joint improvement team
creativity, collaboration and continuous improvement

governance international®
Achieving citizen outcomes

CO-PRODUCTION

of Health and Wellbeing in Scotland

CO-PRODUCE

Scottish Co-production Network

ALLIANCE
HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND
people at the centre

photo credits
cover :
4 © NHS Scotland Photo Library website
1, 2, 3, 5 © Governance International
6 © Gina Sanders – Fotolia.com
p. 80 © The Food Train

designed by
ruediger_kern@gmx.de

Published by Governance International
© 2013 Governance International
ISBN 978-0-9572533-2-2 (pbk.)

Co-Production of Health and Wellbeing in Scotland
Elke Loeffler, Gerry Power, Tony Bovaird and Frankie Hine-Hughes (eds.)

CO-PRODUCTION OF HEALTH AND WELLBEING IN SCOTLAND

Elke Loeffler, Gerry Power,
Tony Bovaird and Frankie Hine-Hughes (eds.)

Contents

6 **Foreword**
Derek Feeley, NHS Scotland and Rory Mair, CoSLA

8 **The co-production journey in Scotland**
Dr. Margaret Whoriskey, Joint Improvement Team, Scottish Government

12 **Co-production in Scotland – a network for change**
Olivia Hanley, Scottish Co-production Network Coordinator

THE VISION

20 **The role of co-production for better health and wellbeing: Why we need to change**
Tony Bovaird, University of Birmingham and Elke Loeffler, Governance International

28 **Assets for health**
Sir Harry Burns, The Chief Medical Officer for Scotland

34 **Co-production in Scotland – a policy update**
Gerry Power, Joint Improvement Team, Scottish Government

CO-PRODUCTION IN ACTION
Good practice cases from Scotland and Sweden

46 **Co-production in Scotland: Two case studies**
Andrew Jackson, Joint Improvement Team, Scottish Government

52 **The Family Nurse Partnership programme in Scotland: Improving outcomes for child, parents, and society**
Elke Loeffler, Governance International

64 **The ALISS System**
Christine Hoy, Health and Social Care Alliance Scotland

72 Reducing crime and improving health in NW Kilmarnock using community assets
Tony Bone, Strathclyde Police

80 The Food Train: Supporting older people to eat healthily at home
Frankie Hine-Hughes, Governance International

90 Empowering patients to need less care and do better in Highland Hospital, South Sweden
Jörgen Tholstrup, Clinic of Internal Medicine, Highland Hospital, Eksjo, Sweden

100 The Esther approach to healthcare in Sweden: A business case for radical improvement
Nicoline Vackerberg, Director of the Esther Network

ON THE TRANSFORMATION ROAD

114 Co-producing with communities in Scotland – the potential and the challenges
Fiona Garven, Scottish Community Development Centre

120 Seizing opportunities: Housing and prevention
Jackie Walder, Housing Transitions and Support, Scottish Government

126 Talking Points: A personal outcomes approach for health and care services and support
Chris Bruce, Joint Improvement Team, Scottish Government

132 Co-production – driving change in health and social care
Ian Welsh, Health and Social Care Alliance Scotland
Shelley Gray, Health and Social Care Alliance Scotland

138 Five steps to making the transformation to co-production
Elke Loeffler, Governance International
Frankie Hine-Hughes, Governance International

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.

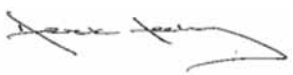
Co-production recognises that people have 'assets' such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be brought to bear to support their health and well-being.

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.

The first edition of this book, entitled 'Co-production in Health and Social Care', has proven to be an invaluable reference resource for strategists and practitioners in planning and developing services which aim to maximise the assets of citizens and communities with those of statutory and non-statutory providers. The first edition of the booklet has had three print runs with 3000 copies of the publication having been distributed through Scotland and beyond. We are delighted to welcome this updated and extended edition which incorporates examples of good practice from both Scotland and our international learning partners.



Derek Feeley

Director General Health and Social Care and Chief Executive NHS *Scotland*

Rory Mair

Chief Executive, Convention of Scottish Local Authorities

The co-production journey in Scotland

DR MARGARET WHORISKEY, *Director, Joint Improvement Team, Scottish Government*

Like many other European countries, Scotland faces a significant increase in service demand during a time of demographic change and a period of sustained decline in financial resources. In response the Scottish Government has developed policies which specifically promote and fund co-production approaches in health and social care.

Sir Harry Burns, Chief Medical Officer for Scotland, has been highly influential in promoting this direction of travel through his championing of an 'assets-based approach' to planning and delivering health and social care. His vision was reinforced by the publication of the Christie Commission Report on the Future Delivery of Public Services in June 2011. This highly influential report argued that it is necessary "*… 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 …*"

The Scottish Government has recognised this challenge and together with the Convention of Scottish Local Authorities (CoSLA) and other stakeholders, has developed a ten year change programme for 'Reshaping Care for Older People', which promotes the development of co-production and community capacity building as key elements of public service transformation. Most importantly, the Scottish Government has invested to support the transformational change required by creating a four year older people's services Change Fund of £300 million in order to drive the necessary shift in service models and organisational cultures. Government funding has also been made available to adopt co-production approaches to deal with specific issues such as teenage pregnancies (e.g.

through the Family Nurse Partnership Programme) and the limited access for older people to healthy food and supportive social networks (e.g. through the Food Train).

On an operational level, the Joint Improvement Team (JIT), which is co-sponsored by the Scottish Government, CoSLA and NHS Scotland, working in strategic partnership with the Third and Independent sectors, provides support to 32 locally based partnerships across Scotland (including the NHS, local council, third and independent sector organisations) to integrate co-production as an approach within health and social care. This work has been led by the two National Co-Production and Community Capacity Leads – Gerry Power and Andrew Jackson working with geographically based JIT Associates. Activity to date has included:

- Awareness raising activities, such as the first Co-Production and Community Capacity-Building Conference in Dunfermline in January 2012, which was attended by more than 300 participants.
- Providing case study evidence that co-production works including the publication with *Governance International* of "*Co-production in Health and Social Care: What it is and how to do it'*, and the building of management and front-line staff capacity across local councils, the NHS, independent and voluntary sectors by rolling out training based on the *Governance International* Co-Production Star.
- Gathering good practice case studies from all of the 32 local partnerships in Scotland.
- Strengthening networking and the exchange of experiences through the Scottish Co-Production Network.

The change management strategy of JIT is showing signs of success as a number of councils have already started to take action to roll out co-production across their services. For example, Midlothian Council has adopted a Council wide approach to co-production enabling all council services in the county to make effective use of the *Governance International* Co-Production Toolkit. In addition JIT has provided coaching to assist the implementation of action plans being drawn up by participants in the co-production training sessions. This process has uncovered good examples of co-productive practice already taking place in the Council

which are being used as drivers to convince more colleagues to adopt this way of working and promote culture change.

Co-production is also being rolled out in other public services in Scotland. For example, Strathclyde Police and the national Violence Reduction Unit have been leading an assets-based approach in a highly deprived area in North West Kilmarnock, which was previously characterised by high crime rates. The project uncovered enormous reserves of creativity and energy in the community, which have helped to turn around the quality of life of local people in the area. The lesson which Chief Inspector Tony Bone took away from his involvement with this project was, 'You don't know what you need in a community until you know what you already have'.

In other organisations, however, full buy-in remains to be achieved and work continues to demonstrate the value of this approach in delivering better outcomes and/or efficiency savings. For example, JIT is currently working with a number of partnerships on Contribution Analysis to develop an evidence base which can demonstrate the economic utility of co-production and community capacity building as well as their impact on personal outcomes.

It is recognised that embedding co-production and community capacity building in organisations and services will require whole systems change which spans commissioning of public services through to organisational and individual performance improvement. One example of how this might be achieved in future is by recognising the capacity and capability of front-line staff to co-produce with users and communities in organisational competency and performance management frameworks. This will support the principle of co-production by emphasising it is more rewarding for the service user, the professional and the provider organisation to solve problems together and not simply do things 'to' and 'for' service users.

I am delighted to announce that this book '*Co-Production of Health and Wellbeing in Scotland*', our second publication on co-production and community capacity building in Scotland, produced in association with *Governance International* and other partners, will be launched by Mr Alex Neil, Cabinet Secretary for Health and Wellbeing, at the National Co-Production and Community Capacity-Building Conference on 20 February

2013 in Edinburgh. This publication includes updated and new chapters covering the background to co-production, case studies and good practice from within Scotland and from our learning partners in Sweden. This I hope will help to demonstrate the great strides that have already taken place in making co-production and community capacity building a key part of the strategy and the practice of public services in Scotland. Further, JIT hopes that this book will help you in making these approaches central to the way you plan and deliver services.

CONTACT DETAILS

Dr Margaret Whoriskey
Director, Joint Improvement Team, Scottish Government
Email: Margaret.Whoriskey@scotland.gsi.gov.uk

Co-production in Scotland – a network for change

OLIVIA HANLEY, *Scottish Co-production Network Coordinator*

As will be discussed in other chapters, the past two years have seen growing interest and investment in embedding assets-based approaches such as co-production in reshaping how public services are designed and delivered in Scotland. At a national level, this is represented in key strategy commitments such as the Christie Commission on the Future Delivery of Public Services and the Scottish Government response, *Renewing Scotland's Public Service*.

The Reshaping Care for Older People strategy has co-production and community capacity building as a key strand of the Joint Improvement Team's remit to support local health and social care partnerships across Scotland to reshape how health and social care is planned and delivered at a local level. Co-production is one element of the National Person-Centred Health and Care Programme, one aim of which is that *"by December 2015, all health and care services will support people's right to independent living and good health and wellbeing by working in partnership with individual and community assets to design, deliver and improve support and services"*. Across other policy areas such as housing, policing, health and community planning, co-production is increasingly being recognised as a collaborative approach that fits clearly within the prevention agenda being taken forward to tackle inequalities and deliver public services in Scotland.

But how can we embrace this policy environment which invites innovation and change as an opportunity to embed ways of working that involve people and communities in tackling the root causes of health and social inequalities? Scotland has an established history of looking to our internal resources and local knowledge to find solutions to tackling inequality through collaborative working, community-led activity and creatively engaging with people in informing and influencing decision making. It

is this resource that we can bring together to learn from and build upon to enable us to embrace co-production and ensure we take this approach forward in a meaningful and informed way.

In 2010, an informal network was established which was co-facilitated and chaired by the Scottish Community Development Centre (SCDC) and NHS Tayside on a voluntary basis to facilitate dialogue and collaboration around this growing resource and momentum. The network first came into being as a result of contacts established between the New Economics Foundation (nef) and NHS Tayside as part of their work around the *Health Equity Strategy: Communities in Control* and as a result of the national capacity building for the community-led health programme, *Meeting the Shared Challenge* led by SCDC. The network began to bring together practitioners with an interest in a co-production approach, and to facilitate networking between an established body of community-led activity and new strategic responses to tackling inequality which had co-production principles at their core.

As the network gained momentum and began to establish itself as a key resource for exploring and developing understanding around co-production, it received support from the Joint Improvement Team. This enabled it to be formally developed in 2012–13 and has since expanded to a membership of almost 250 people with a reach that stems across policy areas, across sectors and across operational and strategic levels of both local and national bodies.

As interest in co-production grows, the Scottish Co-production Network will continue to provide a locus for the sharing of learning and the exchange of co-production practice. Through the resource provided by JIT, the network has the support of a dedicated part time Coordinator to take forward the development of network activities. Through a new interactive website, regular network meetings, national and regional learning events and support to local activity, the network aims to:

- Build on existing co-production activity in Scotland
- Provide a forum for learning, debate and development of ideas
- Create a space for practice and information exchange
- Support dialogue and advance co-production thinking and approaches in Scotland

How does the network define co-production?

"On a personal level it's about learning to let go of my control, and rely instead on my influence, as an equal partner, over the things which affect the lives of other people."

Dr Drew Walker, Director of Public Health, NHS Tayside

By its very nature, the network represents a breadth of understanding, experience and opinion of what co-production should be, and can mean in practice. There are many different definitions of co-production in use and it is helpful to draw out the key values and elements which underpin these different definitions and the range of activity which sits within a co-production ideology. Essentially co-production is:

- **an assets approach** which builds on the skills, knowledge, experience, networks and resources that individuals and communities bring,
- **built on equal relationships,** where individuals, families, communities and service providers have a reciprocal and equal relationship,
- an approach where services **'do with, not to'** the people who use them and who act as their own catalysts for change.

The network is made up of practitioners, volunteers, policy makers and agencies who share an interest in, or experience of co-production. The network learning events are hosted by network members and focus on sharing learning from real life practice examples We have facilitated several meetings in Perth, Glasgow and Edinburgh. Our first Regional Learning Event was hosted by a local organisation which supported a community-led response to an identified need for mental health support services. This resulted in a co-designed and delivered service. Practice Exchange also featured a local Timebanking initiative which builds on local community activity and the skills of individuals to work with service providers in responding to community needs.

"As a project working with disabled people and their organisations to achieve independent living through equal and active citizenship, co-pro-

duction has real potential to ensure that disabled peoples' voices are part of the solution. The Scottish Co-production Network enables us to hear other perspectives, grow understanding and share learning. It is particularly valuable in enabling us to network with a wide range of practitioners from a broad spectrum of organisations."

Over the coming year, the network will be working with JIT and national programme partners to support the embedding of the approach by offering a platform for knowledge exchange and dialogue. The network is supported by a Reference Group which will drive the promotion of the network and its learning through local and national channels in order to widen and expand its impact.

The Scottish Co-production Network is free and open to anyone who is interested in co-production in Scotland. As a member of the network, you will be invited to learning events, network meetings and be able to take part in discussions and information sharing on the website. In order to ensure the network is effective in developing practice around co-production in Scotland, members are encouraged to contribute to the network by sharing their learning and experience through the online discussions, attending meetings and sharing useful information and case studies.

If you would like to join the network you can sign up here –
it's free and only requires basic information :
www.coproductionscotland.org.uk

The network is currently supported by a dedicated part-time Coordinator based at Scottish Community Development Centre. You can contact Olivia Hanley at olivia@scdc.org.uk; also Co-Chairs Catriona Ness catriona.ness@nhs.net and Fiona Garven fiona@scdc.org.uk.

References

Reshaping Care for Older People: A Programme for Change 2011–2021 – COSLA, Scottish Government, NHS Scotland (http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/)

People at the Centre of Health and Care, National Person-Centred Health and Care Programme: Improvement Collaborative Learning Session 1, 20–21 November 2012, SECC, Glasgow

National Person-Centred Health and Care Programme – The Third Sector as Key Partner: Report of session held by LTCAS and the Scottish Government, 31 May 2012 (http://www.alliance-scotland.org.uk/news-and-events/news/2012/06/third-sector-to-play-key-role-in-new-national-person-centred-health-and-care-programme/)

Communities in Control, Draft Health Equity Strategy – NHS Tayside, 2009 (http://www.thpc.scot.nhs.uk/PDFs/Health%20Equity%20Strategy.pdf)

Continuing to Meet the Challenge: A report on 'Meeting the Shared Challenge' a national initiative to encourage and embed community-led health' – Stuart Hashagen and Peter Tayor, Scottish Community Development Centre, August 2010 (http://www.scdc.org.uk/media/resources/what-we-do/mtsc/Continuing%20to%20Meet%20the%20Challenge.pdf)

Co-production Self-assessment Framework: A working reflection tool for practitioners, New Economics Foundation, 2011 (http://api.ning.com/files/VqSMh5MT5ZMNc9040–7x-3tlsar02l0JTvoqW7EeoW6MoLSEhi*CKaDWNipgAPhL0zyoXMHLIKSzAiH2Q2pyKnf0GbgscwEG/Coproductionaudittool.pdf)

Community Resilience and Co-production: Getting to grips with the language, SCDC Briefing Paper, 2011 *(http://www.scdc.org.uk/media/resources/assets-alliance/Community%20Resilience%20and%20Coproduction%20SCDC%20briefing%20paper.pdf)*

CONTACT DETAILS

Olivia Hanley
Scottish Co-production Network Coordinator

Email: olivia@scdc.org.uk

THE V

THE VISION

VISION

The role of co-production for better health and wellbeing: 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 organisations 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). The survey also showed a very strong statistical correlation between people's willingness to co-produce and their belief that they could make a difference, reinforcing the point by Sir Harry Burns in the next chapter that co-production is likely to improve outcomes by giving people more control over their lives (Parrado et al., 2013).

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". 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 "professionals 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 and can collaborate with other service users and with other members of the public to bring out the best in them ('*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** of services – e.g. personal 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 (Figure 1) 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.

Distinguishing between these different service activities allows us to identify different ways into public service 'co-production'. In most public agencies it will readily be apparent that at least one of these types of co-production is already present, reinforcing the insight from earlier that co-production is not new, normally it is simply hidden (and therefore not systematically harnessed for the mutual good of the service users, citizens

and public services involved). At the same time, this list also serves to make public managers aware that a much wider range of co-production activities is possible.

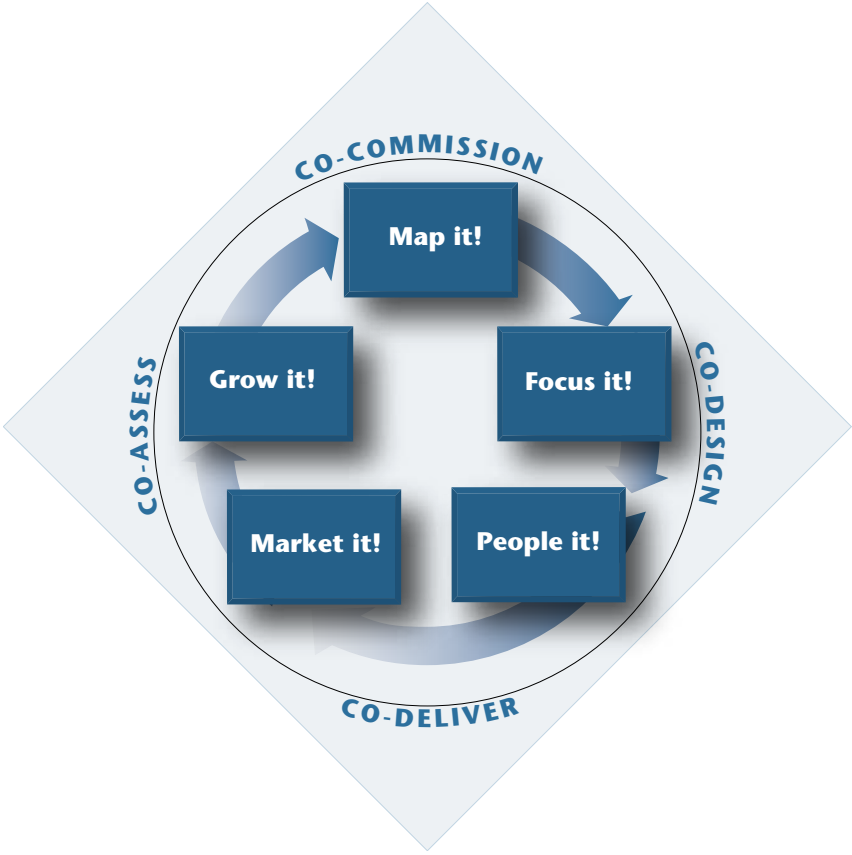


Figure 1: The *Governance International* Co-Production Star

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.

The current drive towards co-production will only produce the desired 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

Bovaird, T. (2007), "Beyond engagement and participation – user and community co-production of public services", *Public Administration Review*, 67 (5): 846–860.

Bovaird, T. and Loeffler, E. (2012), "From engagement to co-production: How users and communities contribute to public services" in Taco Brandsen and Victor Pestoff (eds.), *New public governance, the third sector and co-production*. London: Routledge.

CoSLA, Scottish Government and NHS Scotland (2011), *Reshaping care for older people: A programme for change 2011–2021*. Edinburgh: Scottish Government.

Kotler, P. and Lee, N. (2008), *Social marketing: Influencing behaviours for good*. 3rd edition. Thousand Oaks, CA: Sage Publications.

Loeffler, E.; Parrado, S.; Bovaird, T. and van Ryzin, G. (2008), *"If you want to go fast, walk alone. If you want to go far, walk together": Citizens and the co-production of public services.* Report to the EU Presidency. Paris: Ministry of Finance, Budget and Public Services. Available at: http://www.govint.org/good-practice/publications/co-production/ (accessed 30th March 2012).

Loeffler, E. (2009), *A future research agenda for co-production: Overview paper*. Swindon: Local Authorities Research Council Initiative.

nef (2008), *Co-production: A manifesto for growing the core economy*. London: New Economics Foundation.

Normann, R. (1984), *Service management: Strategy and leadership in service business*. Chichester: John Wiley and Sons.

Parrado, S.; van Ryzin, G.; Bovaird, T. and Loeffler, E. (2013), "Correlates of co-production: Evidence from a Five-Nation Survey of Citizens", International Public Management Journal (forthcoming).

Thaler, R. H. and Sunstein, C. R. (2008), *Nudge: Improving decisions about health, wealth, and happiness*. Yale University Press.

CONTACT DETAILS

Elke Loeffler
Chief Executive, Governance International

Email: Elke.Loeffler@govint.org

Tony Bovaird
INLOGOV and TSRC
University of Birmingham

Email: t.bovaird@bham.ac.uk

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 comple-

ments 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: section 8.2). 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

Antonovsky, A. (1967), "Social Class, Life Expectancy and Overall Mortality", *The Milbank Memorial Fund Quarterly* 45 (2) pp. 31–73. in Scottish Government (2009), *Health in Scotland 2008 Shedding Light on Hidden Epidemics: Annual Report of the Chief Medical Officer Health in Scotland 2008*'. Available at: http://www.scotland.gov.uk/Publications/2009/12/16103619/0 (accessed 6th March 2012).

Burns, H. (2011), *Annual Report of the Chief Medical Officer – Health In Scotland 2011, Assets for Health*. Available at: http://www.scotland.gov.uk/Resource/0038/00387520.pdf (accessed 6th March 2012).

Christie, Campbell (2011), *Commission on the Future Delivery of Public Services*. Edinburgh: Scottish Government.

Harrison, D. et al. (2004), *Assets for health and development: Developing a conceptual framework*. Venice: European Office for Investment for Health and Development, World Health Organization.

Needham, C. and Carr, S. (2009), *Co-production: An emerging evidence base for adult social care transformation*. London: Social Care Institute for Excellence, Research Briefing 31.

SCDC (2011), *Community development and co-production: Issues for policy and practice*. SCDC Discussion Paper 2011/02. Glasgow: Scottish Community Development Centre.

Slay, J. and Robinson, B. (2010), *In this together: Building knowledge about co-production*. London: New Economics Foundation.

CONTACT DETAILS

Sir Harry Burns
The Chief Medical Officer for Scotland
Email: cmo@scotland.gsi.gov.uk

Co-production in Scotland – a policy update

GERRY POWER, *Joint Improvement Team, Scottish Government*

Context

The socio-economic challenges facing Scotland have changed little in the 12 months since the first edition of this book appeared. Encouragingly, however, there is evidence that provider organisations increasingly recognise the need to work ever more closely with service users and their circles of support in order to optimise the use of both citizen and corporate resources in designing and delivering health and social services.

Statistics from the General Register Office for Scotland (GROS, 2010: 22) project that between 2008 and 2033 Scotland will experience a rise of 50% in its over-60s population and a 84% increase in it is over-75s. It is suggested 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 circa £5.0 billion to £8.0 billion by 2031 (Joint Improvement Team 2011: p. 10). This is against a wider economic backdrop where the Chief Economic Adviser to the Scottish Government projects a shortfall in the Scottish public purse of £39 billion over a similar timescale (Scottish Government, June 2010: p. 10).

The inevitable challenge facing public sector organisations in Scotland remains how they respond to significant increases in service demand during a period of sustained decline in financial resources. Clearly, it is imperative that new models of service planning and delivery are developed which are supported by a framework of coherent and cohesive underpinning policies.

Policy influences

The Scottish Government's ten year programme for 'Reshaping Care for Older People' (Joint Improvement Team, 2010), and its associated Change Fund, continues to be pivotal in encouraging the development of new service models which employ co-production and community capacity building in helping to address the underlying economic and demographic challenges facing Scotland's public services. Throughout Scotland many examples of good practice have emerged funded by local Change Funds which are beginning to alter the way service users, carers, community organisations and professionals work across the statutory and non-statutory sectors to redesign and deliver services. Some examples of this are included in this book and it planned to highlight many others from across the 32 Scottish Change Fund partnerships on the Joint Improvement Team website during 2013.

As discussed in a previous chapter by Sir Harry Burns, Chief Medical Officer for Scotland, the inclusion of co-production as a central plank in Scottish Government health and social care policy has been significantly influenced by Aaron Antonovsky's philosophy of *salutogenesis* (Scottish Government, December 2009: p. 11) as a basis for developing an 'assets-based approach' in planning and delivering health and social care in Scotland. This also links to the "person-centered ambition" outlined in the Healthcare Quality Strategy for NHS Scotland (Scottish Government, May 2010) which 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: p. 7), all of which clearly resonates with definition of co-production of Boyle and Harris (2009: p. 11).

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

In order to achieve this, Christie (2011: p. 26) argued for urgent and sustained reforms of public services in Scotland with the first key objec-

tive 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 …*".

The report goes on to reference 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 Health and Social Care Alliance, Scotland ('The ALLIANCE') as a method of achieving co-production through 'personalisation' i.e. user-led service planning and provision. Christie also 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: p. 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 recognised the need for public service reform based around four pillars:

- Prevention – "*…directly aimed at improving outcomes and reducing the demand for a range of acute services over time …* (by) *… better utilis(ing) the talents, capacities and potential of our people and communities …*" (Scottish Government, November 2011: p. 6 and 8)
- Partnership – which will be "*… comprehensive and participative, harnessing the full spectrum of talents and capacities of public bodies, citizens, third sector organisations and local businesses … (and)… where appropriate … place greater responsibility and control in the hands of citizens and communities …*" (Scottish Government, November 2011: p. 10)
- Workforce development – building on Christie's recommendation that frontline staff working with people and communities are best placed to plan and deliver services: A Scottish Government priority is that "*… management and frontline staff in public services need to be encouraged and supported to prepare for change, promote innovation, embrace new approaches, improve performance and involve com-*

munities and services users in the design of public services …"(Scottish Government, November 2011: p. 14)

- Performance improvement – Christie emphasises the importance of outcomes in improving and measuring performance. In response 'Renewing Scotland's Public Services' calls for "*… greater clarity around the objectives of public organisations which offer transparent measurement of progress and benchmarking …*" (Scottish Government, November 2011: p. 16).

All four pillars clearly support a direction of travel in which the principles of co-production are enshrined as part of a design and delivery process with citizens and communities as full partners together with statutory and non-statutory service providers.

'Renewing Scotland's Public Services' describes a vision from which a 'golden thread' of co-production and community capacity can be traced to other Scottish Government planned and extant legislation, this includes:

- **Age, Home and Community: Scottish Government's Housing Strategy for Older People** (Scottish Government, December 2011), recognises that housing and housing-related services provide a cost effective way of enabling older people to live as independently as possible at home rather than in hospital or care homes. This can only be delivered in a concerted and co-ordinated partnership with older people, local communities and service providers. The importance of Housing Support to this agenda is further emphasised later in Jackie Walder's chapter in this book.
- **Self Directed Support(Scotland) Bill** (Scottish Government, February 2012) which is at an advanced stage in its legislative cycle has at its heart the principle of choice in how people live their lives, where they live and what they do. Allied to this people's is control in determining and executing the who, what, when and how their support is provided. Crucially the Bill emphasises that the process for delivering Self Directed Support is through co-production i.e. support that is designed and delivered in equal partnership between people and professionals.

- **Scotland's National Dementia Strategy** (Scottish Government, 2010) resonates strongly with Reshaping Care for Older People and Self Directed Support. It stipulates the rights of people with a diagnosis of dementia and their carers to be part of decisions that affect them and fully participate in planning care. In addition, it stresses the need to better use natural supports, peer support and wider community resources to ensure people with dementia are enabled to live well with dementia and remain part of their communities.
- **The Integration of Health and Social Care Bill** (Scottish Government, September 2012) is currently being drafted following extensive consultation. This will place a requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services (reflecting the workforce development pillar above).
- **The Community Empowerment Bill** (Scottish Government, August 2012) is another Bill going through the legislative process. The Scottish Government wants communities to get the chance to do more for themselves, it wants people to take part and help decide what happens where they live. This includes making it easier for communities to take part and have their say, helping them to own land and buildings in their area, and make the best use of local resources.

An additional programme of work which is central to this agenda the '*National Person-Centred Health and Care Programme*' launched in November 2012, and within this its co-production strand entitled '*People Powered Health and Wellbeing; Shifting the Balance of Power*'. This is described in more detail in the chapter later in this book by Ian Welsh and Shelly Gray.

It is also important to recall that two additional Change Funds which seek similar results in early year's interventions and reduced reoffending were announced in 2011. 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: p. 1), in their recent paper on asset-based approaches to health improvement the size of this investment in change 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 …*"

It is acknowledged that there is some evidence that co-production and assets-based approaches do contribute to the well-being of individuals and indeed financial bottom lines (Loeffler and Watt [2009]; Sigerson and Gruer [2011]). This is, however, mainly qualitative in nature and it is difficult to make precise links between the cause and effect of investment in co-production and 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: p. 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 tested in three pilot sites by 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: p. 1). Unlike conventional cause-and effect analysis this method does not attempt to prove that any one factor e.g. a policy, 'caused' a specific outcome but rather builds a credible 'performance story' demonstrating the influence certain activities have had in driving change, possibly along with other factors. Work on using this methodology is at an early stage and the author hopes to report further progress during 2013. It is hoped that the results from the three test sites will be reported in late 2013.

Conclusions

Two years into the Older Person's Change Fund process 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. Early in the Change Fund process JIT identified that one reason for this is a lack of a logical process or 'toolkit' which could support partnerships develop co-production within and between their organisations and the communities they serve.

During 2012, JIT, working with *Governance International*, delivered a programme of training opportunities to help partnerships develop practical approaches to co-production. Feedback on these programmes has been very positive. Some partnerships have indicated that they would now like tailored, partnership specific support to develop co-production locally. The JIT and *Governance International* have already commenced this type of focused work with one partnership.

During 2013/14 JIT will continue to provide ongoing support for all partnerships on this agenda and will look to respond to local requirements as necessary.

References

Antonovsky, A, (1967), "Social Class, Life Expectancy and Overall Mortality", *The Millbank Memorial Fund Quarterly 45 (2) pp. 31 – 73.* in Scottish Government. (2009), *Health in Scotland 2008 Shedding Light on Hidden Epidemics: Annual Report of the Chief Medical Officer Health in Scotland 2008.* Available from: http://www.scotland.gov.uk/Publications/2009/12/16103619/0 (accessed 15 November 2011)

Boyle, D. and Harris, M. (2009), *The Challenge of Co-production*, NESTA, London.

Christie, Campbell (2011), *Commission on the Future Delivery of Public Services*. Scottish Government.

General Register Office for Scotland (2010), *Scotland Population 2009, page 22.* Available from: http://www.gro-scotland.gov.uk/files2/stats/annual-review-09/rgar2009.pdf (accessed 28 April 2011).

Joint Improvement Team (2011), *Reshaping Care for Older People, page 10.* Edinburgh: Scottish Government.

Loeffler, E. and Watt, P. (2009), *Understanding the Efficiency Implications of Co-production*. Commissioned Summary Report. Local Authorities and Research Councils Initiative. Available from: http://www.rcuk.ac.uk/document/innovation/larci/Larci.CoproductionSummary.pdf (accessed 31 March 2011)

Scottish Government (December 2010), *About the Community Payback Order.* Available at: http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/examples/payback/CPO (accessed 21 November 2011).

Scottish Government (November 2008), *Achieving Our Potential: A Framework to Tackle Poverty and Income Inequality in Scotland.* Available at: http://scotland.gov.uk/Publications/2008/11/20103815/0 (accessed 21 November 2011).

Scottish Government (December 2011), *Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012–2021.* Available at: http://www.scotland.gov.uk/Publications/2011/12/16091323 (accessed 12 December 2012).

Scottish Government (August 2012), *Community Empowerment and Renewal Bill*. Available at: http://www.scotland.gov.uk/Resource/0039/00394566.pdf (Accessed 12 December 2012)

Scottish Government (December 2009), *Contribution Analysis Guide 6 in the Social Science Methods Briefings series.* Available from:

http://www.scotland.gov.uk/Topics/Research/About/Social-Research/Methods-Guides/Guide-6 (accessed 21 November 2011).

Scottish Government (January 2009), *Early Years Framework.* Available at: http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf (accessed 21 November 2011).

Scottish Government (June 2010), *Equally Well Review.* Available at: http://www.scotland.gov.uk/Resource/Doc/315880/0100454.pdf (accessed 21 November 2011).

Scottish Government (September 2012), *Integration of Adult Health and Social Care Bill – Programme for Government.* Available at: http://www.scotland.gov.uk/About/Performance/programme-for-government/2012-13/Adult-Health-Bill (accessed 12 December 2012).

Scottish Government (June 2010), *Outlook for Scottish Government Expenditure: June 2010 Emergency Budget Update, page 10.*

Available at: http://www.scotland.gov.uk/Resource/Doc/918/0101175.pdf (accessed 15 November 2011).

Scottish Government (September 2011), *Renewing Scotland's Public Services – Priorities for Reform in Response to the Christie Commission*. Available at: http://www.scotland.gov.uk/Publications/2011/09/21104740/0 (accessed 20 November 2011).

Scottish Government (July 2011), *The Evaluation of the Family Nurse Partnership Programme in Scotland: Phase 1 Report – Intake and Early Pregnancy.* Available at: http://www.scotland.gov.uk/Publications/2011/07/28142203/0 (accessed 21 November 2011).

Scottish Government (May 2010), *The Healthcare Quality Strategy for* NHS *Scotland*. Available at: http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf (accessed 15 November 2011).

Sigerson, D. and Gruer, L. (2011), *Asset-based Approaches to Health Improvement*. Available at: http://www.healthscotland.com/uploads/documents/17101-assetBasedApproachestoHealthImprovementBriefing.pdf (accessed 15 November 2011).

CONTACT DETAILS

Gerry Power (MSc, MBA,BSc.)

National Lead – Co-production and Community Capacity (Reshaping Care for Older People Programme)

Joint Improvement Team, Scottish Government

Email: Gerry.Power@scotland.gsi.gov.uk

IN AC

CO-PRODUCTION IN ACTION

GOOD PRACTICE CASES
FROM SCOTLAND AND SWEDEN

CTION

Co-production in Scotland: Two case studies

ANDREW JACKSON, *Joint Improvement Team, Scottish Government*

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 co-production 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

IDeA (2010), *A glass half-full: how an asset approach can improve community health and well-being*. London: Improvement and Development Agency.

Joint Improvement Team, *Talking Points: A personal outcomes approach*. Available at: http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/ (accessed 28 March 2012).

Time Banking Scotland, *What is Time Banking?* Available at: http://www.vds.org.uk/Volunteers/VolunteerNow/TimeBankingScotland/tabid/156/Default.aspx (accessed 28 March 2012).

CONTACT DETAILS

Andrew Jackson (BA, PGCCE, LLB)

National Co-Lead, Coproduction and Community Capacity, Reshaping Care for Older People Programme, Joint Improvement Team, Scottish Government

Email: Andrew.Jackson@scotland.gsi.gov.uk

The Family Nurse Partnership programme in Scotland: Improving outcomes for child, parents, and society

ELKE LOEFFLER, *Governance International*

Introduction

Being a parent is a challenge for most people, but being a teenage parent brings with it even greater challenges. NHS Tayside has the highest teenage pregnancy rate in Europe and is one of several areas being supported by the Family Nurse Partnership (FNP) programme in Scotland. The approach was first developed by Professor David Olds at the University of Colorado and is based on strong scientific evidence (Olds, 2006). The Scottish Government has made a manifesto commitment to 'roll out FNP across Scotland' and plans to support almost 1200 young families by 2013.

Objectives

Seeking to provide early and effective intervention FNP moves away from the traditional approach for supporting families, being directive to working alongside families. It aims to introduce a different approach where nurses engage with young parents early on in pregnancy building a therapeutic relationship with them to enable them to build their parenting skills and resources, whilst also developing and realising their own aspirations.

The aims of FNP are to support first time teenage parents to improve child and maternal health, improve school readiness and educational achievement and help parents become economically self sufficient i.e. help parents to find meaningful employment or return to education. The

importance of nurturing families was highlighted by Sir Harry Burns, Chief Medical Officer for Scotland, when he said consistent parenting can reduce sickness and increase life expectancy – with inconsistent parenting potentially adversely affecting children in later life.

Nicola Sturgeon, then Cabinet Secretary for Health and Wellbeing and Cities Strategy with a client of the FNP programme

Change management

FNP is aimed at first time pregnant teenagers (19 years and under). These are required to be resident for the 2.5 years that the programme is delivered, with no plans to relinquish the baby (as it is an attachment programme). It is optional for clients and those not wishing to be supported by FNP will receive the support from a Public Health Nurse/ Health Visitor. It is an intensive home visiting programme that focuses on the ambitions of the young parents, helps them to work out an action plan and uses a variety of methods to work with them in a respectful and meaningful way.

The FNP is delivered by highly trained family nurses who hold open a caseload of 25 clients (whole time equivalent). The partnership begins during very early pregnancy, ideally at about 16 weeks and at the latest before the mother reaches 28 weeks, and lasts until the child's second birthday. This is based upon the premise that pregnancy and the birth represent an opportunity when parents are especially open to receiving support and help (even if they have normally rejected help from public services). It works on a mother's intrinsic desire to care for her baby and pregnancy offers a wonderful window to do just this. In the ante-natal period, maternity care (screening and core ante-natal appointments) is delivered by midwives, whilst the family nurse delivers the home visiting programme to the client. Family nurse visits are regular – initially every week and once a fortnight, the number of visits decreases as the young parent's confidence develops towards the end of the programme. The programme is set out in standard form in a manual but is adapted to meet the family needs. Each visit usually lasts for around an hour.

The FNP is a strengths-based approach which recognises the skills and resources that parents possess and that can contribute to improve their own and their child's outcomes. The role of the family nurse is to ensure those skills come to the fore and develop confidence in the young parents. FNP focuses on an expecting mother's natural motivation to do the best for their child, respecting that the parents are the experts on her own lives, and working to develop achievable goals for the family.

There are three theories that underpin the programme. They are:

- **Human ecology:** The importance of understanding the context in which people live their lives;
- **Attachment:** The formation of the bonds between parent and child as basis for subsequent positive child development, and the child's learning from the responses it gets from its parents (be they negative or positive);
- **Self efficacy:** A belief that people can be supported to take control of their own lives and are the only ones who can really bring about change for themselves.

This premise requires a one-to-one alliance with the Family Nurse. This strong partnership aids the parents to change their behaviour to healthier habits and deal with the emotional problems that can prevent parents providing good care and forming a positive relationship with their child.

The capabilities of the mothers and fathers are realised through structured home visits in which the nurse will work with the parents to identify the resources they have and, where appropriate, signpost them to further support. Each of the visits is designed to provide guidance and support to the parents so that they are aware of how best to look after their child and how to change their behaviour accordingly. These conversations also serve to allow first-time mothers to bring up the many questions that arise during pregnancy – 'How do I know if my baby's healthy?', 'What do I need to change in our house to make it best for my baby?', 'How big will my stomach get?', 'How does breast feeding work?'. The Family Nurse is able to address these questions and concerns to enable the mother to take the healthiest route possible and prepare them for childbirth. The Family Nurse is also able to coach the mother and father about how they can realise their own goals and give them the confidence to do so.

The Scottish Government holds the license with University of Colorado, Denver to implement the FNP. Implementation is supported by a consultancy agreement with the Department of Health FNP National Unit, which provides training, access to expertise and support.

The first Scottish FNP programme received funding of £1.6 million from the Scottish Government and is being delivered by NHS Lothian during a three-year period. A second cohort of FNP families was supported in Lothian later in 2012, with Scottish Government match funding NHS Lothian's contribution to delivering the programme (approximately £800,000). The NHS Lothian team consists of a supervisor, six family nurses, and an administrator/data manager. The delivery team is supported by a full-time local FNP lead to implement the programme locally and ensure that it is integrated with other services within Lothian and NHS Lothian.

Over a nine month period from January 2010 148 clients who were eligible to be included on the programme were recruited. Issues such as gender-based violence have also been included in the FNP programme delivery in Lothian. This included hosting an event to raise awareness of

the issue during the '16 Days of Action Opposing Violence against Women' campaign.

A second pilot site for the FNP was established in January 2011 in NHS Tayside and its surrounding area. NHS Tayside's area has the highest teenage pregnancy rate in Europe. The project received financial support of £3.2 million over three years from the Scottish Government and a contribution of £600,000 from NHS Tayside. This pilot was staffed with 12 family nurses, supported by two supervisors – forming two teams. The aim of NHS Tayside is to reach in excess of 300 families by summer 2012.

Outcomes

These two examples below provide real life cases of how the Family Nurse Partnership helps young parents.

Client story 1 (by a Family Nurse)

Moira was 18 years old when recruited onto the programme. She had left school at age 15 years with no qualifications. She had a history of being a looked after child and was in a relationship currently with an abusive partner. Both Moira and her partner had a criminal history and were addicted to heroin and other street drugs. Moira was mistrusting of professionals and had limited support from family and friends.

The family nurse worked to build a therapeutic relationship with Moira. The strength-based approach worked well and in time a trusting relationship has been established. It was evident to the family nurse that part of the mistrust Moira had of services was related to her belief that they were negative about her ability to become a good parent. Due to the level of concerns identified in the life of Moira and potential risk for her baby, the unborn baby's name was placed on the Child Protection Register. The family nurse worked with Moira to help her recognise her own self-belief and how she could demonstrate this to the other services involved. The family nurse respected that Moira was on a difficult journey with many demands being placed upon her and aimed to not judge her when things went wrong. The family nurse continued to work with Moira to achieve her 'heart's desire' to become a good mum. Using the FNP materials and a variety of approaches including motivational interviewing Moira began to flourish. She no longer takes illegal substances and has maintained this through working with the support of an addiction service.

Moira was able to recognise the importance of relationships in her life and worked hard to re-establish the support of her parents and siblings. During this period she separated from her partner and was able to reflect that this was a good decision for her and her baby as he could be influential in her return to an adverse lifestyle.

Having found her inner confidence Moira has recently moved home and independently cares for her baby. She continues to actively participate in the Family Nurse Partnership Programme. Moira is excited about

her future life with her child with whom she now has a secure attachment. Moira has set up child care for her son on a part-time basis as she herself has successfully registered to start at college. She is keen to take the basic qualifications which she feels she was unable to do earlier due to leaving school at such a young age. The motivation and drive for success demonstrated by Moira has been recognised by support agencies. Moira's child was removed from the child protection register and Social Work is no longer involved. Moira openly describes herself as a good mum and is proud of what she has achieved.

Anonymous

Client story 2

The family nurse contacted me when I was still coming to terms with being pregnant. Her approach was the first thing I noticed. I remember how she never offered any comments and seemed to listen to what I had to say. I wondered if this meant she was no good and that she knew nothing. I found myself testing her by trying to shock a reaction out of her. She was kind of warm and made me feel good about myself.

Age 18 and pregnant had not been my plan and the father of the baby was less than supportive. Before I knew what was happening I found myself involved with Social Work and worried that I would not be allowed to keep my baby after the birth. The family nurse "helped me to believe in myself" and to plan for how I could manage the baby as a single parent. I know now that I was really frightened and would find myself "behaving badly by shouting at the professionals who were only doing their job." The family nurse helped me to recognise why I felt angry and in time I have got better at managing to "think before I speak." I have even managed to change my behaviour with people in the street. Being tough was what I believed was the best approach and I would fight in the street if I just didn't like someone.

By the time my baby was born I wanted to show everyone how I could manage and could rely on the visits from my family nurse who was working to support me with what I felt was important in the life of my baby.

I am a good parent for my daughter and have been able to enjoy every minute of her life, well almost because it is okay to say it is tough and hard work. People doubted that I could keep her safe but my family nurse got me to see that I was really doing well. I love my daughter and the time

we spend together. It is different being a mother than what I imagined or seen with my pals. My daughter is my main focus in life but I have been able to return to work and move to a suitable home for us to live in. My family nurse has helped me to recognise that I can achieve whatever I put my mind to and guess what I believe her.

The programme will come to an end for me soon. My child is no longer on the child protection register and I am managing well to raise her on my own. I hoped she would be a happy child who I could feel proud of, and she is.

My family nurse asked if I could give her any advice about when she starts to recruit new clients. I told her how I would never have accepted seeing her if in the beginning she had not just kept coming back to see me. I worry that others could do the same so have told her to tell them about me and that I truly believe that this programme has helped me with every single aspect of my life as well as allowing me to be a really great mum for my daughter. Having a family nurse is different to what anyone could imagine and is the best thing I ever agreed to be involved with.

Anonymous, age 19

Performance indicators

A wide range of data is collected about the programme in Scotland including an externally commissioned evaluation looking at the transferability of the model into the Scottish context. Early signs are promising. The programme is seeing a high uptake, low attrition, good fidelity to the model and nurses feeling empowered and well supervised to support vulnerable families. The Department of Health has also commissioned a randomized control trial due to report in 2013. The findings of the trial will have significant impact on FNP in the UK.

The FNP model improves pregnancy outcomes, child health and development and the mother's life course in the short, medium and longer-term.

In the US research, FNP children and mothers, mainly those who were high risk with low psychological resources, compared to children and mothers in the comparison group had (Trotter, 2012):

Improved Pregnancy Outcomes

- 79% reduction in premature birth amongst mothers who smoked
- Fewer pregnancy related complications and infections

Improved Child Health and Development

Increase in Children's School Readiness

- 50% reduction in language delays at 21 months
- 67% reduction in behavioural/intellectual problems at age 6

Increase in Academic Achievement

- 26% higher scores on school reading and maths achievement in Grades 1–3

Better Mental Health and Risk Taking Behaviour

- Lower rates of anxiety and depression at age 12
- Less use of tobacco, alcohol and marijuana at age 12
- Girls had had fewer pregnancies by age 19

Reduction in Criminal Activity

- 59% reduction in child arrests at age 15
- 90% reduction in PINS (US equivalent of supervision orders)

Reduced Child Abuse and Maltreatment

- 39% fewer injuries
- 56% reduction in emergency room visits for accidents and poisonings
- 48% reduction in child abuse and neglect

Improved Maternal Self Sufficiency and Life Course Development

Fewer Unintended Subsequent Pregnancies

- 23% fewer subsequent pregnancies by child age 2
- 32% fewer subsequent pregnancies

Increase in Labour Force Participation by the Mother

- 83% increase by the child's fourth birthday

Reduction in Welfare Use
- 20% reduction in months on welfare
- Saved the government over $12,300 per family in welfare payments alone by time children aged 12, greater than the programme cost of $11,511

Increase in Father Involvement
- 46% increase in father's presence in household

More Sustained Relationships with Partner
- 18% longer with current partner
- Longer time with an employed partner

Reduction in Criminal Activity
- 60% fewer arrests
- 72% fewer convictions

The information above is drawn from three different NFP trials, each of which has followed families up at different points in time and measured different factors which is why different outcomes are evident at different ages. This list sets outs the main benefits observed. Of course, there were also a number of measures that showed no significant differences between the FNP group and the comparison groups.

Cost and savings

The first Scottish FNP programme in Edinburgh was funded by the Scottish Government to the extent of £1.6 million and is being delivered by NHS Lothian during a three-year period. The second pilot received financial support of £3.2 million over three years from the Scottish Government and a contribution of £600,000 from NHS Tayside. It is estimated to cost approximately £3,000 per annum per client who completed the programme.

The economic benefits of FNP are being reviewed as part of recently commissioned work in England. Current estimates suggest that for every £1 invested, £3–5 is saved.

References

Ashton, Charlotte (2010), "Family nurses offer young mothers a bright future": http://www.bbc.co.uk/news/education-11062614.

NS World "Nurse Family Partnership Co-Produces Results in the US": http://www.nsworld.org/discoveries/nurse-family-partnership-co-produces-results-us

Olds, D. L. (2006), "The Family Nurse Partnership: An evidence-based preventive intervention". Infant Mental Health Journal, 27 (1), 5-25.

Scotland's Early Years Framework: http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/Early-Years-Framework.

Trotter, Gail (2012), "Family Nurse Partnership – Background", http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership/background

USA Nurse Family Partnership website: www.nursefamilypartnership.org

CONTACT DETAILS

Elke Loeffler
Chief Executive, Governance International

Email: Elke.Loeffler@govint.org

The ALISS System

CHRISTINE HOY, *Health and Social Care Alliance Scotland*

The Access to Local Information to Support Self Management (ALISS) was established by the Self Management Programme, Scottish Government. The first phase of the project ran from early 2009 until March 2011. The focus of the current, second, phase is implementation and further development, which is being managed by the Health and Social Care Alliance Scotland.

The ALISS vision is to encourage improvement by enabling the contribution of our greatest asset – the expertise and diversity of our Scottish population. ALISS referred to principles of co-production to address the following problems:

- People and community groups have valuable knowledge, however, there is no easy way for them to share that knowledge, connect and mutually support each other. Making connections will make best use of local infrastructure, services, assets and knowledge.
- Local assets are hard to find, as they are often informal and cannot be systematically discovered by word of mouth or an internet search. Online searches are often a frustrating waste of time, as traditional approaches to creating online directories don't reflect how people and staff find and use information.[1]
- Valuable information about support to live well is usually scattered on paper and over the web as lists of resources are held separately in local libraries, health centres, GP practices and voluntary sector organisations.
- People living with long term conditions may only have contact with health professionals for about three hours a year.

1 http://inthelongterm.wordpress.com/about/

The project aimed to make it easy to make connections in communities and access local information and then pool these precious resources. Rather than creating another website or single solution, the project planned to develop an infrastructure which identified and linked *existing* information about local assets so that they were better utilised – and then ensure that the infrastructure was co-produced and designed by the people who would use it. Creating a method for citizens to contribute – by creating, sharing and redistributing information – will produce a much more sustainable resource, which by its very nature will represent the diversity in our multicultural communities. This is in line with the vision of the NHSScotland Quality Strategy, *Putting People at the Heart of our NHS*, and the recommendations for improving public services described in the Christie Commission.

However, the technical solution to linking data did not exist and so the ALISS programme is both ambitious and innovative. The team agreed that ALISS should not be a "top down" Information Technology (IT) project, which would traditionally be delivered "ready made" to users. It was predicted that a very effective and rich resource could be developed by tapping into Scotland's talent for user-led innovation and insights of people living with long-term conditions, creative service designers and experts in digital technologies.

The co-production aspect was vital, as development was informed by a deep insight into people's needs and how they access and act on information. Co-production has been described by David Boyle and Michael Harris as meaning "*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*."[2]

The ALISS team wanted to explore the idea that people themselves are "information hubs", and then develop ways to "let go" and de-institutionalise information by creating an opportunity for citizens to add value to both local and national health and social care services.

2 The Challenge of Co-Production: How equal partnerships between professionals and the public are crucial to improving public services, David Boyle and Michael Harris (2009) http://www.neweconomics.org/publications/challenge-co-production

The project aimed to develop a whole system which would deliver a service rather than bits of data and which would involve and connect people, to allow them to contribute information rather than simply consume it. Distributing control of information is the only approach which will ensure a sustained service, as existing centralised methods involve intensive and expensive efforts to contact groups and organisations to continually update national and local resource directories.

The ALISS programme had three work streams, including Health Literacy, Communities and Technical Development. It was recognised that developing and managing relationships with partner agencies would be a significant factor in achieving success. Therefore, the Communities and Technical work streams worked in parallel. As much time and effort was spent in face-to-face contact (engaging individuals, mapping local assets with groups such as schools, libraries, primary care, adult literacy groups, churches, youth groups), as was spent on technical development.

The Health Literacy work stream confirmed for the team that finding information about support to self manage in your local area is hard, and may be even more challenging if a person's understanding of the health and social care environment is poor. The Communities work stream tapped into the expertise of a wide range of people who were invited to attend a series of five workshops, inspired by BarCamp and Social Innovation Camp methodology[3]. The workshops were aimed at a mix of people who don't normally have an opportunity to come together – people living with long-term conditions, designers (with a focus on public service redesign), experts in open air information technology and social networking, representatives of Scottish Government policy and planning, and major information providers. Creating this environment fostered new ways of thinking.

Participants were asked to think in detail about their own quality of life and experience, what would improve their lives and how managing their condition could be improved. The workshops used service design tools to spark new ideas and encourage collaborative working. Participants confirmed again and again that support can be there but be hard to find, and they placed a high value on informal, non-statutory support. The workshops produced dozens of ideas about building mutual support

3 http://www.sicamp.org/social-innovation-camp-scotland-on-film-2/

and capacity in communities, and valuable insights into what is really important. Key themes were:

- Loneliness, social isolation – people often want to connect with other people and not necessarily local groups and organisations, in particular they're rarely just looking for lists of services.
- People make their own judgement about what they find useful and comforting, and this is more than quality assured information about their condition.
- Frustration with the wealth of irrelevant websites, lists of services and online directories, and the time wasted on failing to find relevant information.
- The desire and need for technology to connect disparate pieces of local information to make them easy to find.

The workshops chose six ideas to develop further.[4] These included ideas about time banking, buddy networks, and storytelling as an underused business tool and information services for those newly diagnosed with a condition. Participants were helped to develop a business and marketing plan, and think about ways to make their 'project' happen. The ideas were:

- It's About Time[5] (about social isolation, small connections make a difference).
- First Things First[6] (first steps for someone newly diagnosed with a long-term condition).
- INCA[7] (peer to peer bookmarking – relevant information at the right time).
- People helping People[8] (facilitating access to the extensive number of support opportunities that already exist but are hard to find, which enable people with similar conditions and experiences to support each other).

4 The six ideas can be seen at http://wearesnook.com/snook/2010/03/09/aliss-providing-better-information-for-people-living-with-long-term-conditions/
5 http://alissproject.wordpress.com/ideas/its-about-time/
6 http://alissproject.wordpress.com/ideas/f2f/
7 http://alissproject.wordpress.com/ideas/inka/
8 http://alissproject.wordpress.com/ideas/people-helping-people/

- Plugged in[9] (ALISS as a "socket" for connecting information and developing idea of people as information hubs).

This collaborative approach defined the technology requirements and created a new, wide-ranging, multidisciplinary open community who placed a high value on developing something useful for the public good. Real enthusiasts keen to be involved in making a useful product which they could see will make a difference. ALISS has been shaped by many altruistic contributors who find huge satisfaction in making things together, learning and sharing their skills.

One of the most challenging aspects of developing a national system to share citizens' knowledge has been concern about quality assurance. However, the team was reassured throughout that the most useful and beneficial support was often local and personal, and not likely to be kite marked. A high value was placed on informal support from family and friends. For instance, people living with mental health conditions described the benefit they feel from being outside, digging in allotments, or meeting people to have a walk with. These are not activities which can be quality assured, but equally they are not likely to be as dangerous a threat to health as a side effect of a medicine.

ALISS also provided a platform for innovation, some examples include:

- The ALISS team collaborated with pupils and staff at Trinity Academy, an Edinburgh secondary school, to co-produce a learning plan about community assets and support for self management. The school was successful in a European wide competition – Comenius – "Our Healthy Future"[10] and presented their ALISS project in Bremen, Germany in September 2011.
- Renfrewshire Libraries and the local Health Improvement team adopted the ALISS approach to actively involve people living with long-term conditions, their families and carers, by running an 'innovation workshop'. A result is an app (digital application) called

9 http://alissproject.wordpress.com/ideas/plugged-in/
10 http://comenius.waldschule-schwanewede.net/index.html

'Living Well @ The Librar' information service. (http://demo.aliss.org/living_well/).

- The technical aspect of linking disparate pieces of data is generating interest in the potential to re-purpose the system for other sectors. The system has been developed using open source software and all ALISS products are available for re-use.
- The ALISS technology stream has developed a novel process to curate (filter and tag) data, which makes ALISS different from Google. Anyone with an ALISS account can curate their own list of useful resources, which can be shared with others. This saves time and effort.
- Tools to Talk[11] emerged from a workshop in Renfrewshire, an idea to improve communication between health care staff, individuals, families and carers. This focussed on talking about emotional aspects of living with conditions, and developing visual representations and simple phrases which avoid medical jargon.
- Expertise in asset mapping processes have been developed in the ALISS programme. Asset mapping has emerged as being a vital component of making sustainable connections in communities.

Groups and organisations, engaged through the communities work stream, are now beginning to share their directories of information. This varies from just one individual and general practice, to very large information providers such as Health Boards and large voluntary sector organisations. The more content that is shared, the more useful ALISS will become.

ALISS has developed multiple roles:

- Providing a flexible and stable platform for sharing local assets
- Acting as mechanism for linking siloed collections of data
- Facilitating individual and community curation
- Providing vital support for asset mapping processes
- Linking people and organisations to grow an 'ALISS eco-system' in which new ideas incubate and flourish

11 http://wearesnook.com/snook/2010/11/09/tools-to-talk/

Key processes in the ALISS system

- Asset Mapping – establishing local relationships by providing an opportunity for people living and working in communitites to get together to share their local knowledge and map local sources of support. This can be in form of half-day asset mapping workshop with staff from health and social care, GP practices, local librarians, third sector.
- Add resources collected in workshop into ALISS. Anyone can have an account with ALISS; you need an account to add resources to ALISS. All resources are tagged with number of tags to ensure ease of finding.
- Using ALISS – signposting people to local resources
- Evaluation – this is being developed through partner projects

Current status of ALISS

Following an options appraisal process, ALISS is now managed by the Health and Social Care Alliance Scotland (The ALLIANCE) and is in implementation phase. The technical development (the core system referred to as the ALISS Engine) is robust and working (see www.aliss.org) and provides a method for people to create content, share their directories of resources and develop local assets registers. The ALISS community expect that as the utility of ALISS system is understood the number of applications will grow around the core ALISS Engine. Additional development of the engine is ongoing.

The Royal College of General Practitioners and Long-Term Conditions Alliance Scotland are partners in a new project (2012 – 2014) which aims to introduce ALISS as a tool which general practices can use to maintain their directories of resources and strengthen connections between primary care and the communities they serve.

NHS Greater Glasgow & Clyde's ehealth programme are developing user requirements for using ALISS in primary care.

Work is ongoing to encourage large national groups, such as voluntary sector organisations and health boards, to share their database of resources in ALISS.

Future for ALISS

ALISS began with an idea to use the web to link up data sources around Scotland for the benefit of those living with Long-Term Conditions. It now has the potential to become a hub for a range of activities which will make it easier for Scots to maintain and improve their health and wellbeing. The novel approach used, the development of an open digital service and use of social innovation methodology has potential benefits to sectors well beyond health and social care.

The ALISS system has been co-produced in open source software. This approach means developers worldwide have an opportunity to share and improve the software and adapt it to meet new challenges, and we welcome this. We envisage the core "script" will be a platform for new information services, providing opportunities for new mash-ups and applications not yet imagined.

It is likely that a future focus will be around developing services that use the data, with a range of applications, tools and processes contributing to a new national service. However, further development and implementation of ALISS will need strong support from creative and innovative people such as those in the voluntary sector and NHS Scotland and, in particular, where people have most contact with health services, in primary care. If everyone joins in, there is an opportunity for Scotland to develop a novel world class information system which will benefit all who use it. It is only by making "not thought of before" connections that Scotland's ambition to be a world class health service will be realised.

The ALISS team are grateful to Renfrewshire Libraries and Grampian Care Data, who contributed data and enthusiastically subscribed to the ALISS approach.

CONTACT DETAILS

Christine Hoy
Health and Social Care Alliance Scotland
Email: Christine.Hoy@alliance-scotland.org.uk

Reducing crime and improving health in NW Kilmarnock using community assets

TONY BONE, *Strathclyde Police*

"It's not about what we don't have, it's about maximising the things and the people we do have."

Introduction

The areas of Onthank and Knockinlaw in North West Kilmarnock are home to 3,500 people with a fairly even distribution of ages. Due to higher than average rates of crime and violence, this location was nominated by the local police commander as a Public Reassurance area, which indicated the need for increased targeting and co-ordination of public service resources to enhance community safety. The same area also features in the top 5% most deprived areas in Scotland – in fact, out of 6,500 datazones it features within the top 150 most deprived. However, local people and organisations in this area also had a lot to offer when Hazel Stuteley OBE asked them, "what can you do to help others?"

Objectives

The assets-based approach provides a means for previously connected and unconnected people and organisations to work in collaboration with residents and communities in order to improve their quality of life. This approach is based on identifying existing assets within communities and empowering residents to make a significant change to their environment, health and wellbeing. By creating the right conditions, people and community groups, previously marginalised, are encouraged to apply their

own inherent or learned skills and talents to various projects and initiatives. The transformative change and outcomes which follow, not only empower and strengthens individuals, they also convert people them from passive recipients of services into participating agents in their neighbourhoods.

Such talent and skills were discovered in abundance in North-West Kilmarnock in Scotland. In the neighbourhoods of Onthank and Knockinlaw, residents and community groups readily embraced this new approach. Being led by Strathclyde Police and the national Violence Reduction Unit the overarching aim was to explore ways in which residents could take greater control and ownership in their neighbourhood in order to reduce violence and the fear of crime.

Change management

The project was started in spring 2010. The starting point was spreading awareness and gathering support from public service commissioners for experimenting with an assets-based approach. In order to get buy-in for this new way of working Strathclyde Police invited the local council, health visitors and midwives, community workers and drugs counsellors, employability staff, local college representatives and third sector organisations and many more to an awareness seminar. Once that was achieved it was time to meet with the community. Initially there was suspicion and mistrust but as relationships developed people came on board.

For example, John and Julie, local volunteers, took over the management of a youth project with a vision to support and develop young people from the area. Along with their newly formed community group, and

with zero funding, they started an after-school club for primary school-aged children. With the help of local volunteers they added a homework club and then a breakfast club, which attracted significant funds from the People's Health Trust Lottery. Some of the kids reported for the first time that they were being rewarded at school with 'well done' and 'smiley' stickers in their jotters. These made them feel really good about themselves and will hopefully inspire them onto even greater things as their levels of aspiration increase.

By now the word was spreading fast about the regular *Listening Events* being held in the local primary school. These were informal gatherings held in the heart of the community and used to connect with local people – this enabled a shared understanding of the most pressing needs and priorities to be heard at first-hand. The listening events attracted hundreds of local residents and local service providers from all three sectors and helped raise expectations. For example, a local church minister who was motivated to build greater momentum in communities within his parish committed the support of his congregation and who went onto become an integral part of this innovative approach.

Another example was a local lad who had been raised in the area and had gone on to become a senior partner in a global architect's firm. He advised on the creation of a new community garden and resource centre which he went onto help design and project manage.

The offers of support from the community and numerous organisations became overwhelming and there was a need to establish a means of co-ordinating and communicating ongoing work. It was also necessary to map existing physical and people assets – '*you don't know what you need in a community until you know what you already have*'. The mapping exercise of agencies and community groups identified gaps but also highlighted many opportunities.

By following the community capacity-building framework developed by Hazel Stuteley OBE and the *Connecting Communities (C2) Network*, new ways of joining up all forms of working in collaboration were uncovered. This involved following a 7-step model through a number of workshops on a near weekly basis within the first six months. The attraction for everyone was the fluid nature of the assets-based approach and the realisation that it produced tangible results.

One offer of support came from an elderly and highly energetic resident called Jim who had expertise in Archery. His suggestion of teaching young people about bows and arrows did initially raise eyebrows. However, he demonstrated that while bringing the young and the elderly together he was also breaking down barriers and reducing fear and suspicion between different generations. Not only that, he was also capturing the essentials of many school-taught subjects by explaining the vagaries of velocity, cable strength and origins of the wood.

Another inspiring project was sparked off by two local volunteers who had a vision of improving the lives of young children from the local area but had no prior experience in this field other than looking after their own children. They took over a building lease … After a few months about 300 young people were involved in various activities. One of their flagship policies is 'Children's Choices' which basically translates as the children are consulted on all aspects of the youth project.

Outcomes

Feedback was captured from the *Listening Events* and used to collect views and concerns of residents. These were categorised into themes and fed back to the community. They were then asked what collaborative solutions could be found which produced a number of ingenious suggestions.

Collaboration between the local youth project and the local drug addiction service was developed. The significant benefit was that many registered addicts lived locally but previously had to travel 2 or 3 miles to their treatment centre. As the service was now on their doorstep they could take their children along who would gain from the programme of services on offer at the youth project. The number of addicts attending increased dramatically.

It became apparent that it would be necessary to find a means of co-ordinating increasing offers of support, which led to creation of the multi-agency *Community Capacity Building Group* with residents integral to its success. The Group was really dynamic as only the agencies that could impact on specific issues would attend meetings. This Group acted as a filter for great ideas. For example, the local Kilmarnock College representative collaborated with the health visitor to deliver beauty treatments for free to young mums from the area. The young mums felt better about themselves and the students gained invaluable 'on-the-job' training.

The local church minister was appointed as chair and a representative from East Ayrshire Council as vice-chair. This enabled a direct link into the local community planning framework and ensured that although the assets work was very localised, at the same time, it also operated within the strategic aims of the community planning framework. Simultaneously, the local community police officers were becoming much more accepted and on first name terms with many people.

A high point for this exceptional community came in May 2012 when HRH Prince of Wales, who had heard about their achievements, singled them out for a visit.

Performance indicators

A key aspect of the delivery of local policing is public reassurance and a commitment to tackle the issues of most concern to the community. The police were encouraged to attend *Listening Events* and other community group meetings. This didn't mean that the strong emphasis on enforcement came to a stop. Instead, it was being done with the consent and co-operation of local communities. As a result, police activity increased in the form of patrols, stop/searches and offender management.

Consequently, surveys in North West Kilmarnock have indicated some of the highest rates of public confidence and satisfaction in local police compared to other areas in Strathclyde. A public consultation survey in 2012 showed the following improvements, compared to the previous year:

Public Consultation Survey Results in 2012:

- Good place to live +25%
- Feel safer +28%
- Police listen and act on information +25%
- Satisfied with police +21%
- Feel ASB issues are being tackled +19%

Police activity was also measured to ensure that key priorities were being targeted. This indicated an increase in reported private space violence especially domestic abuse-related cases. Traditionally, this type of violence is difficult to detect as many victims are reluctant to call the police. However, it is clear that the assets-based approach improves familiarity and trust in services – people who have a stake in their community protect their community.

The University of St Andrews Public Health Department conducted a survey of residents and service providers to gauge perceptions. This focused on existing levels of social capital and produced evidence that residents with high social capital scores have high health scores and residents who have low social capital scores have low health scores. This suggests that social/community factors are related to health at both a community and individual level. The analysis therefore suggests that that by improving social capital it is possible to positively impact on health.

Costs and savings

Early indications are that that the assets-based approach maximises engagement opportunities between residents and organisations like the police. There are also some signs that it will positively impact on physical and mental health. All of this was done without any sort of formal funding stream as all of the investment was in people. As the work progressed there were increasing levels of interest from third sector organisations that were happy to contribute resources to enhance sustainability.

Not everything can be achieved without money so funds were secured to appoint a community catalyst on a three-year contract whose role was to inspire low-level, community-led initiatives. That particular role has developed into an excellent template that could be incorporated into existing service delivery models. However, it is unclear what cost savings have been made. The local council have embraced this approach, especially in light of the Christie Commission report, and the need to tackle 'failure demand'. They have also transferred a small amount of funds to a local community group to enable them to commission their own services.

Learning points

Early indications are that that the assets-based approach maximises engagement opportunities between residents and organisations like the police. There are also some signs that it will positively impact on physical and mental health. All of this was done without any sort of formal funding stream but increasingly third sector organisations that were happy to contribute resources to enhance sustainability.

CONTACT DETAILS

Tony Bone
Chief Inspector, Strathclyde Police
Email: tony.bone@strathclyde.pnn.police.uk

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,

Figure 2: Food Train volunteers and customers check through the delivery together

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 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. 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* now 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 and 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 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.

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 help *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 improvements to:

- 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

	1995	2000	2002	2006	2008	2010	2012
Number of grocery deliveries	300	2,000	3,000	11,000	14,000	16,000	20,000
Number of volunteers	8	12	15	110	150	220	400
Area covered by deliveries	Dumfries Town	Dumfries Town	Dumfries Town	Dumfries and Galloway	Dumfries and Galloway	Dumfries and Galloway, West Lothian	Dumfries and Galloway, West Lothian, Stirling, Dundee

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. These activities 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 'the evaluation of the *Food Train*, which 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.

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 of activities, 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.

References

Communities Scotland (no date), *The Food Train – Supporting vulnerable people to live at home*. Available at: http://www.communitiesscotland.gov.uk/stellent/groups/public/documents/webpages/cs_019374.hcsp (accessed 28th March 2012).

Denny, A. (2008), "An overview of the role of diet during the ageing process", *British Journal of Community Nursing*, 13(2), pp. 58–67.

Erlend Clouston (2004), *Retail therapy*, The Guardian Newspaper. Available at: http://www.guardian.co.uk/society/2004/oct/13/charityawards.voluntarysector3 (accessed 28th March 2012).

Lacey, M. (2009), *Evaluation of the Food Train in terms of its economic value.* Community Food and Health (Scotland). Available at: http://www.thefoodtrain.co.uk/images/stories/docs/Evaluation-of-The-Food-Train-in-Terms-of-its-Economic-Value-Final-Report.pdf (accessed 28th March 2012).

Scottish Government (2009), *Older people living in the community – Nutritional needs, barriers and interventions.* Edinburgh: Scottish Government Social Research.

Schenker, S. (2003), "Undernutrition in the UK", *National Bulletin*, 28(1): pp. 87–120.

Wilson, L. (2009), *Preventing malnutrition in later life – The role of community food projects*. London: Age UK.

WHO (2002), *Keep fit for life. Meeting the nutritional needs of older persons.* Geneva: World Health Organisation.

CONTACT DETAILS

Frankie Hine-Hughes
Project Manager, Governance International

Email: Frankie.Hine-Hughes@govint.org

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

JÖRGEN THOLSTRUP, *Clinic for Internal Medicine, Highland Hospital, Eksjo, Sweden*

Introduction

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

Objectives

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

Change management

Given the waiting lists in 2001, we decided to undertake a fundamental review of the values behind the relations between our patients and the healthcare system. In particular, we analysed our service from a patient

perspective. This analysis suggested to us that we needed to redefine the roles of the patients to give them greater personal responsibility for their health. As we redesigned the unit, we also had to find a way to monitor quality, as it was unacceptable to both patients and the hospital that quality should deteriorate and we realised that a shift in attitudes like this (which can be characterised as a paradigm shift) would be criticised. It was essential to us to prove that quality was at least preserved and hopefully improved.

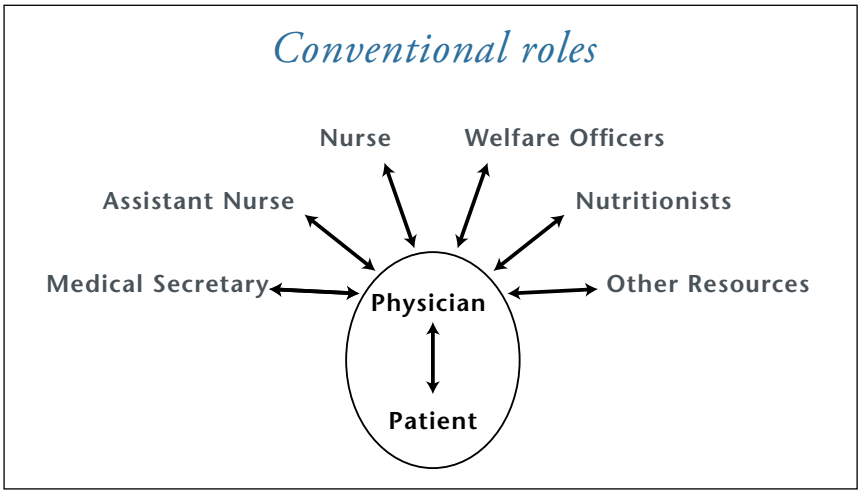


Figure 1: Conventional roles in a hospital

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

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

dog', his/her views were considered to be the central element of the process. Both the patient and the other staff were simply seen as being supportive to this central process. We decided that this had to be changed – we had to create a setting where the team and the patients are partners and where the patients are responsible for their own health. This view actually has a deep impact on the way we are working, as the care team has to negotiate with the patients instead of 'ruling' over them. So we de-

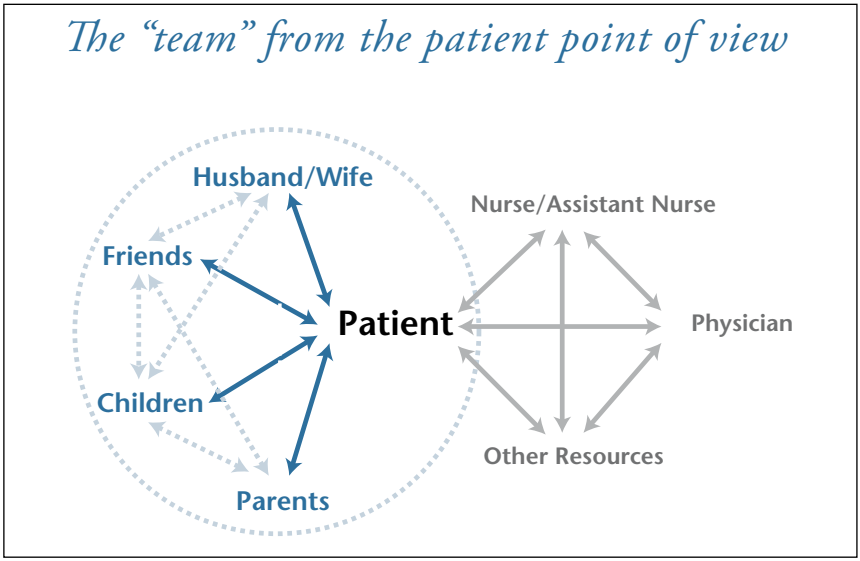


Figure 2: The 'team' from a patient's point of view

signed a team where all participants, including the patient, would be involved, using their individual competences. We wanted each participant to feel in charge of at least part of the process. The patient is actually in the middle of two teams – the 'community team', made up of their family and friends and support system, and the 'medical team', the staff here in the hospital. The hospital team's role is to support the patient in his/her "real" team, where the patient expects to be a well functioning individual, with full control over his life (see Figure 2).

The first thing we realised in the analysis was that it was essential to change the patient monitoring system. The underlying principle had previously been that the healthcare system tried to monitor the patient's health status through regular visits, instead of adapting the system to meet the patient's real needs. We realised that we were actually doing too much for some patients, and doing too little for others. At the same time, we were unable to guess when was the right time to intervene – this was when we realised that patients actually knew better than us when their disease was getting worse. This made us realise that we actually harmed some patients, as we could not deliver help when the patients really needed care (partly because of an overcrowded system, the capacity of which was often used up in efforts that did not create real value for the customers). We therefore redesigned the unit to set up a team-based healthcare delivery system in which all participants, including our patients, put their individual competences to use in a proper way. This immediately helped us to cut out some of the inappropriate work which had previously been done, even though it had no real value for the patient.

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

We were aware that many of the annual visits were of little use – at scheduled visits, we often found patients had no obvious health problems. These visits took up a great deal of our time on the ward, did not create any real value to the patients and, of course, were stressful and disruptive to the patients. Moreover, most of the flare-ups of the disease took place during the rest of the year – patients should, of course, have contacted us when flare-ups occurred, but we didn't have appropriate routines in place to encourage that (nor the time to deal with such contacts, given that we were constantly dealing with the 'well patients' who had come in for their regular check-ups). Consequently, patients' flare-ups were often more serious than they would have been if they had been picked up in time. Indeed, the very worst case can occur where a flare-up occurs when the patient has already made an appointment for some time in the future and decides to wait for that appointment, rather than

contacting us. This will often allow the flare-up to become worse – in this way, having a scheduled appointment will actually harm the patient.

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

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

A further change we made was in the way we worked with in-patients. We realised that we seemed to apply a different set of values in the ways we treated in-patients compared to out-patients. Instead of the medical team 'doing the rounds' every morning, and inspecting each patient in their bed, discussing their case 'over their heads', we have reversed the procedure. We invite each patient to come to our team room for a planning meeting, where we can put up the relevant charts, X-rays, etc. relevant to their case. Here they can interview us about what has changed since our last discussion, how

they feel, what they are worried about and what we are suggesting might be done. What we do is actually to create a scenario which is designed for negotiation instead of top-down prescription.

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

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

Outcomes

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

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

Performance indicators

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

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

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

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

Availability: Referrals are registered in a computerised system and the number of patients coming for revisits in the ward is recorded manually – all data is presented once a week at the clinic review meeting. The goal is to have no waiting lists for re-visits, less than 14 days waiting time for referral patients, less than 3 days waiting time for urgent visits and immediate availability for all phone contacts. In practice, there is now no waiting list for planned revisits nor for urgent visits. Telephone availability is

good – 93% of incoming calls are answered within 3 minutes. For referral visits, the average waiting time for non-prioritised referrals in 2006 was 23.5 days. (The first 7 days is taken up in handling the referral, before it is passed to the clinic, so the actual time taken from when the referral is made to the clinic until the patient actually visits us is only 16.7 days on average).

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

Medical: The number of hospitalisations of patients with inflammatory bowel disease decreased 48% during the period 1998–2005, compared to the nationwide decrease of 4% reported by the National Board of Health. Our clinic has moved from above the national average of in-patients per

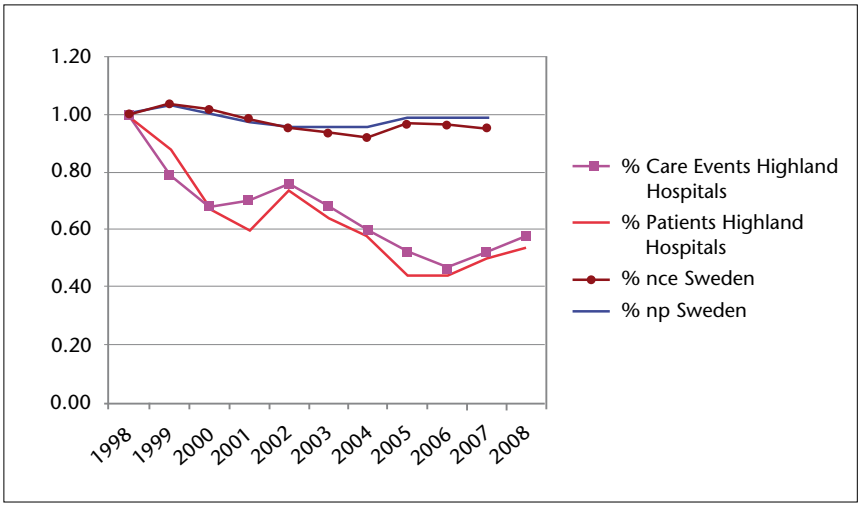


Figure 3: Highland Hospital has about half the Swedish average of hospitalisation of patients with bowel disease – and it has fallen rapidly since 1998

100,000 residents to being almost half the national average during this period (see Figure 3).

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

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

Costs and savings

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

Learning points

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

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

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

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

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

CONTACT DETAILS

Jörgen Tholstrup

Senior Consultant, Clinic for Internal Medicine, Highland Hospital, Eksjo, Sweden
Email: Jorgen.tolstrup.rasmussen@lj.se

The Esther approach to healthcare in Sweden: A business case for radical improvement

NICOLINE VACKERBERG, *Director of the Esther Network*

Introduction

Jönköping in Southern Sweden has a population of around 330,000 a large proportion of whom are over 75 years of age and need social or healthcare services. The Esther Network has addressed this challenge using a patient-focused approach to health care, one that demonstrates a shift from a traditional service provider-focused approach to one centred on the patient.

Objectives

The key objective of this new approach was to create a network that would help patients feel confident, independent and secure by ensuring that they:

- receive care in or close to home;
- know where and who to turn to for care;
- see the healthcare system as an entity working together to provide their care;
- have access to quality care across the whole region.

This required the healthcare system to commit to the following principles of quality management (Wackerberg and Svensson, 2011):

- staff commitment to the vision of the Esther Network;
- increased competence across the whole care chain;
- close working relations and support within the entire care chain to achieve the best for the patient;
- efforts to continuously improve quality.

Change management

The Esther Network was initiated by the Chief Executive of the Medical Department in Eksjö, Mr. M. Bojestig, in 1997. It was triggered as a result of the experience of an elderly woman patient called Esther with the healthcare system. Esther lived alone and one morning developed breathing difficulties. After seeking advice from her daughter, who did not know what to do, Esther sought medical advice, was then seen by a district nurse and told to visit her GP. The GP said she needed to go to hospital and called an ambulance. After being admitted to emergency care she retold her story to a variety of clinicians at the hospital during a five and a half hour wait. In fact from first seeing the district nurse, Esther saw a total of 36 different people and had to re-explain her story at every point – which was made all the more troublesome by her breathing problem. This process caused Esther to become confused (which could, in a worst case scenario, have resulted in her being mis-diagnosed with

dementia). After her long wait, a doctor finally admitted her to a hospital ward and treatment began. In light of this story 'Esther' has become the generic name and character used to establish the Esther Network to help focus clinical and social care on the needs, expectations, priorities and fears of people entering the care system. An 'Esther' is usually described as an elderly woman (or man!) with one or more chronic conditions, who requires care from a variety of providers.

Looking at this experience from a patient perspective shows that limited value was created from Esther's interactions before and during her admission to hospital – in spite of the best efforts of healthcare professionals. The episode highlighted significant wastage in the healthcare system because the links in the care-giving chain didn't fit smoothly together. Furthermore, Esther's lack of knowledge of what to do and who to contact when faced with her health issues created a delay in her treatment and added to the workload of the nurses that could have been prevented (Davies, 2012).

Following this event between 1997 and 1999, an analysis of patients' care journeys was undertaken to identify redundancies and gaps in the current system, and to develop an action plan to reshape the system. This process consisted of over 60 interviews and several workshops with patients, staff, and government officials (Carlsson, 2010). It identified that patients felt that healthcare personnel didn't have enough time to listen, and that too many people were involved in their care. It was also clear that individual work processes of staff in the care chain didn't fit together with the work of other colleagues, before or after their patient contact. This lack of coordination could mean, for example, that although a patient's social worker may have gathered information about their circumstances the patient would also be asked the same questions by their GP, nurse, and so on. This inadequate coordination causes considerable waste, redundancy and, in the worst case, medical errors.

An action plan was developed to redesign the system to avoid past errors and gaps.

The thinking of healthcare providers and planners was therefore reshaped to focus on the aspects of a service that *patients, rather than clinicians and managers*, most valued – to create 'patient value'. In order to look at services through the eyes of a patient, providers and planners had to learn:

- what a patient needs or wants;
- what is important for them when they are unwell; and
- what is important for them when they leave hospital.

Staff discovered that most patients want to receive as much care in their home or as nearby as possible. If they have to go to the hospital, the patient prefers to leave as soon as is feasible, and have their continuing care needs met at home. This understanding led to a key part of the new system seeking to 'move responsibility to the patient'.

The 'patient charter' illustrates the new vision of the relationship between professionals and patients which developed in the Esther Network (Wackerberg and Svensson, 2011). In addition, there is a direct telephone line for complaints, whereby patients can talk with a person who will write down the complaint and give feedback to the involved partners. This can also lead to improvement meetings with patients and staff where appropriate. Of course, every caregiver and provider makes their own promises in addition to this overall statement.

A simple, but effective way in which the network has tried to prioritise the patient's wishes has been through the introduction of 'Quality Time for Esther' sessions. This is personal time, usually a half hour period each week, in a social care environment that the patient uses to focus on activities which they prioritise themselves (often with nursing assistants). In 2010, 78% of users had made use of this opportunity (Wackerberg and Svensson, 2011).

Also, the Esther Network focuses on the patient's illness as a 'journey' – from illness, to treatment, and finally recovery. By evaluating every interaction with healthcare professionals, from the first contact point to the patient's recovery, professionals are able to remove unnecessary contact points and improve efficiency. Focusing on the patient journey also creates greater understanding amongst staff of the role of all other actors in the journey. This has improved cooperation between different professionals, who come from different departments and organisations to work together to meet the needs of the patient.

To further enable this action plan meant that organisations within the network improved telephone and email routines to create a speedy and seamless process. An example of this has been that GPs and hospital de-

partments have improved their routines so that the hospital can now admit patients straight to the wards.

The Network has also improved contact between patients in nursing homes and their GP through measures such as establishing dedicated physicians at nursing homes, and regular visits by physicians to the homes.

Staff and patient feedback has also resulted in the design of more effective prescription and medication systems. Medicine lists now follow patients through the chain of care. This common list ensures all affected personnel have up-to-date information that helps avoid unnecessary changes to medication – although this process has still not been perfected.

The speed of passing on information has increased through the creation of targets for transmission. Documentation is also tailored to the needs of the next link in the care chain because each receiving care unit defines what they need from the preceding department. This has been further enabled through the improvement of IT systems to create an integrated and standardised system.

A 'Virtual Competence Centre' has been created to enable the transfer of knowledge and improvement in the capabilities of practitioners involved in the care chain. In particular, the competence centre has (Project Esther and IBM, 1997):

- adapted training to focus on fulfilling the needs of patients and moving efforts towards caring for Esther at home;
- educated personnel about different patient groups' needs;
- introduced multi-professional teams across Hospital, Primary Care, and Community Care;
- sought to improve the quality of meetings between patients and personnel.

In 2006, the Competence Centre received 12 million kronor (£1,14m) to provide a two-year training programme for members of the healthcare network in systems-thinking, communication, and IT development across the care chain. Following a system-wide survey assessing training needs of health care teams, the training was extended to include (Carlsson, 2010):

- medicine management;
- telephone advice;
- documentation;
- IT and communications.

Since its creation, over 700 people have participated in training programmes. An evaluation of the training shows positive results. Staff feel that the project has helped to strengthen team work, and establish better understanding of the different roles through interdisciplinary learning (Carlsson, 2010).

Also, in 2006 the network established 'Esther Coaches' to embed the new approach throughout the network and promote continuous quality improvement. Esther Coaches are members of staff – both clinical and managerial – who have the following tasks (Wackerberg and Svensson, 2011):

- support improvement projects in the frontline – by enabling staff to make the changes they want to see;
- catch improvement ideas and introduce new thinking to improve competencies;
- make the connection between daily work and the improvement of performance;
- inspire and motivate colleagues to improve, and celebrate improvements;
- keep the focus on the patient;
- introduce 'lean thinking' – getting the right things in the right place, at the right time, in the right quantities, whilst minimising waste and retaining flexibility – to make workflows smoother;
- securing 'Quality Time for Esther' to ensure patients can set the agenda.

To enable them to provide this role, coaches receive training on how to analyse problems in health care work and design improvements to address them. To spur innovations, Esther Coaches have to be solution-focused, encourage positive thinking, and be opportunistic. Esther Coaches receive no extra payment for their involvement and, despite being a major commitment, it is considered part of their job. In 2011, 102 members of staff had become Esther Coaches.

Table 1 indicates the professions and their place in the network of the coaches as of 2011.

Profession	Municipality	County	Private practice
Nursing assistants	48	9	0
Nurse	4	16	0
Physiotherapist	4	3	1
Occupational therapist	4	3	1
Social worker	3	2	0
Administrator	3	4	0
Human relations worker	0	1	0

Currently, the Esther Network is made up of over 7000 members from health and social care services in the region. The network is non-hierarchical – although a coordinator works to maintain its success, it has no central budget or bureaucracy, and membership is voluntary.

To ensure the efficacy of the network, regular communication amongst members is encouraged. Workshops, training and site visits are held to bring different staff members together. Furthermore, every six weeks local network meetings are held between municipalities, primary care units and hospital staff and importantly Esthers themselves also participate! This enables staff to understand the challenges facing different professions and why different decisions are made. Annual 'strategy days' are also held that involve patients, staff, Esther Coaches, health care managers and

local councillors which give the network a clear vision and develop action plans. These processes create a shared understanding and direction of travel throughout the network. This makes all members of the network understand that their performance is a link within the system as a whole – and that another department's problem is also their problem. It means that those involved in the chain of care consider the 'next provider', and that problems are not just passed on down the line. Since 2003 clinicians have also been encouraged to report when cooperation breaks down during treatment, irrespective of whether it caused a medical error or not (Carlsson, 2010).

"Everything was ready and prepared when I came home. I was astonished about how well everything was coordinated. I had my doubts when I was at the hospital." Eivor Jansson, 2012

"An Esther coach is a person with a deep and genuine interest to help fellow humans who are affected by the gaps in the health and social care system." Inge Werner, 2011

Outcomes and performance indicators

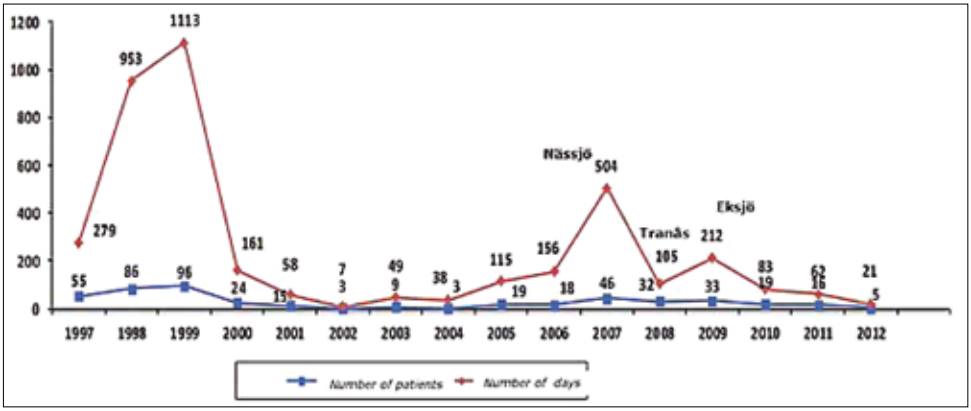
The Esther Network for re-designing patient care has been crucial in delivering improved patients outcomes, whilst delivering resource savings. The success of the project became obvious very early. A total system wide redesign took place, from 2000–2001 onwards to focus energy and funds on caring for the patient at home. This resulted in a 20% reduction in hospital admissions. In 2003, the Esther Network won the 'Gota Priset', which is the Swedish national award for quality improvement. This was because the project exhibited outcomes such as:

- Hospital admissions fell from approximately 9,300 in 1998 to an estimated 7,300 in 2003.
- Hospital days for heart failure patients decreased from approximately 3,500 in 1998 to 2,500 in 2000.
- Waiting times for referral appointments with neurologists decreased from 85 days in 2000 to 14 days in 2003.
- Waiting times for referral appointments with gastroenterologists fell from 48 days in 2000 to 14 days in 2003.
- The number of unnecessary days in hospital decreased from 1113 in 1999 to 62 in 2011.

Unnecessary days in hospital

The measurement here is the amount of days the patient continues to stay in hospital although they no longer have a medical need for specialist care. This can occur for example if the homecare service or primary care does not have the capacity to look after the patient at home.

Esther resulted in the following changes:



Unnecessary days in hospital

Costs and savings

There is no special budget for the Esther organisation within any of the clinical departments. Only one person is paid as a co-ordinator – all others involved in Esther accommodate this as part of their normal work.

It is the continuous improvement work by staff at the frontline who create the results. Esther also involves patients in improvement work and they get some flowers or other compensation 'in kind' but no other form of compensation.

The budget is a problem, Esther gets some funding now and then but meetings and improvement work have to be a natural part of the daily work.

The 2011 budget for Esther was 1.8 million kr (£170,741) including salary of the coordinator, coach education and new improvement projects. In 2012 the budget was reduced to 1.6 million kr (£151,705). In 2013 there will be a very small budget for Esther, forecast to be 800,000 kr (£75,852), which is meant to pay for 100% of the coordinator's time and to provide 40,000 kr (£3,800) to do activities (which is unlikely to be enough to continue activities at their former level).

Learning points

- Start by getting some patients and key actors from across the whole care chain in the same room to talk about improvements.
- Follow a patient story through the whole chain to get the same picture from different perspectives. From this, identify the key processes that are common to every patient journey – for example: The discharge process with an individual care plan and recommendations for further care.
- Use simple questions: What's best for Esther? Who has to cooperate to make this happen?
- Train and trust your patient and the frontline staff to start small improvement projects.
- There must be space in the schedule to atttend Esther meetings.
- Coaches can make a difference.
- Find a way to engage doctors.
- Find a way to bring in stable funding over time.

Further information

General background to Esther case study: www.lj.se/esther

Person driven care, NHS White Paper: http://www.lj.se/info_files/infosida35862/Wales2012.pdf

Inge Werner talks about the Esther network: http://www.lj.se/infopage.jsf?childId=15205&nodeId=31372

Jan Davies, Director 1000 Lives Plus, blogs about the Esther Network and it's lessons for Welsh healthcare: http://www.health.org.uk/blog/how-will-this-affect-esther-a-person-centred-approach-for-wales

References

Carlsson, C. (2010), *Timeline of the Esther Network*, http://www.lj.se/info_files/infosida31383/timeline.pdf

Davies, J. (2012), *Person driven care*, Improving Healthcare White Paper Series – No. 7, 1000 Lives Plus.

Projekt Esther & IBM (1997), Project 'Esther' (http://www.lj.se/info_files/infosida31383/report.pdf).

Wackerberg, N & Svensson, K. (2011), *Network as a strategy for improvement in complex care*, Sweden (http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Introduction%20to%20Esther%20-%20Nicoline%20Wackerberg.pdf)

CONTACT DETAILS

Nicoline Vackerberg
Director of the Esther Network

Email: nicoline.vackerberg@lj.se

TRANSFO

ON THE TRANSFORMATION ROAD

ORMATIO

Co-producing with communities in Scotland – the potential and the challenges

FIONA GARVEN, *Scottish Community Development Centre*

Co-production is, by definition, a two way street. But most of the traffic so far has been coming from the direction of commentators, policy makers and service planners. What are communities and community organisations' interests in making co-production a reality?

Co-production is predicated on developing a different sort of relationship between service providers and service users – a relationship that recognises that people and communities can bring all sorts of resources to bear on the issues they face to complement and add value to the resources provided by service providers. Given that relationships are key, is as important to think about co-production from the bottom-up as it is from the top-down – from the perspectives of people and communities themselves. Yet, community interests are often not fully acknowledged in service planning discussions, and rarely are communities heard to say 'what we need round here is more co-production!' So, it could be argued that a key challenge for policy and practice in working with communities is not yet at the forefront for communities themselves.

To have a balanced discussion about the purpose and value of co-production, professionals and practitioners need to properly engage with communities, seeking to understand their view of the world as much as the professional and policy view. Without this engagement, debate will be rarefied and one-sided and as such will miss the richness and value that flows from purposeful dialogue. The importance of community engagement is now prominent in almost all aspects of public policy and, for nearly a decade, policy guidance has been underpinned by the principles

set out and widely adopted in the National Standards for Community Engagement[1]:

The definition of community engagement given in the National Standards is:

> *'Developing and sustaining a **working relationship** between one or more public body and one or more community group, to help them **both** to **understand and act on the needs or issues that the community experiences**' (our emphasis).*

Does this definition sound familiar? If it does it is perhaps because it is close to definitions of co-production, describing the sort of relationship that needs to be in place to precede any consideration of co-production as the answer to a need or issue.

So, let us look at things from a community perspective. Let's say there are concerns in a deprived neighbourhood about the cost and quality of food available locally. This could correspond with a professional concern about obesity or child nutrition. What could the community do? What options would be open? Which might succeed?

For example, local community organisations could:

- Set up and run local activities such as a walking group, a food co-op or a lunch club.
- Campaign for public bodies to change their policies – for instance around school meals, breakfast clubs; or lobby local shopkeepers to adjust their stock or pricing.
- Get together with NHS, local government or others to design and deliver a collaborative programme of action.

For communities, the options identified above are versions of the main choices that may be available to community groups or organisations wanting to do something about a health issue or other local concern. The first can be described as the self-help route; the second as the social action route; and the third as a social planning or a collaborative approach.

1 Scottish Executive (2005), *National Standards for Community Engagement*. Also online at http://www.scotland.gov.uk/Resource/Doc/94257/0084550.pdf

For the community, the choice of which route to follow will depend on the nature of the problem and local peoples' understanding of its causes and effects, on the ability of one or more community groups to take action, and levels of energy, enthusiasm, motivation and confidence that the action will succeed. Of the available options, it may be easy to see that the co-production route may be the least attractive and would really only work if community awareness and understanding of issues is shared by the Community Health Partnership, Community Planning or any other relevant partnership or agency structure. For these reasons, co-production may be an option only for the most sophisticated and experienced groups and even they may be less than enthusiastic – despite it being the most likely route towards sustainable and valued change.

In the real world groups do not emerge fully formed and ready to engage. There is usually a lengthy and sometimes painful process of development to build organisations that are accountable, effective and strategic. SCDC explored the route from self-help to sustainable change with several community organisations with interests in food and health as part of a project with Community Food and Health Scotland[2]. Two of the projects we visited had started out as small-scale food co-ops but had grown in different, though significant ways.

Broomhouse Health Strategy Group in Edinburgh had been established for more than 20 years, and still operated a fruit and veg co-op. As part of its activities it created a local health hub in partnership with another community organisation, employed a community development worker to raise awareness of local health services and how to access them, recruited trained and supported volunteers to run cooking and aerobics classes and contributed to several other local health inequality issues.

Lanarkshire Community Food and Health Partnership was originally established to support food co-ops in the Lanarkshire Health Board area – there are now 37 of these in operation. While food co-ops continue to be core to Lanarkshire Community Food and Health Partnership's role, it has now become the designated lead agency for several outcomes in North Lanarkshire's Single Outcome Agreement and its food and nutri-

2 Community Food and Health Scotland (2011) *"Not only … but also": Celebrating the contribution of community food initiatives towards developing local outcomes.*

tion policy. The Partnership manages a contract with North Lanarkshire Council to provide free fruit to every nursery school child every week alongside a nutritionist providing cookery classes for children, parents and carers. In addition, it manages Bee Healthy (a healthy weight pathfinder project), runs Fruit and Roots (a social enterprise that sells fruit to local companies) and provides a catering service for NHS and local authority events.

These examples raise useful questions that need to be addressed if co-production with communities, particularly those with the worst health outcomes, is to become part of the way we work.

First, we should ask ourselves whether these are examples of co-production or not and, secondly, does it matter? Both may also be seen as examples of community engagement and community-led service delivery. As such they are of value in a much wider range of ways than may currently be recognised by policy-makers. Co-production should involve collaboration in service design *and* service delivery. If there are agreements in place between community organisations and their various sources of funding on how local services could and should be delivered, this can be seen as co-design. If public sector staff or other resources are involved alongside communities in providing services, this can be seen as co-delivery. The examples cited above could thus be portrayed as embodying at least some elements of co-production.

Ultimately we may conclude that, whether we call these examples of co-production or not, they both provide important and much-valued services to disadvantaged communities in ways that the public sector cannot match, while contributing to the national outcomes that the public sector and government has signed up to. So the key question is how can we sustain some of the good work which has been achieved to date? And, how can we best encourage and support new community-originated and new joint public and community-originated initiatives?

It was clear from the research that we carried out and from the examples highlighted above that community groups and organisations have to be at a sophisticated stage of development if they expect to engage effectively and productively with public bodies and progress to co-producing public services. They need to have evidence to convince public agencies that they are financially sound and legally compliant before any such en-

gagement can be entered into – and they also need to be clear that the benefits to the community will outweigh the costs incurred. Good governance, business and financial planning skills are pre-requisites for such partnership activity. Staff of public bodies are normally paid to co-design and co-deliver services whilst on the other hand, community activists or the staff employed by community organisations may be paid to co-deliver but co-design time is not usually paid time. Added to this, community organisations often need to participate in working groups or partnership arrangements to be on the radar of public bodies – again this is usually unpaid.

It is important to recognise that the above issues apply more acutely in communities that are not well organised and therefore not yet well placed to benefit from co-production arrangements. The benefits are thus most likely to fall to the better organised and more prosperous communities, which tend to be those that already have better connections and contacts, greater skills and more confidence. Research at Glasgow University points to the evidence that middle class communities benefit more from public services than the poorer communities who should benefit[3]: presumably we do not wish to see this replicated in co-production. For any community to participate in co-production they need to have the motivation, the capacity and the opportunity to do so – factors that are often less evident in the more deprived communities that struggle to cope with life's hard realities.

Bearing in mind the issues discussed above, any public body seeking to adopt a co-productive approach needs to put several things in place. It needs to assess community conditions and invest in community building and building community capability. It needs to recognise that many communities already have a rich network of community groups and organisations to engage with, so it needs to take time to identify where those assets lie and how best to complement them. Finally, if co-production is to be an effective long-term option, public bodies need to understand the vulnerability of community organisations that are almost always dependent on insecure and short-term funding environments: if a co-produced

3 Hastings, A. and Matthews, P. (2011) *"Sharp Elbows": Do the Middle-Classes have Advantages in Public Service Provision and if so how?* Project Report.University of Glasgow, Glasgow, UK.

solution with communities is to be sustained, community organisations themselves need to be sustained.

CONTACT DETAILS

Fiona Garven
Scottish Community Development Centre
Email: fiona@scdc.org.uk

Seizing opportunities: Housing and prevention

JACKIE WALDER, *Housing Transitions and Support, Scottish Government*

The independent Preventative Support Working Group completed its report, *Seizing Opportunities: Housing and Prevention*, in October 2012.[1] This chapter provides a summary of the report.

The Group was established by the Scottish Government in early 2011, with a remit to consider a range of preventative support services provided by the housing sector for older people and disabled people. It was also asked to examine the scope for delivery using social enterprise. The focus of the Group's work developed during the time it met, to reflect important developments in the integration of health and social care and their links to housing.

Prevention and the role of housing

The housing sector has a crucial role to play in supporting older people and disabled people to live independently. Two aspects are key: the physical aspects of the home; and that housing-related support is available where necessary.

At the most basic level, the provision of homes that are warm, dry and in good repair is inherently preventative and supports health and wellbeing. The standard of social housing is improving, and some providers are also taking the opportunity of refurbishment programmes to 'future proof' their stock, reducing the future need for adaptations. Housing ad-

1 http://www.scotland.gov.uk/Topics/Built-Environment/Housing/access/ROOPH/PSWG/pswgreport

aptations and handyperson services also help to improve physical aspects of the home, on an individual basis.

Another core function of housing organisations is the delivery of housing support services. There has been a move towards softer and more flexible support, such as shopping and cleaning. This greater flexibility provides opportunities for greater integration with other services.

These core services can make a real difference to people's lives and prevent negative consequences in the longer term, reducing the risk of falls and inappropriate admissions to hospitals and care homes. However, preventative services have not always been given great priority by service commissioners with pressured budgets. Crisis management generally attracts greater attention. There is now greater recognition of the value of low level support, although arguably this has still to feed through into funding priorities.

Supporting communities

The housing sector has long since moved beyond the provision of core services. Housing organisations also provide a wide variety of community services and activities, ranging from the facilitation of tenants' associations, social activities, arts and exercise classes to harnessing more informal community cohesion and neighbourly assistance. These services and activities help people to feel part of and contribute to their communities, as well as improving health and wellbeing.

Many housing associations have a particular basis in the community and often see themselves as having a duty of care towards their tenants that goes beyond collecting rents and doing repairs. They recognise that improvement of people's lives can pay future dividends, with savings in property maintenance and reductions in negative impacts on communities.

At a very practical level, housing organisations are often able to provide venues for support and services, such as clinics, day or respite care. They also have people on the ground working in communities, in a way that few other sectors do. Most older people and disabled people are not in the social care system, but some may benefit from low level support. The housing sector is well-placed to provide a route of access to such wider services, and there is growing interest in expanding holistic housing options advice.

Informal community support can sometimes be a better way of providing low level preventative help than formal services. The housing sector can help to build community capacity, if communities are unable to do it for themselves. This type of support is likely to be broader than helping their own tenants and could be seen as a form of re-ablement, where help is provided until the community can become self-supporting. In many cases, partnership with other organisations will be important in bringing together different skills and in signposting to services and support that the housing sector cannot provide itself.

No one model of services or support will suit every area, but a range of different approaches can be used, depending on local circumstances, including time-banking, social enterprise and volunteering schemes. Participation in volunteering schemes is already encouraged as part of housing support services and can lead people to contribute more to their communities in later life when they have more time.

Housing organisations generally have fewer links with people living in the private sector, who are often unaware of what support might be available and how to access it. There is scope to provide services on a more tenure neutral basis, but there are financial implications in doing this.

An environment of change, challenge and opportunity

The current financial challenges to publicly-funded services are well known. The impact of funding reductions is being felt in service commissioning, with many local authorities reviewing and tendering services. This increases the importance of developing new funding models, which are less dependent on public funding. The use of community benefit clauses can also be helpful, and there needs to be greater awareness of them and the benefits they could provide.

Although the housing sector is not directly part of health and social care integration, it is central to its achievement, given that health and social care policy is based on enabling people to live independently in the community. It can play its part in different ways, by providing an environment for the delivery of care services, as well as delivering preventative services. A growing awareness of the need for closer working between strategic planners, commissioners and procurement officers in health and

social care has led to the development of joint strategic commissioning and plans for the integration of adult health and social care.

The main engagement between health and social care and housing is currently with local authorities. The Change Fund's approach of requiring joint commissioning and sign off from different partners, including the third sector, is a step towards a more integrated approach. Joint strategic commissioning will require the development of new planning documents. It will be important to clarify the role of housing, and a housing contribution statement will be included in the plans.

Self-directed support is a key part of the changing health and social care agenda. This should mean more people taking control of the support they receive; having greater choice; and becoming more involved in service development. Work will be needed to create a market place of potential services. Local authorities will need to engage with service providers more widely than the traditional third sector, including with housing organisations. Information and advice services will also be important.

Social enterprise is a key part of the third sector. Around 30% of housing associations are already involved in social enterprise.[2] However, only a third of these projects are self-financing. This position may change, as public funding becomes more limited, and with greater emphasis being placed on community benefits. However, the Group found it difficult to identify examples of provision of preventative support services for older people and disabled people by the housing sector through social enterprise.

Charging for preventative support services has been limited, but is likely to increase with use of self-directed support and individual budgets. There are concerns that charging will put people off services, but many people just need reliable services, for which they are willing to pay. The housing sector is well placed to attract clients for chargeable services. The Group considered that there is a potential role for social enterprise in supporting the diversification and sustainability of preventative support services, but that it is not a panacea for replacement of public funding.

2 Raising the Bar: Accelerating social enterprise across the housing association sector in Scotland http://www.sfha.co.uk/component/option,com_docman/Itemid,82/gid,88/task,cat_view/

Conclusion

Prevention is higher up the political agenda than it has ever been before. With an ageing population and limited financial resources, there is a need to reduce demand for intensive services. Some fundamental changes are required in the priority given to services that set out to prevent negative outcomes.

The housing sector delivers many services that help older people and disabled people to live independently. It does a lot more than provide core services, including supporting prevention and community development, but is under financial pressure. Social enterprise may bring in additional funding, but is not a substitute for public money. There may also be a market for chargeable services.

Integration of health and social care in Scotland provides an opportunity and a challenge for the housing sector. Increases in the use of self-directed support and individual budgets will require the development of flexible and personalised services. Links between the housing sector and health and social care are developing, and moves to align strategic planning and commissioning are welcome.

Further development is required for preventative support services to achieve their potential. There is also work to be done to ensure that strategies feed through into service development and resource allocation. The benefits could be vast and would pay dividends way beyond the financial investment made.

CONTACT DETAILS

Jackie Walder
Policy Officer, Housing Transitions and Support, Scottish Government
Email: jackie.walder@scotland.gsi.gov .uk

Talking Points: A personal outcomes approach for health and care services and support

CHRIS BRUCE, *Joint Improvement Team, Scottish Government*

> *Personal outcomes are defined as what matters to people using services, as well as the end result or impact of activities, and can be used to both determine and evaluate activity.*
>
> Miller and Cook, 2012

The Personal Outcomes Approach 'Talking Points' is an evidence-based, organisational approach that puts people using services and their carers at the heart of their support. At the centre of the approach is a conversation with an individual using services or unpaid carer that seeks to understand the extent to which they are achieving the outcomes important to them in life. These conversations form a core part of relationship building between practitioners, people who use services and their families. The approach brings co-production into everyday interactions with individuals because it involves negotiation and decision-making based on what is important to the person, bringing together the perspectives of all the key players. The approach is described by practitioners as taking them back to their core values, in enabling them to engage with people, as compared to some of more process-driven, tick-box approaches to assessment which have been prevalent in recent years.

Over the past 15 years researchers have sought to understand the outcomes that are important to people using services and unpaid carers. This

research has been summarised in three 'Talking Points' frameworks that capture the outcomes that are most important to:

- people using services
- unpaid carers
- people living in a care home.

The 'Talking Points' Outcomes Framework for people using services classifies the outcomes important to individuals into three broad categories:

- **Quality of Life** outcomes (also known as maintenance outcomes) are the aspects of a person's whole life that they are working to achieve or maintain. Quality of Life outcomes are necessarily attained by working across agency boundaries and by working in partnership with the person using the service, their family and local community.
- **Process** outcomes relate to the experience that individuals have seeking, obtaining and using services and supports and can have a significant influence on the extent to which other outcomes are achieved.
- **Change** outcomes relate to the improvements in physical, mental or emotional functioning that individuals are seeking from any particular service intervention or support. For some people it might be possible to identify a point where the change has been achieved and then the focus moves on to maintaining a good quality of life. For others it may be necessary to focus on small changes over short timescales, particularly when managing symptoms of progressive illness or towards the end of life.

The exchange model of assessment (Fig. 1) has proven particularly useful in working with practitioners and organisations to think differently about engagement. This model emphasises the collaborative nature of assessment, support planning and review, showing how the views of the individual service user, carer, assessor and agency are brought together to negotiate, agree and record outcomes. The concept of negotiation is important here in the context of real world constraints. There may also be challenges initially for the practitioner in reconciling the outcomes that the individual is identifying with their own professionally-sought out-

comes. For example, many healthcare practitioners already use outcome measures to understand individual needs and progress in relation to aspects of functioning. Adopting a personal outcomes approach does not negate the importance of these outcomes. Instead it emphasises the difference that the changes make to the person's whole life.

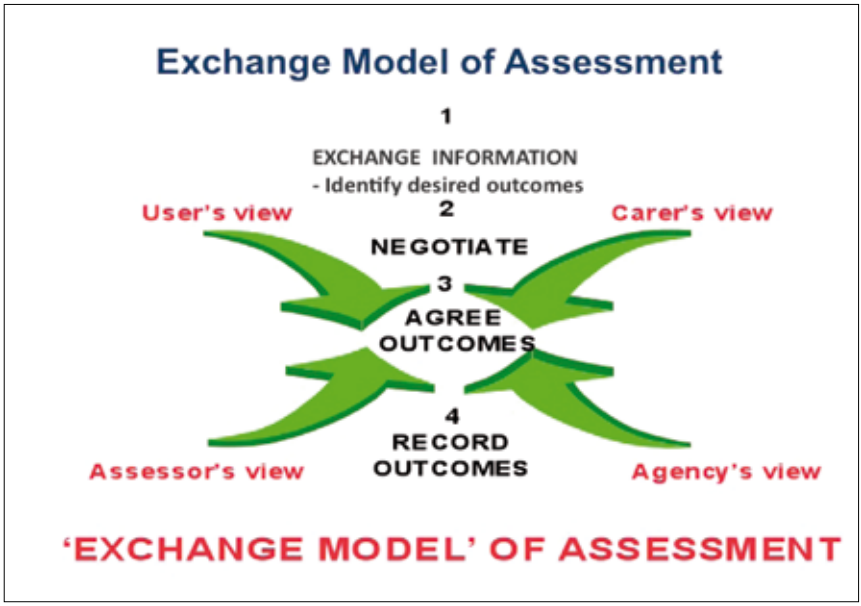


Figure 1: The Exchange Model of Assessment (Smale et al 1993)

The exchange process (see Figure 1) starts with developing an understanding with the person about their life, the outcomes they want to achieve and the barriers and supports to achieving those outcomes. Evidence has shown that this kind of exchange is best obtained through a semi-structured conversation that gives space for both parties to reflect and respond to what is being said. This conversation can be built around the Talking Points framework. Prompts for each outcome have been developed for use by practitioners (see Figure 2; Cook and Miller, 2012).

In some cases individuals and carers may have a well developed view of what they want in life and how they can best be supported. However, many people can at times feel overwhelmed and under-informed about their situation and the alternatives. The engagement provides an opportunity for the person to reflect on their situation and the possibilities for moving forward, and may require more than one conversation. How an individual practitioner approaches this part of the process, and critically the time they have available, will influence the robustness of the plan at the end. The process of negotiation provides opportunities to build on the assets, strengths and abilities of the individual. Adopting solution focussed approaches can be useful to this end, as illustrated in the Talking Points guide.

A personal outcomes approach further supports co-production because the planning stage involves consideration of the role that the person themselves can play in contributing towards their outcomes. This is in contrast to service-led ways of working, whereby individual problems are

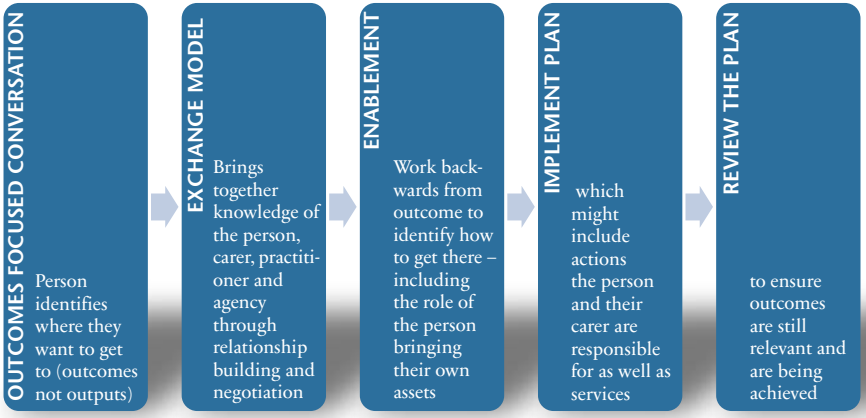


Figure 2: Good conversations

matched to a range of service solutions. The conversation should always involve consideration of the assets the individual brings, as well as considering the role of other supports and services.

So the *engagement* about outcomes is the essential first step in implementing outcomes-based working. Secondly, there is the *recording* of relevant outcomes identified through the conversation in the support plan, to enable the person to work towards their outcomes. At a later point it is essential that the outcomes be reviewed with the individual to assess progress and to find out if any changes to the plan are required. Thirdly, information recorded from these conversations should be collated, analysed and used to inform decisions at an organisational level in relation to the planning and commissioning of services. This *use of information* puts outcomes for individuals at the centre of decision making processes and ensures that improvements are driven by the priorities of service users and carers. These three key elements form the cornerstones of the Talking Points approach: *engagement*, *recording* and *use of information*.

Information on personal outcomes can be used for a range of purposes. The rich and detailed nature of the information gathered means it is particularly valuable for improvement purposes. However, the subjective nature of the information (as with all information based on personal experience) does limit the extent to which generalisations can be made from aggregated data on personal outcomes, which is a limitation when using information for performance reporting. Having said this, many organisations have aggregated personal outcomes data at a service level and used this quantitative information, alongside other measures, to inform performance management, inspection and regulation processes. Expertise is developing in using qualitative data about outcomes in several organisations, which is proving valuable in understanding how outcomes are achieved and where the limitations lie. There is also a growing interest in the ways in which personal outcomes information can inform planning processes and the redesign and commissioning of services.

In summary then, personal outcomes approaches like Talking Points support co-production in the following key ways:

- Involve conversations with the individual based around their priorities in life, bringing together the perspectives of all relevant parties, as illustrated by the exchange model
- Involves planning how to achieve the outcomes, and in a departure from service-led approaches, includes consideration of the role

that the individual will play in achieving their outcomes, as well as other people in their lives, and other supports and services
- Uses aggregated data about personal outcomes – at the team, service or organisational level to understand how outcomes are being achieved, where the limitations are, and inform decision making about improvements, planning and commissioning

This article is based on the Talking Points practical guide (Cook and Miller, 2012) at http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/

CONTACT DETAILS

Chris Bruce
Lead on Outcomes
Joint Improvement Team, Scottish Government
Email: chris.bruce@scotland.gsi.gov.uk

Co-production – driving change in health and social care

IAN WELSH, *Health and Social Care Alliance Scotland*
SHELLEY GRAY, *Health and Social Care Alliance Scotland*

> *"We will need to involve the people of Scotland to a greater extent in the co-production of health and healthcare, recognising and valuing diversity and promoting a person-centred approach and involving people in the design and delivery of healthcare."*
>
> Healthcare Quality Strategy[1]

Co-production is not a new term in health and social care policy. Indeed the Health and Social Care Alliance Scotland (formerly the Long Term Conditions Alliance Scotland) itself formed around the self management agenda which is strongly rooted in co-production. Other organisations have also long championed co-production in this arena, for example the Scottish Community Development Centre and its work on community-led health; the learning disability sector with its focus on person-centred approaches; the user advocacy movement within mental health; and the work of organisations like IRISS (Institute for Research and Innovation in Social Services) placing co-production at the heart of service design.

Self management offers an example of co-production at all levels. The National Self Management Strategy – 'Gaun Yersel'[2] – was developed by people living with long term conditions and its implementation has been driven by those same people and communities, supported by the AL-

1 Scottish Government, May 2010
2 Gaun Yersel, The Self Management Strategy for Scotland ALLIANCE (then LTCAS) and Scottish Government 2008

LIANCE. The many projects supported through the Self Management Fund for Scotland are designed and delivered by people who live with long term conditions, often working with the third and statutory sectors.

Looking more widely into the ALLIANCE's membership, there are many organisations putting co-production into practice, both in how they develop and deliver their own services, and in working with the statutory sector to enable them to work in partnership with those they seek to serve. The Breakthrough Service Pledge is enabling service improvement and redesign through a model that empowers people at the frontline of delivering and receiving services; Chest, Heart and Stroke Scotland are supporting other organisations to use their 'Voices' model which allows people to gain skills and confidence and work together to influence local services; and the Scottish Recovery Network is developing new peer working roles across the mental health sector in Scotland. Many of the ALLIANCE's much smaller member organisations are products and drivers of co-production, often having been established by people to support others living with similar experiences and to ensure they and their peers have a voice in policy, support and services.

There are many more examples that demonstrate how co-production is already bringing change to health and social care in Scotland. All of these approaches value lived experience, support people to take control individually and as communities, and help people to live well and stay well for longer. They embody the central tenet of the Christie Report[3], which argued for an approach not led, or wholly reliant upon formal services, but instead based on harnessing the capacity of individuals and communities to be partners in health and care.

The third sector is key to enabling these individual and community assets to flourish. It provides the infrastructure of support through which people come together, develop skills and confidence and support one another.

In Scotland there is much to celebrate in co-production, however there remains some distance between where we are now and the Christie Commission's vision in which co-production becomes the mainstream, with Scotland embracing' … *a radical new collaborative culture throughout our public services*'.

3 Commission on Future Delivery of Public Services 2011

National Person-centred Health and Care Programme

Within the arena of health and care we have a significant opportunity to hasten progress through the new National Person-centred Health and Care Programme. Launched in November 2012, the Programme aims to deliver on the 'person-centred' ambition of the Healthcare Quality Strategy:

'To achieve mutually beneficial partnerships between patients and their families and those delivering healthcare services. Partnerships which demonstrate compassion, continuity, clear communication and shared decision-making.'

The aspiration is to build on pockets of excellence and, through co-production, to drive the improvement and spread of person-centred approaches throughout health and social care, aiming for improvement by 2015 in:

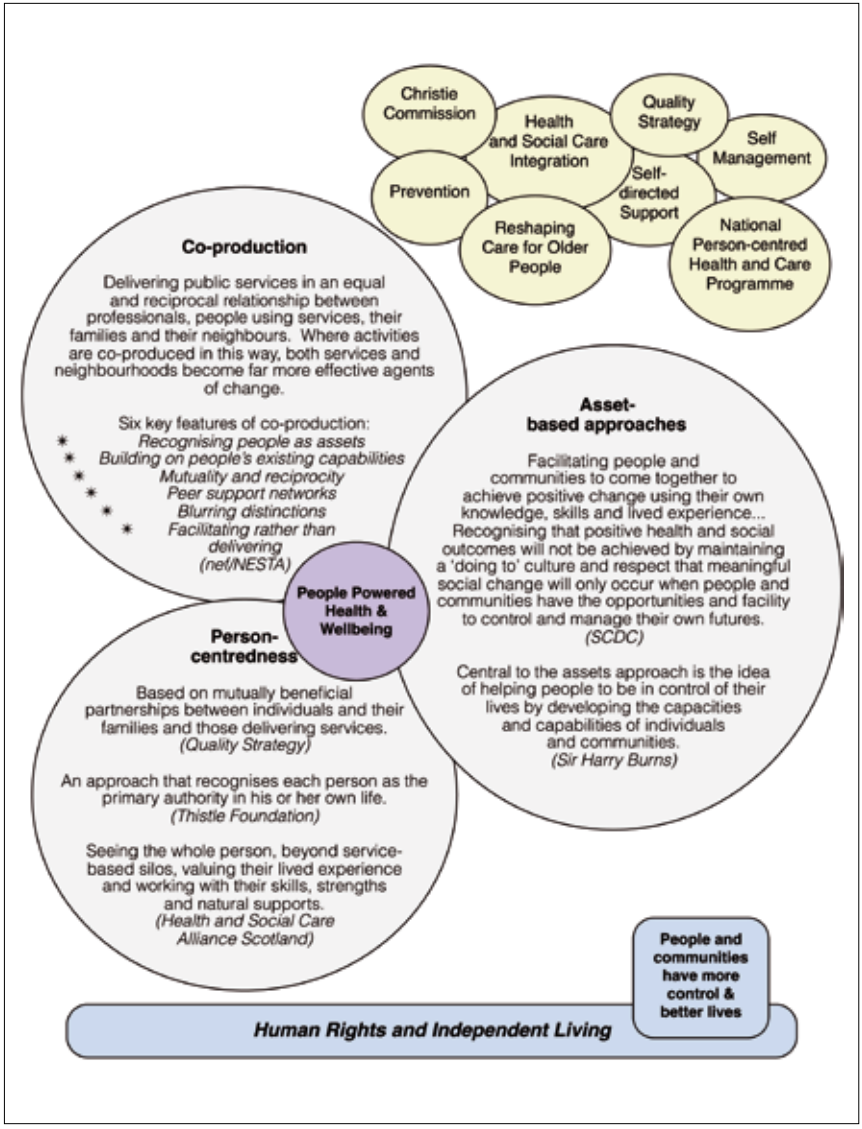
- Care experience
- Staff experience
- Co-production

The ALLIANCE has already begun to work with the JIT and Scottish Co-production Network, along with other partners, to take forward the co-production strand. This element will take the form of a programme entitled *People Powered Health and Wellbeing; Shifting the balance of power* and broadly aimed at:

- Driving cultural change to support co-production
- Building capacity for co-production among people using, delivering and designing services
- Working with the ALISS (Access to Local Information to Support Self Management) project and IRISS to support local asset mapping
- Building leadership capacity among people, communities and the third sector
- Working with the other National Programme Leads to ensure that co-production drives improvements in care and staff experience

Over the coming three years, the Programme will seek to significantly enhance capacity for co-production across health and social care in Scot-

land. This will require a fundamental cultural shift, underpinned by changes in attitudes, behaviours and systems. The National Programme



offers an important opportunity to work at all levels – individual, system and policy and political environment.

Co-production, person-centred and asset-based approaches are closely related, mutually reinforcing concepts. Co-production is key to driving design, delivery and continual improvement of person-centred support and services.

As an independent Scottish charity and strategic partner of the Scottish Government, the ALLIANCE works with its 270-plus members towards the vision of:

A Scotland where people who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens with support that puts them at the centre.

The ALLIANCE does this through **three core aims**; seeking to:

- Ensure **people are at the centre**, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support **transformational change**, towards approaches that are preventative and that work with individual and community assets, supporting human rights, self management, co-production and independent living.
- Champion and support the **third sector** as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.

CONTACT DETAILS

Shelley Gray
Director of Policy and Communications,
Health and Social Care Alliance Scotland
Email: shelley.gray@alliance-scotland.org.uk

Five steps to making the transformation to co-production

ELKE LOEFFLER, *Governance International*
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 Five Step Public Service Transformation Model which involves mapping existing co-production initiatives, focussing on those with the highest impact, involving the right people, inside and outside the organisation, who can make the strategy succeed, marketing it to the sceptics and growing it within and beyond the organisation.

Step 1: 'Map it!'

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

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

Self-assessment workshops for managers, staff, and service users and communities can map existing co-production activities, looking at:

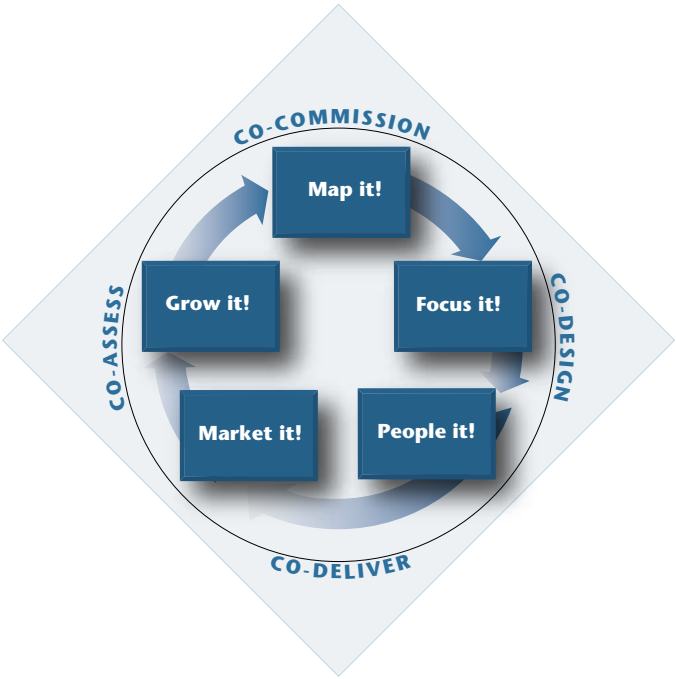


Figure 1: The *Governance International* Co-Production Star

- 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 them-

Figure 2: Are we nearly there yet?

selves. Such mapping exercises should separate the four dimensions 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. In Scotland, this tool has recently been extensively used by NHS Tayside to support its co-production work. 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 what your current level of co-production looks like, you can start to think how to prioritise your next steps. Generally, it would be over-ambitious to waste efforts by trying to do too much, too quickly. Focus is critical. Moreover, in a context of fiscal austerity and open govern-

ment, 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 (Figure 3) is a simple technique to help choose and grade activities, distinguishing which are priorities – and which can be dropped. Clearly 'quick wins' (high improvement, high citizen involvement) 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 want to be involved and to associate with success. Conversely 'hard slogs' (low improvement, high citizen involvement) 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.

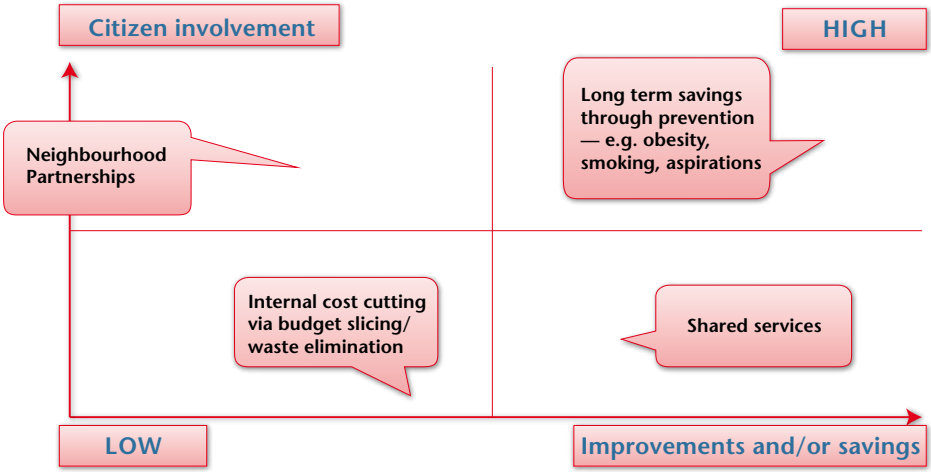


Figure 3: Example of a Co-production Priority Matrix

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.

Another approach which we have developed is a Capabilities Assessment with service users (to complement any 'needs assessment' process). This identifies the strengths, assets and potential contributions they might make to improving their own outcomes and those of other citizens.

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 Interest' analysis can help to decide who to involve:

- **High Power – High Interest 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 their damage.

- **High Power – Low Interest stakeholders:** tend to be 'arms length' to your decisions – but you should generally inform them and get their support, without over-involving them.
- **High Interest – Low Power stakeholders:** important to keep them informed, 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 Interest – High Power' – with a very negative attitude.
- **Low Interest – Low Power stakeholders:** these are part of the 'silent majority' – it's important to find out what they think and tell to them why you are doing what you are doing – their 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!

Attract 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 ser-

vices 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 !!!

CONTACT DETAILS

Elke Loeffler
Chief Executive,
Governance International

Email: Elke.Loeffler@govint.org

Frankie Hine-Hughes
Project Manager,
Governance International

Frankie.Hine-Hughes@govint.org

Joint Improvement Team

Area 2ES
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Phone: 0131 244 2374
Email: jitscotland@gsi.gov.uk
Web: www.jitscotland.org.uk

Governance International

Ground Floor
1 Victoria Square
Birmingham B1 1BD

Phone: (0044) (0)121 698 8743
Email: info@govint.org
Web: www.govint.org

Company Limited by Guarantee No. 04488214
Companies House for England and Wales

jit joint improvement team
creativity, collaboration and continuous improvement

governance international®
Achieving citizen outcomes

Scottish
Co-production Network

Olivia Hanley
Coordinator

Phone: 0141 222 4839
Email: olivia@scdc.org.uk
Web: www.coproductionscotland.org.uk

The Health and Social Care
Alliance Scotland

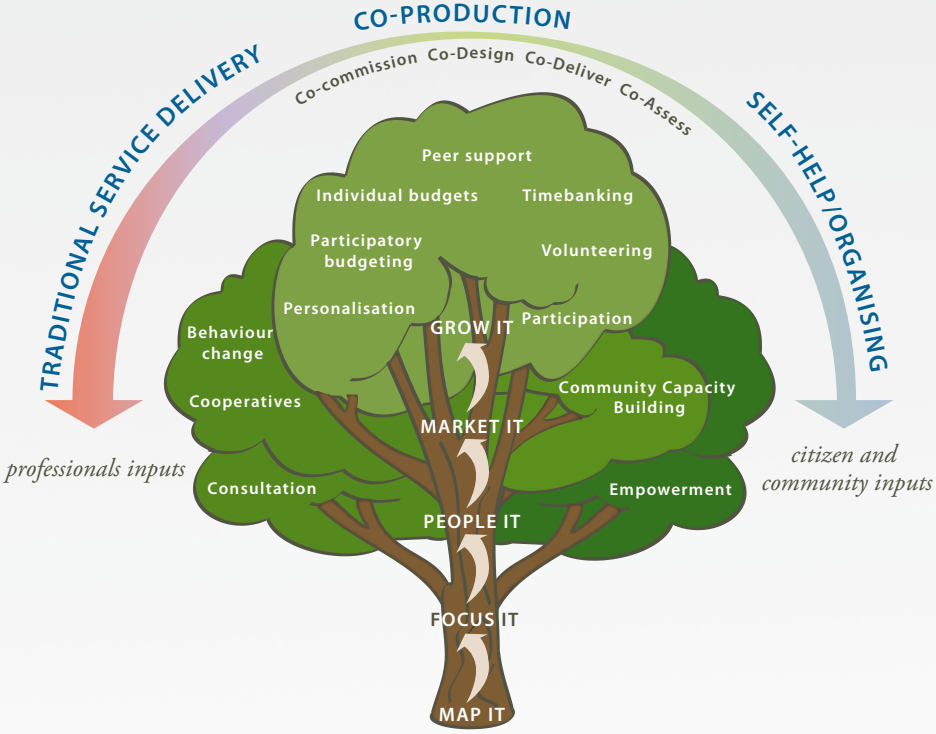
The ALLIANCE
Venlaw Building
349 Bath Street
Glasgow
G2 4AA

Phone: 0141 404 0231
Email: info@alliance-scotland.org.uk
Web: www.alliance-scotland.org.uk

Scottish
Co-production
Network

ALLIANCE

THE GOVERNANCE INTERNATIONAL CO-PRODUCTION TREE



joint improvement team
creativity, collaboration and continuous improvement

governance international®
Achieving citizen outcomes

Scottish Co-production Network

ALLIANCE
HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND
people at the centre