CO-PRODUCTION
IN HEALTH AND SOCIAL CARE
What it is and how to do it

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Foreword

People in Scotland are living longer healthier lives. As they grow older we know that people want to be supported to remain living independently in their own homes and communities. In achieving this, the task of public services is to make sure that support is available for all those who need it. Against a fast developing economic and demographic background however, we need to start doing things differently if we are to realise our vision for the care of older people in the future.

The Scottish Government and CoSLA are of the view that using ‘assets based approaches’ such as co-production are instrumental if we are to successfully shift the balance of health and social care and develop public services that are focused on prevention and independence.

Co-production recognises that people have ‘assets’ such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be brought to bear to support their health and well-being.

Co-production begins and ends with the person, placing them at the heart of any given service and involving them in it, from the creation and commissioning of that service through to its design and delivery, its assessment and sometimes, where appropriate, its end.

We welcome this publication as one of a number of valuable contributions to an increasing body of literature and practical approaches available to planners and practitioners in advocating the role of co-production in reshaping care. It describes the concepts of co-production and the assets based approach and places these within the wider strategic context in Scotland. Importantly it demonstrates how the practical application of these approaches delivers value for individuals in maximising their independence and well being.

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The role of co-production in health and social care: why we need to change

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

Why public service co-production matters

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

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

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

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

- Improving public service quality by bringing in the expertise of customers and their networks
- Providing more differentiated services and more choice
- Making public services more responsive to users
- Cutting costs
This trend has already begun to change the relationship between professional service providers and service users by making them more interdependent. As a result, there is now new interest on the part of professionals in the co-production of public services and its implications for service delivery.

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

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

What is co-production of public services?

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

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

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

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

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

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

### Types of co-production

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

- **Co-commissioning** of services, which embraces:
  - Co-planning of policy – e.g. deliberative participation, Planning for Real, Open Space,
  - Co-prioritisation services – e.g. individual budgets, ‘community chests’, participatory budgeting – stakeholder representation in commissioning decisions,
  - Co-financing services – e.g. fundraising, charges, agreement to tax increases.
- **Co-design** of services – e.g. user forums, service design labs, customer journey mapping.
- **Co-delivery** of services, which embraces:
  - Co-managing services – e.g. leisure centre trusts, community management of public assets, school governors,
  - Co-performing of services – e.g. peer support groups (such as expert patients), Nurse-Family Partnerships, meals-on-wheels, Neighbourhood Watch.
Co-assessment (including co-monitoring and co-evaluation) of services – e.g. tenant inspectors, user on-line ratings, participatory village appraisals.

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

Implications for public service providers in health and social care

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

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

References


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Assets for health

Sir Harry Burns, The Chief Medical Officer for Scotland

Introduction

In my most recent report on health in Scotland, ‘Assets for Health’ (Scottish Government, 2011), I noted that whilst there is evidence of significant improvements in survival from many cancers, reductions in prevalence of some risk factors and even some evidence of reduction in relative inequality in deaths from cardiovascular disease and the prevalence of low birth weight babies, many areas remain where the trends are showing no improvement or even show signs of moving in the wrong direction.

The Scottish Health Survey seems to indicate that around 25% of Scots eat a poor diet, take insufficient exercise, drink too much alcohol and are overweight or obese. Numerous attempts have been made over the years to encourage individuals to alter their behaviour. Health promotion campaigns usually have a positive effect on some people but often those in most need of changing their behaviour are least likely to take notice of such campaigns. Risky behaviours such as smoking and excessive alcohol consumption are often a response to adverse life circumstances; simply to focus on the behaviour, without tackling the underlying circumstances which provoke the behaviour, misses the point. A new approach which allows individuals to feel more in control of their lives and social circumstances is necessary and that is why, in my previous publications, I have mentioned the concept of the “assets approach” to improving health and wellbeing. This approach offers a coherent set of ideas and concepts for identifying and enhancing those protective factors which help individuals and communities maintain and enhance their health even when faced with adverse life circumstances.

The underlying theory

Aaron Antonovsky, the American sociologist, describes the process by which individuals and communities create health as “salutogenesis” (Antonovsky, 1967). The medical profession, he argued, was obsessed with pathogenesis – the causes of disease. They should, he argued, be studying the factors which create health in individuals and communities. By studying factors which create and support human health rather than those which cause disease, we should be able to identify resources and capacities which impact positively on health and which explain why, in adverse circumstances, some stay healthy and others don’t. The assets approach to health improvement is therefore based on Antonovsky’s concept of salutogenesis. It is a set of concepts and actions which seem to offer the most coherent and evidence-based approach to the creation of health and wellbeing. It does this in several ways. A key aspect of Antonovsky’s theory is the idea that having control of one’s life and circumstances is health enhancing. Central to the assets approach is the idea of helping people to be in control of their lives by developing the capacities and capabilities
of individuals and communities. It draws on existing approaches that foster effective and appropriate involvement of the people and the professionals who serve them. In addition, it identifies techniques (for example asset mapping) which facilitate collaborative work between individuals, communities and organisations towards securing better health and wellbeing.

Current approaches

The conventional approach to the delivery of public services is based on meeting needs or delivering treatment. Individuals are characterised as “smokers”, “drinkers”, “drug addicts”, “unemployed”. Communities are described in terms of their problems. They are “areas of multiple deprivation” with high levels of crime, single parent families, and premature mortality. People and communities are defined by their deficiencies. Public services set out to fix problems for individuals and communities and, in doing so, they take away control from people by making them passive recipients of services. Evidence suggests that a sense of control over one’s life is associated with better health and a greater likelihood of adopting healthy behaviours. Undermining that sense of control, it is argued, increases passive acceptance of risk. It is not particularly surprising if people who are consistently told they are living deprived, hopeless lives tend to respond with passive acceptance. The outcome is an increasing dependence on services provided by others. Over time, areas of Scotland which have seen the collapse of industry and employment have experienced the greatest concentration of social and health problems. Once again, economic problems are threatening the ability of communities to sustain themselves. The economic difficulties facing European countries such as Greece are having an inevitable impact on health, with increasing rates of suicide and HIV already apparent. The ability of public services and third sector organisations to continue to meet needs of individuals and communities at times of contraction in the economy is significantly impaired. If we are to avoid health and social inequalities continuing to widen, we need better ways of working.

Alternative ways of working

Every community has assets. Harrison and colleagues (2004) have defined assets as the collective resources which individuals and communities have at their disposal, which protect against negative health outcomes and promote health status. These assets can be social, financial, physical, environmental, or human resources, for example, employment, education, and supportive social networks. Individuals may not be aware they possess many assets and, if they are, they may not use them to any particular purpose. However, everyone has resources at their disposal which can act to protect them against adverse circumstances and which can promote health and wellbeing.

The asset based approach sets out to work with individuals to make visible their skills and give them confidence that they are valued. Critically, it allows people to become connected with each other and encourages a spirit of co-operation and caring for one
another. Communities in which violence, drug addiction and crime are common are often full of suspicion and mistrust. As confidence and self-esteem builds in individuals, neighbours learn to trust each other and community cohesion is built. The assets approach is not an alternative to public services, it complements them. However, the balance is currently wrong. If asset based approaches are to be implemented, there needs to be a rebalancing between directly meeting needs of people and communities and nurturing their strengths and resources. If this approach is to become an integral part of mainstream development thinking, it will require a change in individual and organisational attitudes and practice. Instead of doing things to communities, public services need to develop a mindset which sees them working with individuals and communities to co-create health and wellbeing. Asset based approaches, however, are not an alternative to investment in service improvement or addressing the structural causes of health inequalities. Individuals trying to build lives for themselves need access to affordable housing. They need access to good education for their children. They need to feel safe in their communities. They need the chance to lead healthy lives through access to opportunities for physical activity and to buy food.

Co-production

Asset based approaches can be applied using a number of techniques. Many have not been developed with an assets perspective in mind – however, common features are that these techniques focus on identifying and sharing what individuals and communities have to offer that might enhance health and wellbeing. Different methods are often used in combination with one another and it is not unusual to find many being used in the same community. One of the best known examples is co-production which clearly uses an assets type of approach.

Co-production is the process of active dialogue and engagement between people who use services and those who provide them. It is a process which puts service users on the same level as the service provider. It aims to draw on the knowledge and resources of both to develop solutions to problems and improve interaction between citizens and those who serve them (SCDC, 2011), (Needham and Carr, 2009). Co-production changes the dynamics between individuals and communities, creating more collaborative relationships. Frontline staff are more able and confident in sharing power and are more ready to accept user expertise (Needham and Carr, 2009). Co-produced services work with individuals in a way that treats individuals as people with unique needs, assets and aspirations, but also as people that want support tailored to their needs (Slay and Robinson, 2011). Services learn to work with people and not do things to them.

Asset based and co-productive approaches are concerned with identifying the protective factors that support health and wellbeing. They offer the potential to enhance both the quality and longevity of life through focusing on the resources that promote the self-esteem and coping abilities of individuals and communities. Society could benefit from a more concerted effort to conduct its activities in this way.
The way ahead for Scotland?

The conventional delivery model does not address underlying problems that lead many to rely on public services, so it inevitably fails to resolve those problems, thus carrying the seeds of its own demise. Conventional approaches disempower people, failing to recognise that service users have assets which can contribute to solutions. Conventional approaches preserve dependency that stimulate further demand for services. By working with people rather than by doing things to people, co-production has the potential to transform the way public services are delivered so that they are better positioned to assist people in addressing their problems in effective and sustainable ways.

The recently published report of the Commission on the Future Delivery of Public Services in Scotland (Christie, 2011) has spoken of the need to work differently in Scotland. The Commission is firm in its view that “irrespective of the current economic challenges, a radical change in the design and delivery of public services is necessary to tackle the deep-rooted social problems that persist in communities across the country”. A programme of reform is necessary to ensure that “public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience” (Christie, 2011). This reform cannot succeed unless individuals, communities and public organisations work together in co-producing the services they use. Both public services and communities will need to find a new balance in their relationship if health and wellbeing is to be enhanced in our society.
References


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

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Context

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

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

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

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

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

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

Policy Influences

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

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

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

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

**Government’s response**

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

Commitment to this approach has been further evidenced by confirmation of the Older People’s Change Fund over the spending period 2012/13 – 2014/15 and the publication of a National Strategy for Housing for Older People with clear links to this agenda (Scottish Government, December 2012).

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

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

**Practical Opportunities and Challenges**

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

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

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

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

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

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In this chapter, two interesting and successful co-production projects in Scotland are showcased, with special attention to some of the very impressive qualitative results which have been achieved.

The SHINE Project in Fife

The SHINE project in Fife is being taken forward by NHS Fife, Fife Council and BRAG Enterprises Ltd (a social enterprise) with advice from Community Catalysts and the International Futures Forum. (Fife is the region to the immediate north of Edinburgh across the Forth estuary).

The project is supported by the Health Foundation’s SHINE initiative, by the Joint Improvement Team (which is an entity jointly sponsored by Scottish Government, the Convention of Scottish Local Authorities (CoSLA) and NHS Scotland) and by the Scottish Government-backed national Reshaping Care for Older People Programme, as it operates in Fife.

The project is designed to generate small, highly tailored community-based care packages for frail and vulnerable older people, provided by independent ‘micro-enterprises’, so that these older people may remain living healthily and independently in their own communities.

A micro-enterprise may take the form of a single volunteer or small team of volunteers, a social enterprise or a sole trader or small business but in any case the relationship between the older person and the micro-enterprise relies on co-production for its successful delivery. An anticipatory care approach is also built in, as the close connection between ‘supporter’ and ‘supported’ allows for health and care issues to be identified and addressed before they escalate.

Health care staff begin their interaction with clients by establishing a shared understanding of what the client considers to be a good quality of life and how their health and care needs, their strengths, their aspirations and the networks that they are part of might interact to achieve this quality. This information is used to build a personalised care package that accounts for the lived experience of the client, places them at the heart of the relationship and maximises their independence. The micro-provider delivers the package in a similarly close relationship with the client and strong connections to the health care staff who helped initiate the process are maintained throughout. Clients report that they “feel human again”, are finally doing things that they want to do and are feeling greatly more independent than they have done for some time.

In the medium to longer term, this shift in the balance of care is intended to reduce demand on acute health services to the extent that resources can be transferred to establish sustainable community-based provision using the SHINE model. The expectation is that
SHINE will contribute to a reduction in delayed discharges from and multiple emergency admissions to hospital and use of community hospital beds.

Success will be measured in two ways. Using the ‘Talking Points’ approach the direct health and wellbeing outcomes reported by those supported will be ascertained and baseline and follow-up data from individual hospital admissions will be tracked (Joint Improvement Team). This will provide an understanding of personal and financial outcomes, both of which are crucial to making the case for shifting resources.

**Time Banking in Argyll and Bute**

Argyll and Bute is a substantially rural area, including islands, on the west coast of Scotland to the west and north west of Glasgow. Through ‘time banking’, Argyll Voluntary Action (AVA) has been putting coproduction into practice for over seven years. The reciprocal and mutually supportive nature of time banking is archetypically co-productive and is entirely concerned with building support for people around their needs and their aspirations for their own health and wellbeing. It also brings local people together to support one another, thereby building community capacity and resilience. It is clearly very much an assets-based approach.

“The asset approach values the capacity, skills, knowledge, connections and potential in a community. It doesn’t only see the problems that need fixing and the gaps that need filling. In an asset approach, the glass is half-full rather than half empty… Working in this way is community-led, long-term and open ended.” (IDeA, 2010).

“Time banking is based on the simple principle that for every hour of time a person contributes to help another, they receive the equivalent in time credits. These time credits are stored and then exchanged for services when needed from others. For example – if you help someone for an hour decorating their home, you can ‘buy’ an hour of someone helping you – let’s say, cutting your grass.” (Time Banking Scotland).

AVA is currently involved in working with partners in the NHS and the local authority to use time banking in the context of the Scottish Government-backed national Reshaping Care for Older People Programme as it operates in Argyll and Bute. This has seen an increased emphasis on improving health and wellbeing outcomes for older people.

AVA’s approach anticipates continued success in achieving the personal outcomes for health and wellbeing that older people determine for themselves, such as independence, autonomy and reduced isolation. Earlier research showed time bank members enjoyed greatly improved mental health (as measured using the Warwick Edinburgh Mental Well Being Scale (WEMWBS)) and extremely positive personal testimony included reported reductions in use of medication. A Social Return on Investment (SROI) analysis showed well over £2 of social value was created for every £1 spent.

Importantly the time bank is increasingly linking its activity to key proxy indicators for health and wellbeing outcomes as used by statutory services, for example, the number of unplanned admissions and readmissions to NHS hospitals. Working with the NHS the intention is to capture the detail of individuals’ pattern of service use so as to demonstrate...
how being supported differently by time banking can ‘shift the balance of care’, prevent health and wellbeing crises from arising and reduce demand for acute services. This is essential in order to be able to confidently make long term decisions about allocating finite resources appropriately between community and institutional health and care provision.

Claire, 39 and Anne, 81 are just two of the beneficiaries of the time bank having been involved for a number of years. Their stories demonstrate that taking this approach can genuinely shift the balance of care. In particular, enabling Anne to remain living independently in her own home is both what she wants and has prevented the need for her to be moved to a costly and inappropriate residential care or hospital facility.

Claire’s Story

“I am a 39 year old woman. My family and I were made homeless after both myself and my partner were made redundant and we lost our house. After moving further north, we were placed into temporary housing twice before being moved into a flat in Oban. During the five months in the flat we suffered excessive noise and aggressive behaviour from the neighbour above us. Because of that we both became depressed, anxious and our confidence and self esteem hit rock bottom. We had no family or friends locally to ask for help or advice. It became difficult to care for our very young child.

We were both introduced to Argyll Voluntary Action and we became (at first, reluctantly) involved in the time bank activities and in volunteering. My partner started volunteering at the Community Garden and I helped out in the Volunteer Centre. Through this we met Anne. Anne was 81 and not very mobile but she was so alive. She had been involved with the time bank for almost a year and was so enthusiastic.

Anne helped us to see things more positively, she was an instant ‘hit’ with our daughter and an inspiration. In return, we helped with her shopping, with transport and my partner was able to repay her kindness doing some small repairs for her. Without the support of other time bank members and the staff we would not have had the money or manpower to move from the flat into the house we were offered. Through using our time credits we were able to get help with childcare, removal transport and decorating. At last we could invite Anne to visit our family in our own home.

Our confidence and self esteem also grew and I trained as a time bank broker. Now I work part time and it has helped both of us to make friends within the community and have a more positive outlook to life now. And our greatest friend is Anne, mentor to our daughter and to me, and someone without whose support and kind guidance we would never have the life we have now.”

Anne’s Story

“I had lived in Oban most of my life and knew quite a few people. Many of my friends had died, some had gone into the old people’s home and although I wanted to stay independent I was struggling. One of my neighbours said she had heard about a time bank run by Argyll Voluntary Action. So, one day I got myself down to their office to see
what it was all about. I could not have been made more welcome. When the girl working there asked what I was interested in, I first thought ‘I can’t do anything’. But she explained just how people can support each other. Within a few weeks I had someone helping with my little garden and I was teaching a young woman to knit and someone else gave me a lift to get to the centre. I began to see I was not too old and felt more useful and valued than in a long while. That made me more positive and less nervous. Even my doctor could see an improvement – he said I was holding my head up more and I said I was sleeping better.

It was then I met Claire, poor soul; she looked lost and was arguing with her partner. They had a little girl who seemed equally lost – I just felt for them. The worker suggested I could perhaps read and keep their child amused to give Claire and her partner a bit of time to work out their problems. I started talking to Claire as well, and to understand the terrible things that had happened to her family. Slowly, we became firm friends. Before long, we were supporting each other in all sorts of ways. One of them would shop with me or for me when my legs weren’t so good and helped me to get around. I loved spending time with the little one and felt like I was doing something really worthwhile. Claire’s partner mended my cupboards and made them easier to open. Without their help I am sure I would not be able to stay in my own home. I could also see the change in the family – they were looking brighter, I never thought at my age I would have such lovely younger friends who wanted to spend time with me.

My greatest thrill was when they eventually were given a house of their own. The time bank people made sure they could move and the first thing they did was to invite me to come and spend afternoon with them and stay for tea. I feel very fortunate and I have a purpose in my life. My legs don’t work well, but that doesn’t matter, with the support I enjoy in my own home and I have friends who make me feel valued and I look forward to every day.”

References


Contact details

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The Food Train: supporting older people to eat healthily at home

Frankie Hine-Hughes, Governance International

Introduction

Inability to go and do the weekly shopping can have a significant impact on the wellbeing of older people – apart from the inconvenience factor, it can also affect their health, as it means they may not be able to meet their nutritional requirements.

Accessibility is one of the three characteristics of food poverty – alongside affordability and education/cooking skills (Scottish Government, 2009). Research indicates that those experiencing the greatest difficulties in food shopping are considered to be at the greatest nutritional risk (Wilson, 2009).

To tackle this problem, The Food Train was established in 1995, with volunteers providing a grocery shopping delivery and home support service to older people to allow them to live independently at home. Created and driven by older people themselves, The Food Train began in Dumfries but, due to the demand for its services, its expansion has been funded by the Scottish Government and local authorities, and it has since spread to Dumfries and Galloway, West Lothian, Stirling, and Dundee.

This case study discusses how The Food Train enables older people to eat more healthy food and to remain part of the community.

Objectives

In 1995 a community survey of older people in Dumfries highlighted that many people struggled with their weekly grocery shopping. The reasons included: not being able to drive; not being able to carry shopping home; and being unable to get out due to illness or a fall. Older people in the community decided to respond and created The Food Train. The objective was to overcome the problems faced by older people with their weekly shopping through a community-capacity building approach. The Food Train was designed from the start to meet wider objectives such as enabling older people to stay in control of their lives and to remain part of the local community.

As well as helping with collecting shopping for older people, The Food Train helps people in other ways, including:

- aid for those that have difficulty writing their own shopping list due to visual or arthritis-related impairments;
- telephone ordering, with prompting for people who have memory problems;
- a variety of payment arrangements to suit differing needs;
- help with checking, and unpacking of shopping;
- help with opening tops, packets and so on, if required;
- aid with returning, exchanging and getting refunds on items provided;
- signposting to other services via leaflets in shopping boxes.
Change Management

From a small commuter train to an intercity express – the development of the Food Train

Following the 1995 survey, a small group of volunteers in Dumfries responded to the community survey results and decided to get The Food Train going. A partnership with local shops/supermarkets was created to sort out the ordering system. Funds were secured from Solway Community Enterprise to buy a van to make deliveries. This service was marketed to local older people with a first set of deliveries in 1995 going to five customers. Small amounts of funding were received from the NHS and, eventually, the council.

The Food Train was set up as a company limited by guarantee, with charitable status being awarded in 1996. All customers are members of the company. Annual membership costs £1. Each grocery delivery has a charge of £2 ( £3 from April 2012). The cost of Food Train ‘EXTRA’ services (practical home support) ranges from a fee of £3 to £10 per job (dependent on the size and time required for each job). Household repair charges from other providers can range up to £10 per hour and more, indicating the price competitiveness of the EXTRA service.

The Food Train services are available to anyone aged 65 and over who finds food shopping difficult. The Food Train operates with a great deal of flexibility: there are no minimum or maximum amounts for ordering; people are able to get the service weekly, fortnightly or less, and either short-term or long-term. Older people can join The Food Train through self-referral or they can be referred by someone else. The service is not
The Food Train: supporting older people to eat healthily at home

linked to health assessments or means testing, which eliminates the bureaucracy of form filling and allows the service to start up immediately.

The Food Train was run entirely by elderly volunteers until 2002. To be a volunteer an individual has to be over 16 years old. Dependent upon their voluntary role, the individual may be disclosure checked – and if they need a disclosure they will be unable to work directly with customers. Since 2011 this has been through the Protecting Vulnerable Groups (PVG) Scheme Record introduced by the Scottish Government.

There are several roles that volunteers for The Food Train can play. They include:

- **Drivers and delivery people**: All volunteers working directly with customers must work in teams of two. Drivers work with delivery people to pick-up shopping lists from members, usually on a Monday and take that list to the relevant shops or The Food Train office. On delivery day, drivers and their delivery mates go to the required supermarket. They will then check orders, load them into the van, and take them to the customer’s house, unpacking and putting away if necessary.

- **Shoppers**: Supermarkets working with the project contribute staff hours to make up the orders for the shoppers, supplemented by teams of volunteer shoppers in each store where required. These volunteers work with supermarkets, to pick and sort shopping and to put it on the van.

- **Promotional work volunteers**: These volunteers ensure that older people hear about the service and they also highlight the benefits of volunteering to members of the community.

- **Office Staff**: Volunteers can aid administrative staff with taking calls, customer orders, completing shopping lists, helping with the rota and so on.

All volunteers are required to undertake some basic training. This ensures that they understand how The Food Train operates, what their role is, and how the shopping service works. Trainees also have the chance to shadow an experienced volunteer or staff member to ensure they are comfortable with their role. Every so often, additional training can be provided by The Food Train or a public sector agency.

When volunteers join they are asked how often they can help and what are their preferred times and days for getting involved. This helps to safeguard success, as volunteering can be tailored to each individual’s lifestyle and desired level of involvement. To ensure volunteers are clear about when they will be volunteering, and can plan accordingly, a rota is drawn up a month in advance.

Another method used to ensure there is open communication is through branch meetings, open to all volunteers, which are held every eight weeks. As well as disseminating news about The Food Train to volunteers, it gives an opportunity for The Food Train family to get together to discuss concerns, raise issues or share stories about how they have dealt with difficult situations and to celebrate when the service ran particularly efficiently.

The Food Train provides each customer with a blank order form so they can write out their grocery order. Most customers have their order collected by the volunteers on a
nominated day and a new blank form is left. Customers who have difficulty writing an order have their order taken over the telephone by staff and volunteers. Orders for the whole week are taken to the various shops, where teams of volunteers will start on them. In some shops the dried goods are packed the day before and fresh items added in the morning and in other stores the whole order is packed on the day of delivery. Delivery routes are arranged for geographical efficiency and worked around the capacity of each van. Customers receive their order complete with their own till receipt and their original shopping list, so it can all be checked off. Customers pay the volunteers the cost of their own shopping plus the delivery charge either by cash or cheque. If this is not possible for whatever reason, there are a variety of different methods to resolve this. Each local branch has a choice of shops that ‘support’ The Food Train, the customer can choose from the shops available in their local branch area.

The public sector in Scotland has recognised that there is great potential in the project. A four year funding package from the Scottish Government was awarded in 2002 through the ‘Better Neighbourhood Service Fund’. This allowed one full-time staff member to be recruited initially to develop The Food Train expand across the region of Dumfries and Galloway (with an extra part-time member of staff in 2005). This investment ensured that by September 2005 The Food Train’s grocery delivery service was expanded from approximately 50 to around 380 customers.

Once the grocery delivery service became fully operational across Dumfries and Galloway in late 2005, The Food Train set its sights on another clear need of its members – an additional support service called The Food Train ‘EXTRA’ Service, which provides practical home support, helping the frailest with home tasks.

In 2008 a planning process to expand The Food Train to other parts of Scotland began. The Scottish Government, Community Food & Health (Scotland), and West Lothian Council provided support to ensure that The Food Train in West Lothian started in September 2010 – providing a grocery delivery service with an ‘EXTRA’ service in development. Moreover, a Food Train in Stirling, providing a grocery delivery service, began in November 2011, following support from the Scottish Government and Stirling Council. In January 2012, a Food Train Dundee, supported by the Scottish Government and Dundee City Council, was established and now provides a grocery delivery service.

Since August 2010 a small pilot befriending service has been added to The Food Train in Dumfries and Galloway to help the most socially isolated and lonely to get out and maintain and develop friendships, helping them enjoy life. Funding just awarded will now help this new service move from pilot phase to region-wide activity.

Outcomes

The Food Train supports members of the community to live more independently through being able to stay in control of their lives and to enjoy a healthy diet. This helps to prevent malnutrition – reducing the likelihood of hospital admissions, and allows older people to remain in the comfort of their own homes within their community – greatly improving their quality of life.
The Food Train also provides unobtrusive advice for individuals about referral agencies in case individuals begin to have additional problems – helping individuals to manage their own conditions more effectively.

Community Food and Health (Scotland) commissioned an evaluation of The Food Train in 2008 to shed some light on its overall social benefits. This involved a customer survey on the perceived benefits of the services. The five key outcomes of The Food Train included:

- Independence 76%
- Health 50%
- Tackling Isolation 35%
- Wellbeing 27%
- Safety 21%

The evaluation concluded that:

‘The Food Train provides a well targeted, effective and flexible service that is highly acceptable to customers, with low cost inputs primarily as a result of its volunteer workforce. It generates high value outcomes for customers and fulfils a critical role in supporting them in their desire to retain their independence and to remain in the comfort of their own homes and within their own communities. Its economic value in delaying the onset of higher-cost packages of care is highly significant, and is in line with current UK and Scottish Government policies on meeting the challenge of an ageing population which is living longer though with unhealthier lives.’

The Food Train’s work also has a beneficial impact on volunteers taking part. Volunteers have improved their mental and physical wellbeing because the project involves:

- working and doing things outside;
- increased social contact;
- getting a ‘feel good factor’ from helping others;
- enabling volunteers to build upon their skills, increasing their employability.

Social cohesion is bolstered by creating contacts amongst volunteers and customers, amongst volunteers, and between local enterprises and the community. This process also creates a culture of active citizenship. The Food Train has a positive economic impact for local shops, supermarkets and garages, enabling them to retain and attract new customers.

The Food Train also contributes to the Dumfries and Galloway’s Local Outcomes Framework, including:

- improving employment and business opportunities (1.1);
- maximising household income (1.4);
- caring for vulnerable people (2.2);
- reducing inequalities in health (2.4);
- leading healthier lifestyles (2.5);
- improving community safety (3.1);
- supporting communities (3.2);
- encouraging people to be responsible citizens (4.4).
The quality of the work that *The Food Train* provides has resulted in many awards such as:

- Queens Golden Jubilee Award (2004)
- Guardian Society Award (2004)
- Best Practice in Volunteering (2005)
- Age Concern Scotland Group of the Year (2005)
- UK Charity Awards – Highly Commended (2007)
- Healthy Working Lives (Bronze 2008 and Silver 2009)
- The Herald Society Awards – Commended (2008)

### Performance Indicators

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<td>Number of grocery deliveries</td>
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<td>14,000</td>
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<td>Dumfries Town</td>
<td>Dumfries Town</td>
<td>Dumfries and Galloway</td>
<td>Dumfries and Galloway, West Lothian</td>
<td>Dumfries and Galloway, West Lothian, Stirling, Dundee</td>
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### Costs and Savings

The economic evaluation calculated that the direct costs of delivering *The Food Train’s* services in 2008/09 were just over £211,000, consisting of:

- staff costs: £81,900;
- central running costs: £77,900;
- delivery of shopping & EXTRA services: £51,500.

These costs arose from over 15,000 grocery deliveries and 1,000 EXTRA home support visits. This generated £31,000 in service charges to customers. Grants and donations levered into the service amounted to an equivalent of over £193,000.

The importance of volunteers to *The Food Train* is demonstrated by an estimate made by an evaluation of *The Food Train’s* economic value. It was estimated that the total
unpaid time invested for the year 2008/09 was 27,500 hours. This works out as invested
time equivalent to £277,000 (using an average hourly rate for volunteers of £10.10).

The Food Train’s customers benefit financially from not having to use transport to get
to shops or other outlets. Moreover, the delivery service has lower costs and higher quality
service than alternatives. The same is true for customers of the EXTRA service. The Food
Train’s customers spent £434,302 in 2008/09. There was a consensus amongst retail
partners that The Food Train had a positive economic effect. Garages have benefited from
the sale of diesel to tune of approximately £11,000.

Learning Points

By creating a good relationship with local enterprises the service is able to provide choice
for customers, establish a guaranteed source of provision, and have access to fresh and
affordable food.

Partnership with the local community: The Food Train has developed a strong network
within the community, allowing referrals for individuals needing assistance to be easily
made from local agencies, groups, clubs or individuals who believe an older person may be
in need of help. Its partnership with the community involves all services being delivered
by local volunteers and coordinated by local staff.

The service’s partnership with its members ensures that it listens and learns in order
to provide members with what they need, when they need it, and ensure it is affordable.
Members are especially able to shape The Food Train by voting at the AGM.

The Food Train has created a mutually beneficial partnership with its funders, which
allows it to diversify and increase its range, whilst providing funders with a strong return
on investment, and allowing local needs to be met, alongside wider benefits such as
enabling a stronger, healthier community.
The Food Train: supporting older people to eat healthily at home

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Five steps to making the transformation to co-production

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

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

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

**Step 1: ‘Map it!’**
If you don’t know where you are, how can you get to where you want to go?

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

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

These workshops should ideally draw on local databases showing how citizens are already engaged with public services – but actually this kind of information is rarely available. Another cost effective way to undertake this mapping process is through staff and citizen mapping exercises, exploring the level and quality of co-production in which they are engaged themselves. Such mapping exercises should separate the four forms of co-production: co-commission, co-design, co-delivery, and co-assess (outlined in the Bovaird and Loeffler chapter earlier in this book). This allows for a more detailed and
nuanced picture of the current state of co-production. For instance, a local authority may have advanced levels of co-delivery, but may have very little co-assessment, so that it is not able to use good feedback from citizens in continuously improving service quality.

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

**Step 2: Focus It!**

*Fools rush in!*

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

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

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**Figure 5: Example of a Co-production Priority Matrix**

![Co-production Priority Matrix Diagram](attachment:image.png)
want to be involved and to associate with success. Conversely ‘hard slogs’ (low impact, high effort) should be avoided as they will sap time, energy, resources, and are liable to alienate staff, service users and the community.

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

**Step 3: People it!**

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

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

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

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

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

- **High Power – High Influence stakeholders**: should generally be treated as partners and champions, as they are central to the success of your initiative. Some, of course, may be ‘potential enemies’ – again you need to work closely with them, either to change their mindset or to offset their interventions, to limit any damage they might do.

- **High Power – Low Influence stakeholders**: tend to be ‘arms length’ to your decisions – but you should generally inform them and get their support, without over-involving them.

- **High Influence – Low Power stakeholders**: important to inform them of what you are doing, ensure they are appreciated, and encourage them to join in – if
they get annoyed about NOT being involved they may find ways of making such a fuss that they become ‘High Influence – High Power’ – with a very negative attitude.

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

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

**Step 4: Market it!**

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

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

One way of predisposing users and other citizens to take part in co-production is to promote co-production charters, which explicitly outline the roles, responsibilities, and incentives for service users, citizens, and staff. This can reassure potential co-producers that their commitment is close-ended and that any dangers concerned (e.g. in relation to accident insurance or potential charges for negligence) have been taken care of. It reminds them of their rights as co-producers (e.g. that they should not be coerced into co-production activities – these should remain something which they do willingly). It also shows in a powerful symbolic way that their effort is part of a wider movement, in which many other citizens are pleased to be involved, and that their efforts are appreciated by the public agency involved. Finally, it reminds people that they also have duties and responsibilities when they agree to be co-producers.
Step 5: Grow it!

Thinking big and scaling up

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

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

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

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

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

And if we may, we’d like to end this Five-Step model by recommending one more step than advertised…
STEP 6: JUST START !!!

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CO-PRODUCTION

SELF-HELP/ORGANISING

professionals inputs

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Co-commission  Co-Design  Co-Deliver  Co-Assess

THE GOVERNANCE INTERNATIONAL

CO-PRODUCTION TREE

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FOCUS IT

GROW IT

MARKET IT

PEOPLE IT

Empowerment

Participatory budgeting

Participation

Volunteering

Timebanking

Individual budgets

Peer support

Personalisation

Cooperatives

Consultation

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