you can add headings or sections that may be useful or relevant to your group or project or take out the picture or age section if people are uncomfortable with this. Remember though that the template needs to be simple and something that can easily be read and understood by everyone.

My One Page profile



Your Name

Age:

What people appreciate about me

What is important to me

How to support me

Gratitude Exercises

The purpose of the tools

The following pages include suggestions for a number of exercises which can be used within co-production groups and meetings. Building in team building activities is important to successful co-production it helps to reinforce the following key elements:

- They blur distinctions by having shared experiences and understanding across the whole team or group
- They create reciprocity and mutuality by creating a shared understanding of each individuals support needs
- They take an assets based approach by giving each individual opportunities to highlight their skills
- They build on existing capabilities by highlighting their strengths
- They build a network of peers through team work

Exercise at the beginning of a group or one to one session

This exercise works best with a group who have already met before. At the start of the session or meeting each group member writes down 3 things they have that have made them feel grateful or happy in the last 24 hours. This can be 'big' news such as moving house or simpler things such as a flower coming into bloom in the garden or the sun shining that morning. Each group member then takes a turn to share their reasons to be grateful.

This exercise sets a positive atmosphere of the meeting and develops shared awareness across the group of the emotions and personalities of all members. It starts the meeting in a positive focussed way.

Gratitude Postcards

These can be used during or at the end of a meeting or session. Each member of the group completes a postcard after reflecting on the session. This exercise can be particularly helpful if the meeting has been a difficult one with differences of opinion and potential conflict areas discussed as it can bring the meeting to a positive close and ensure everyone goes away feeling that some positive work has been achieved that day. It can also help to bring the team back together by realising that though there may be challenges there are still things which are worthwhile in the work they are doing.

Gratitude Post Card

Today I have been grateful for ...

Gratitude Journal

This is a useful exercise for everyone to complete at the end of a co-production project. It can form part of a wider evaluation of the process and gives everyone a sense of equal achievement in eth project and develops a shared vision of achievement which is core to mutuality and respect within co-production.

Gratitude Journal

Thankfulness The things I am grateful this project/service has achieved	Challenges What I have learnt from my challenges
People The people I am thankful for who have helped me in this project	The best thing about being part of this!

Opportunity Cards

Purpose of the tool

Using this tool ensures that everyone in the co-production group has a voice and an opportunity to share their ideas. It encourages creativity and active participation of all members of the group. By using an opportunity card to raise ideas hierarchy is stripped away and those who may struggle to speak in large groups or who do not feel confident to share ideas openly are encouraged to participate.

You will need

A supply of opportunity cards to distribute to everyone

The Exercise

When people join the co-production group ensure they are given a supply of opportunity cards and explain their purpose.

Each member can complete a card whenever they have an idea no matter how big or small that contributes to the work of the group. One member of the group is chosen to receive the opportunity cards and introduce them into each group meeting inviting further contribution from the person who submitted the idea if they wish to participate. This can be the same person throughout the project or rotate at each meeting or event.

EQUIL
Equality in Learning

Opportunity Card

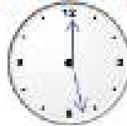
What challenge will your idea overcome?

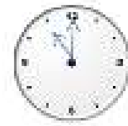
Describe your idea

Draw your idea

Time to Implement

Short term


Medium term


Long term

Possible barriers

Possible benefits

Cost to Implement

£ | ££ | £££

Appendix 1 – History of Co-production in the UK

It is important to have a common definition and understanding of the term co-production. This toolkit is based on the following definition developed by New Economics Foundation and NESTA:

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.

NESTA (2012) People Powered Health Co-Production Catalogue

There are 6 key elements which are the foundation of using co-production principles:

- Taking an assets based approach
- Building on people's existing capabilities
- Reciprocity and mutuality
- Peer support networks
- Blurring distinctions
- Facilitating rather than delivering

Co-production as a concept came to the UK in the 1980's after being developed in the States in the 1970's. It was in the 1980's that the Kings Fund looked at how co-production could be useful in developing health services and in understanding and improving the relationship between patients and health care professionals. More recently the Kings Fund has developed their approach to co-production and describes them through the term 'Experience Based Co-Design'.

The work of Needham and Carr in 2009 developed ideas of co-production and its use within the context of social care and public health. They identified different 'levels' of co-production and looked at the importance of power balance in staff patient relationships and their effect in either limiting co-production or making it a truly transformative experience.

Co-production became a topic for the UK government at around the same time as Needham and Carr were developing their ideas. With increasing cost pressures on the National Health Service (NHS) and development of the 'Big Society' approach by the incumbent Conservative government the shift to co-production across health and other public services was seen as the way forward to provide more efficient, more effective and more sustainable services.

David Cameron, UK Prime Minister in 2007 stated:

The public become not passive recipients of state services, but the active agents of their own life. They are trusted to make the right choices for themselves and their families. They become doers not the done-for.

David Boyle and Michael Harris, NESTA (2009), The Challenge of Co-production.

Within health and mental health services co-production is currently a strong topic in the UK and debate centres on the need to move beyond a dominant 'medical model' within the NHS, especially in helping people to manage long term conditions such as mental ill health. The current challenge in the UK is for health and social care services to become services that 'work with' people rather than 'do to' people. This requires change at all levels from changing individual practice through to changing organisations and structures. Attempts have been made in the UK to introduce ways of working which support this change such as the introduction of individualised budgets for health and social care. The change is strongly supported by government, in fact the NHS Constitution written by the Department of Health in 2012 clearly states 'The NHS belongs to the people', meaning the NHS must move to a point where people are not only more involved in their own care but also in designing and delivering health services.

Appendix 2 – Approaches to Co-production in other European countries

The Italian Perspective

Co-production is increasingly emerging in the public management debate. At policy decision-making level, there are not official policies promoting the engagement of users in governance and delivery of care processes. The experiences of co-production in Italy are very few and they are not addressed by the central government. They are usually promoted by no-profit associations or organizations of the tertiary sector.

More that experiences of co-production, in Italy, we can talk of experiences in patient involvement, mainly during the decisional moment. There could be an overlapping among, for instance, the concept of patient participation, patient empowerment, patient co-production, patient involvement into the service provision, patient activation and patient centred care. One of the reasons behind this overlapping is that in services the distinction between production and consumption cannot be separated. Social services are the results from on-going interaction between providers and users. Consumers, professionals and other stakeholders are all together involved within the service development process (Dunston et al., 2009).

In 2006, the Health Ministry expressed the wish to move from the informed consent to the patient empowerment by saying that patients and their families should be trained to actively participate in the decisional process regarding their health status. The patient should express its own will in the decisional process that characterises the formulation of the health care programme by contributing to the improvement of the social and health care system.

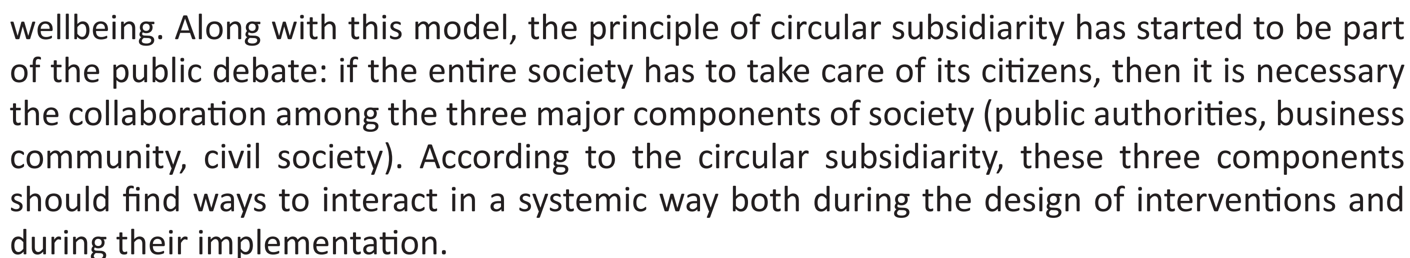
In the preliminary information document of the National Health Plan 2010-2012 (http://www.salute.gov.it/imgs/c_17_pubblicazioni_1252_allegato.pdf), the empowerment and the health literacy of the patient are considered as preparatory elements to set co-production models.

The National Health Plan 2011-2013

(http://www.salute.gov.it/imgs/C_17_navigazioneSecondariaRelazione_4_listaCapitoli_capitoliItemName_0_scarica.pdf), put a strong emphasis both to co-production and patients' empowerment: their involvement in the health care services can be realized by supporting self-care by regaining the users' centrality through the personalization of services and by favouring patients in facing their pathologies in an informed and responsible way.

In the reform of the third sector (http://www.camera.it/_dati/leg17/lavori/stampati/pdf/17PDL0024380.pdf), there is the will to move towards co-production models, even if not directly mentioned with the word co-production. One of the main pillars of this reform is the need to provide Third sector and civil society with financial instruments. Co-production could never work as far as they depend on others to get funds for their activities.

Because of the welfare state crisis, there has been a growing interest to the civil welfare model: the whole society, not only the government, has to be in charge for the citizens



wellbeing. Along with this model, the principle of circular subsidiarity has started to be part of the public debate: if the entire society has to take care of its citizens, then it is necessary the collaboration among the three major components of society (public authorities, business community, civil society). According to the circular subsidiarity, these three components should find ways to interact in a systemic way both during the design of interventions and during their implementation.

This model can help in finding the necessary resources from the business community. The presence of the public authorities is still fundamental in order to guarantee universality and to avoid the exclusion of some social groups from the services.

The business community, the public authorities and the civil society, according to their capabilities, should define partnership protocols for the definition and implementation of social and health care interventions.

The main reasons used to obstacle a civil welfare model, and so co-production, have been the lack of funds, an inadequate bureaucracy, differences among the Italian regions, etc.

But the main difficulty in doing that relies on cultural factors: moving to a civil welfare models doesn't mean moving to a neoliberal one.

In Italy, an alternative to co-production could be the social cooperatives (http://www.cooperativasociale.org/faq.htm). These kinds of cooperatives provide social services (e.g., the care of children, elderly and disabled people, etc.). The general objective is providing benefit for the community and favouring the social integration of citizens. A social cooperative is composed by different stakeholders: paid employees, beneficiaries, volunteers, financial investors and public institutions.

There could be two kinds:

- social cooperatives bringing together providers and beneficiaries of a social service as members. They usually provide health, social or educational services.;
- social cooperatives bringing together permanent workers and previously unemployed people who wish to integrate into the labour market. They usually integrate integrate disadvantaged people into the labour market. The categories of disadvantage they target may include: physical and mental disability, drug and alcohol addiction, developmental disorders, etc. At least 30% of the members must be from the disadvantaged target groups.

Social cooperatives are very developed in Italy. This is caused by many factors, as:

- public authorities outsource to social cooperatives for a growing share of social, health, education and youth policies' services;
- there is a growing need of self-organization among civil society that promote the institution of social cooperatives to answer to their unfulfilled needs or to innovate welfare services.

The Danish perspective

A long tradition of co-operative approach in the Danish labour market

From one perspective, one may say that the tradition for co-production (in the respect of transversal cooperation) in employment policies has a long history in Denmark, because the Danish Model is built on the cooperation between the social partners – trade unions and employers organisations – with the state as the third party.

Co-production as a new perspective

The range of reforms in the Danish employment legislation in recent years has increased the focus on co-production (in Danish co-creation). This particularly applies to amendments in the legal framework for flex-job, early retirement and social benefits for mentally vulnerable citizens. A main objective is that professionals in jobcentres and social and health care authorities shall meet citizens in a much more inclusive and involving manner. Thus, one basic idea is that citizens should perceive themselves as responsible, but also be much more actively involved in a sustainable planning and decision-making about their own situation and employment perspective etc.

LOCAL GOVERNMENT DENMARK - the overall association of Danish municipalities – refers to the concept of so called welfare alliances, corresponding with the ideas of co-production:

> *"Welfare does not only mean services produced by the public sector - and particularly by the municipalities. Welfare is something that we create together. In order to maintain and develop welfare in Denmark, it is required that municipalities find new ways to solve their tasks. One way is to rethink and strengthen the interaction between the public government, citizens themselves, the community and civil society and the private sector. We need to develop what we call the future welfare alliances…"*

Co-production in close interaction with active citizenship

In the wake of the new legal framework, we see a growing awareness of the concept of co-creation in Danish efforts, based on both theoretical and practical contributions in the European context. In the Danish context, the concept of co-creation is the main term for this governance and practice. Thus, many municipalities are developing new local policies strategies to promote co-creation/co-production in close interaction with the general Danish efforts to promote active citizenship.

The intention is to enable citizens to become more engaged and motivated, thereby gaining better results from the employment efforts. The "slogan" would be to talk to the citizen, not about the citizen.

Interdisciplinary rehabilitation teams in all municipalities

As part of recent labour market reforms, all municipalities have established the so called INTERDISCIPLINARY REHABILITATION TEAMS. These teams are meant to ensure that all relevant professional skills across traditional professional borders are cooperating in cases about citizens with reduced working capacity. Thus, the idea is to ensure a holistic perspective and interdisciplinary and intersectional coordination in the planning process across the municipal administrations. The teams are generally consisting of representatives from the local labour market administration, the social administration, the healthcare administration and often also involving local GPs or other relevant external actors. All teams designate a special coordinator.

The interdisciplinary rehabilitation teams are dealing with special cases, where for instance mentally ill/vulnerable citizens may be granted a so called resources course or a so called clarification course in cooperation with a workplace and sometimes with educational institutions etc.

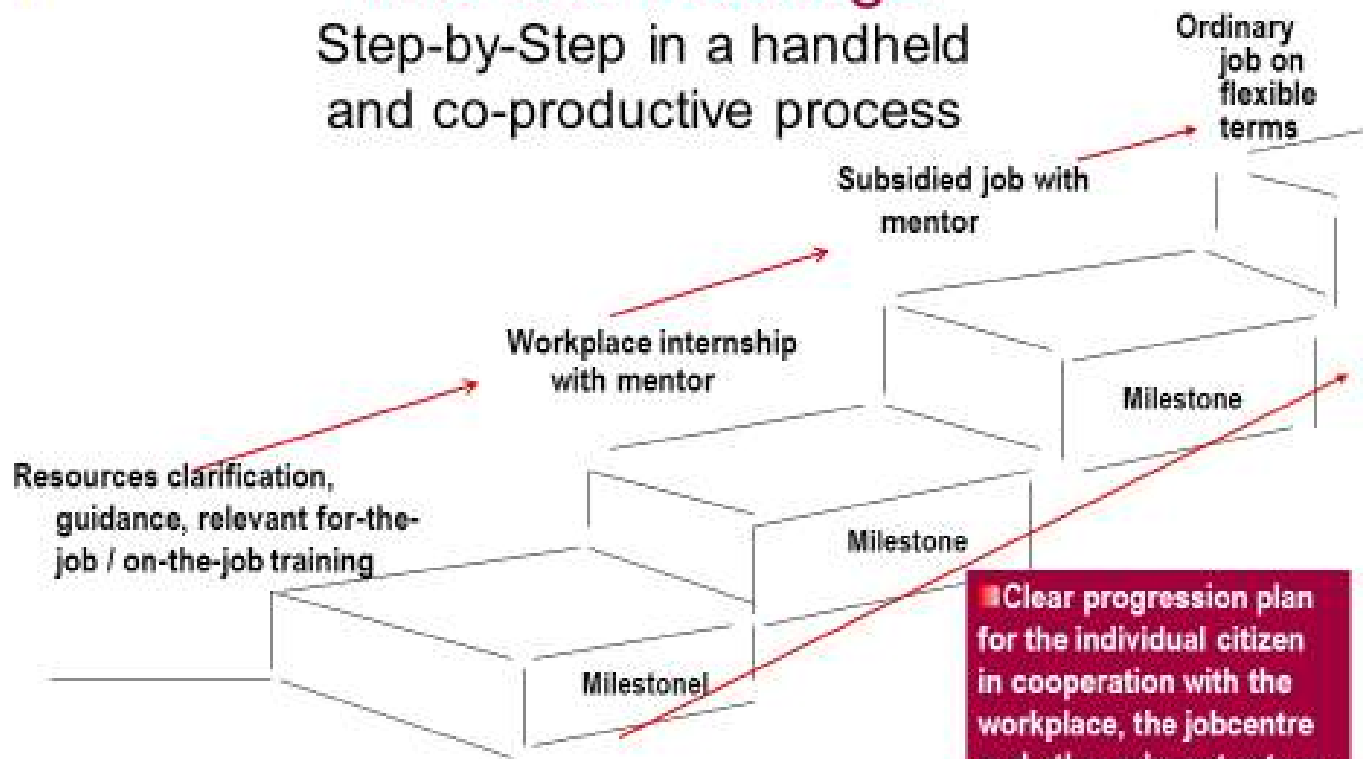
In summary, the interdisciplinary and intersectional rehabilitation teams can be seen as a kind of co-productive practice, which is bound by law.

Job packages as a co-productive practice

As part of the corporative approach in Danish labour market policies, the Danish Confederation of Trade Unions and the Confederation of Danish Employers together with the Local Government Denmark some years ago developed a special method called JOB PACKAGES. The idea was originally to find sustainable methods for involving mentally and physically vulnerable migrants in the labour market, be it that actually the model was appropriate for all vulnerable citizens.

The basic approach in the job packages was to ensure a transversal cooperation around the job preparing process for vulnerable citizens, using a so called handheld step-by-step model.

Nowadays, the job packages are increasingly known and used in municipalities as industry packages. Even though they did not originally build on the coproduction concept, they actually tend to realize the co-productive approach, by putting the individual citizen at the centre and by emphasizing the flexible and need oriented progression.


The Job Package
Step-by-Step in a handheld and co-productive process
Ordinary job on flexible terms
Subsidied job with mentor
Workplace internship with mentor
Resources clarification, guidance, relevant for-the-job / on-the-job training
Milestone
Milestone
Milestone
Clear progression plan for the individual citizen in cooperation with the workplace, the jobcentre and other relevant actors
Clear milestones step-by-step

Appendix 3 – Theory of Co-production practical examples

The following are practical examples of co-production in the UK as they relate to the 6 key principles of co-production.

1. **An asset based approach**

There are many positive examples of how taking an asset based approach can be delivered within mental health services both in strategic projects and initiatives and in individual clinical practice.

An example within a strategic initiative is Mersey Care NHS Foundation Trust's 'No Force First' strategy. This is an ambitious programme to eliminate the use of physical intervention and medication as a response to people who are distressed and challenging when using the Trust's services. The Trust aims to deliver a restraint free future. Taking an asset based approach meant ensuring that service user voices were equally involved in planning the 'No Force First' strategy, ensuring people who had been exposed to the traumatic interventions such as physical restraint had the opportunity to tell their stories to inform this planning, ensuring people who use services as well as staff were involved in examining ward culture for unnecessary rules and restrictions and encouraging and supporting ward staff to come up with creative an innovative ideas. This approach recognises the assets of everyone affected by this strategy, the unique insight of people using service through to staff working day to day on the wards who will implement the strategy.

There are many ways taking an asset based approach can be incorporated into clinical practice. Personal recovery plans, co-produced between practitioner and service user, are central to working in this way. There are many different formats and templates for such plans but the key concepts apply to all. A personal recovery plan is a developmental process not just a one off document or form filling exercise. It supports people to understand and recognise their own condition and unique experience of it. It supports people to identify what helps, what does not help and how to recognise when their mental well-being is breaking down and well as helping to identify how to avoid personal triggers. The plan includes not just what services response to a deterioration in a person's mental well-being should be but also how the person themselves can manage their condition and identifies the resources and networks they can call upon, be these internal or external.

2. **Building on people's existing capabilities**

There are many examples of national initiatives in the UK which use this approach, Recovery Colleges and IPS (Individual Placement and Support) services being just two. Recovery Colleges provide opportunities for service users, staff, families and the wider local community to grow capabilities and learn new skills through an educational approach to helping people live a 'life beyond illness'.

In Mersey Care NHS Foundation Trust the Recovery College gives opportunities not only to learn about conditions and managing that condition but also to learn a new skill such as comic book drawing or stand up comedy. The Trust recognises that an individual can be supported to recognise and grow their capabilities throughout their mental health journey so Recovery College sessions are offered in inpatient settings.

3. **Mutuality and reciprocity**

An example of a project which develops shared responsibility with everyone involved having mutual responsibilities and expectations is the Routes out of Prison (RooP) project in Scotland. This project offers through the gate support from life coaches who have experience of being in prison who aim to empower people to make positive decisions not to dictate to the individual. The whole project is built on shared responsibility for decision making between the life coach and the individual which in turn leads to shared responsibility for outcomes. The peer coaching model means that rather than being a passive recipient the individual plays an active part in the process, which is mutually agreed with shared expectations.

4. **Peer Support Networks**

The SUN (Service User Network) project in Croydon uses a peer support network for people with emotional and behavioural difficulties to bring people together to support others through a time of crisis. It uses peer support to build coping strategies but also to give people the opportunity to attend groups, meet new people and take part in leisure activities providing that link to community and wider resources using the idea of 'community as a doctor'. The peer support network meeting is facilitated by a professional but places an emphasis on sharing and valuing experiences and opinions and encouraging an informal network to build outside the meeting sharing contact details and telephone numbers. Peers participate in forums which develop the rules and processes for the groups, enabling co-production in service design.

5. **Blurring distinctions**

The employing of peer support workers in mental health care settings is one such way of blurring distinctions, where the peer support role is recognised as a professional role within a multi-disciplinary team and lived experience is valued within appropriate roles equally along side a professional qualification or experience. Many mental health trusts in the UK now have peer support worker programmes, including Mersey Care NHS Foundation Trust. Nottinghamshire Healthcare NHS Foundation Trust have an established programme which includes peer support worker training with over 50 peer support workers employed across adult mental health, mental health services for older people and addiction services. Their experience demonstrates that peer support workers introduce recovery-focused, strengths-based practices into teams leading to the team becoming more recovery focused across all clinical/practitioner boundaries.

6. **Facilitating rather than delivering**

Network Employment, Mersey Care NHS Foundation Trust's IPS service takes an approach to supporting people to find work that is built around the principle of facilitating. Individuals are seen as 'Job Seekers' who come with skills, talents and experience that will help them to find the right job for them. Employment Advisors act as facilitators through the job finding process, supporting Job Seekers to identify transferable skills, make informed choices about career opportunities, educating and transferring skills on how to find work and making links with employers, supporting individuals to maintain those links in their journey back to work.

Appendix 4 – Benefits of co-production

The financial imperative

Co-production approaches are now being seen across the world as a way of delivering more cost effective services to people with long term health conditions. For example, in the UK one third of people live with long term health conditions costing the NHS billions each year. Therefore, the NHS estimates it could save billions by co-producing services that involve patients, their families and communities more directly in the management of long term health conditions.

For example, there is now research evidence that peer support improves health outcomes for people with them becoming more stable, this in turn reduces hospital stays, demand on clinical time, decreasing attendance at accident and emergency, all of which are very costly. Taking into account that co-produced services, projects and interventions are a lot less costly than clinical interventions (research shows between £100 and £450 per person) then it is obvious that cost savings can be made by adopting the methodologies. Internationally, evidence now suggests that changing the way in which patients and clinicians work has produced improved health outcomes in all the most common long–term conditions.

A practical example of the cost savings is the Service User Network (SUN) project in Croydon, UK.

SUN focuses on patients with long–term emotional and behavioural problems. Its model of peer support reduced planned hospital visits by its cohort from 725 to 596 (18 per cent), reduced unplanned visits from 414 to 286 (31 per cent), reduced A&E attendances by 30 per cent, and reduced the total time spent in hospital by patients from 330 to 162 days (51 per cent).

(Nesta, Innovation Unit and nef 2012)

Improving health and well-being

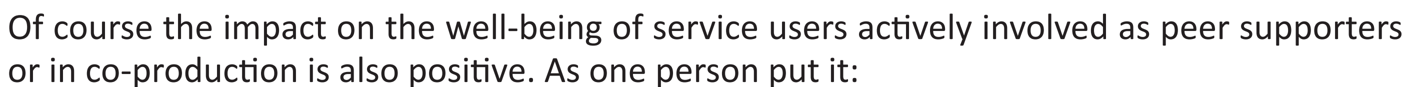
As mentioned above there is increasing evidence that using co-production improves health outcomes for people with long term conditions, therefore giving wider health and well-being benefits.

In the context of mental health, it can have the added benefits of empowering the service

users involved to develop their voice and skills, which can often impact positively on their recovery, and lead to other changes in their lives.

(Rethink Mental Illness, 2015)

This not just anecdotal evidence, a robust research base is being built about the benefits of co-production on health and well-being. For example, evaluation of the Earls Court Health and Well-being Centre, which employs a team of community researchers who are all service users, demonstrated that there was a 60% improvement across all service users on their quality of life scale scores, this reduced the use of primary care by 30% and planned hospital admissions by 60%.



Of course the impact on the well-being of service users actively involved as peer supporters or in co-production is also positive. As one person put it:

‘the only reason I’m as healthy as I am is that I’m so busy helping other people’.

(Nesta, 2012)

Decreasing social isolation

These effects are particularly pronounced in mental health. People with more social contacts, and higher quality relationships, tend to report better mental health than those without, especially if they are also in work. The use of peer support within co-prodcution methodology actively supports people to build social contacts.

In a literature review of co-production in 2013 nef found that:

‘The strongest theme to emerge in the literature concerned a cluster of outcomes related to improved social networks and inclusion. This theme was a consistent feature of the literature, and included stronger relationships with peers, family, and friends; a reduced sense of stigma associated with mental health conditions; and a greater sense of belonging to local groups, communities of interests, and networks.’

Appendix 5 – Co-production case studies

Italian Case study – Piani Personalizzati della Regione Sardegna (Personalized Plans in the Sardinia Region)

Name of the organization: Regione Autonoma della Sardegna (Sardinia Autonomus Region)

According to the national law 162/1998, the regions have to communicate to the central government the measures adopted to improving the life conditions of people with disabilities in order to get funds to implement them. Sardinia, with the regional law 2/2007, art. 34, introduced personalized plans for people with disabilities (http://www.regione.sardegna.it/j/v/48?s=1&v=9&c=64&c1=2770&idscheda=288065). These plans are decided and managed with the collaboration of the Region, the local authorities (i.e., municipalities), third sector associations, people with disabilities and their families.

The Region supplies funds to the municipalities in order to realize personalized and individual plans of social and health care interventions for children, young people, adults and old people with disabilities. These plans aim at developing the full potentiality of the person, to support the health treatment and to the full integration in family, school and society.

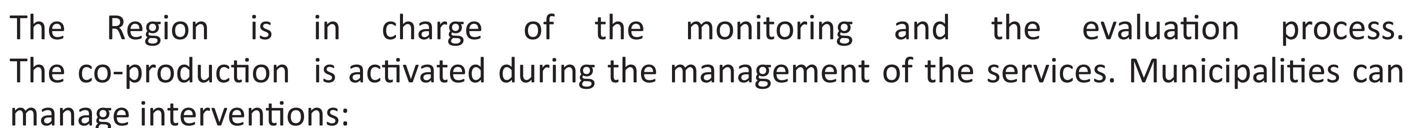
The services included in the personalized plans are:

- educational service (up to 65 years old);
- personal and domestic care;
- welcoming in day-care assistance centres (centri diurni assistenziali);
- permanence in social and health care structures and healthcare residences (up to 30 days in a year);
- sport and social activities (up to 65 years old).

The plan is prepared in collaboration with the family and, if necessary, with the health care services on the basis of two evaluation forms:

- a health care evaluation form: on the assessment of the degree of autonomy and disability of the user. This form has to be filled and signed by the doctor who is following the user. It could be: a general practitioner, a paediatrician or another doctor working in a public or in a conventional private hospital ;
- a social evaluation form: there are necessary information for the preparation of the personalized plan (e.g., age, used services, familiar and social conditions, education and work situation, etc.). This form has to be filled and signed by the social assistant, the responsible of social policies in the municipality and the user or the legal guardian.

On the basis of the information in both evaluation forms, the municipality gives to the plan some points in order to identify the funds that could be given to it. Then, the Region determines the amount of funds for each person according to the tax return.



The Region is in charge of the monitoring and the evaluation process. The co-production is activated during the management of the services. Municipalities can manage interventions:

- directly: they provide the service to beneficiaries;
- indirectly: users or their legal guardian stipulate a contract with operators and professionals.

In the last way, families can choose a professional and be responsible of his/her contract, training, evaluation of the job done. Families are usually supported by local associations of disabled people families during these steps.

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Appendix 6 – Focus group findings

The Dutch Perspective

Co-production

Most participants of the focus groups are not familiar with the term co-production. After introducing the Armsteins Ladder of Participation and giving examples of projects of ZOG MH they understood the meaning of it. All participants found the principle of co-production important. They indicate the importance of the involvement of all parties to develop a project or product of good quality. The effects of a project concerns all the people involved and therefore they should be at least consulted. Several participants stated that they have ideas in improving the care system because they are consumers of it and experience the bottlenecks themselves. Through co-production all people involved are approached as equal.

Only a few participants have experiences with co-production with another organisations besides ZOG MH. An example of a participant: “I have been in a fight separation and experienced that my wishes were not taken into account. Later on I came in a project where we looked with a group volunteers what would be helpful in the given situation. We had a team for the whole family. All family members wishes and ideas were taken seriously and we came to solutions supported by all”.

One participant mentioned an example in which co-production did not work out well for him. “I had an idea for the youth to deal with certain problems and made a project plan. I was allowed to present that project plan to the municipality. They wanted to go forward with the project. I wanted to work at the project, but the municipality did not want that. They hired another person to work on the project. I was allowed to think of the idea and make a project plan an discuss it with the municipality, but wasn’t allowed to work at the project.”

Values and benefits to coproducing services and health care

The participants mention the following values and benefits to co-producing services and health care: more focused work, greater chance of success, time-saving, cost-saving. An example of a participant: “I knew a better method to unload trucks. They let me show the method. Other companies copied the method. It was a quicker way and therefore cost-saving”.

Other values and benefits mentioned are: increase of self-esteem of the participants, feeling worthwhile, equality, empowerment, more knowledge, better communication between all involved.

Support and processes/ procedures needed to feel an equal partner in co-coproduction

Most participants stress the importance of co-production on all levels. All the people involved have to be included in projects to come to the best results. Knowledge of all parties can be joined by co-production.

Another important aspect of support in co-production is a person who monitors the overview of the project. A person who takes the direction, gathers all information and communicates well with all the people involved.

An example of a participant: “My child is ill and has to go to several specialists. The family practice monitors the overview. One person who supports the whole process so that the planning and communication is well”.

The participants also mentioned that the support needed in co-production has to consist of advice on an equal level. In this kind of support it is important that the decision making is with the participants of co-production.

The Italian Perspective

Co-production

Participants found the principle of Co–production very interesting. They recognize a challenge for maintaining the relation among all the parties equal.

In the field of health care at regional level there is still not a coproduction experience that involves actively and equally people with mental health issue - they are merely seen as final beneficiaries of the services, and not co-producers.

The participants of Focus group did not have previous experience in Co-production, and can’t share any example. However, they plan to create an association, aiming at promoting their integration in job market and society. Thus the concept and principles of co-production could be a good starting point and base for the development of the association.

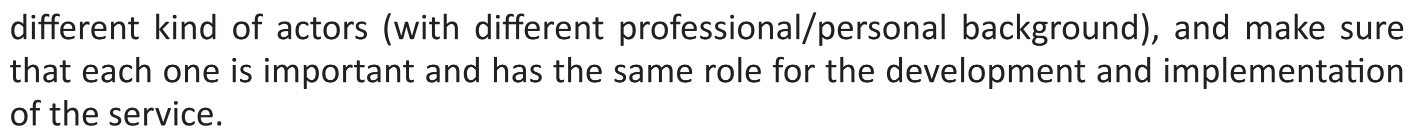
Values and benefits to coproducing services and health care

Coproduced health care and services would be very appreciate. Unfortunately the Regional Health system does not foreseen it. Participants affirm that a coproduced health services would benefit to users/beneficiaries as well as the other actors directly and indirectly involved, as the families.

In fact, users of the services (with high experience) could gain a working/active role in society, and could improve and give an adding value to the services.

Support and processes/ procedures needed to feel an equal partner in co-coproduction

Participants affirmed that this is quite difficult. Maybe organizations have to realize the positive effect from an economical and a qualitative point of view. Moreover they should involve



different kind of actors (with different professional/personal background), and make sure that each one is important and has the same role for the development and implementation of the service.

In the co-production process, organizations should support and tutoring actors involved, in order to guarantee equality.

Participants wish a coproduces health care service provider. To ensure this the following measures/suggestions came out:

- Synergy among the actors involved
- Equal repartition of tasks and responsibility
- Clear view of the adding value that each actor (thanks to his/her background and experience) can give for the realization of the project – thus confirm the importance of the contribution of all.

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Co-funded by the
Erasmus+ Programme
of the European Union

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