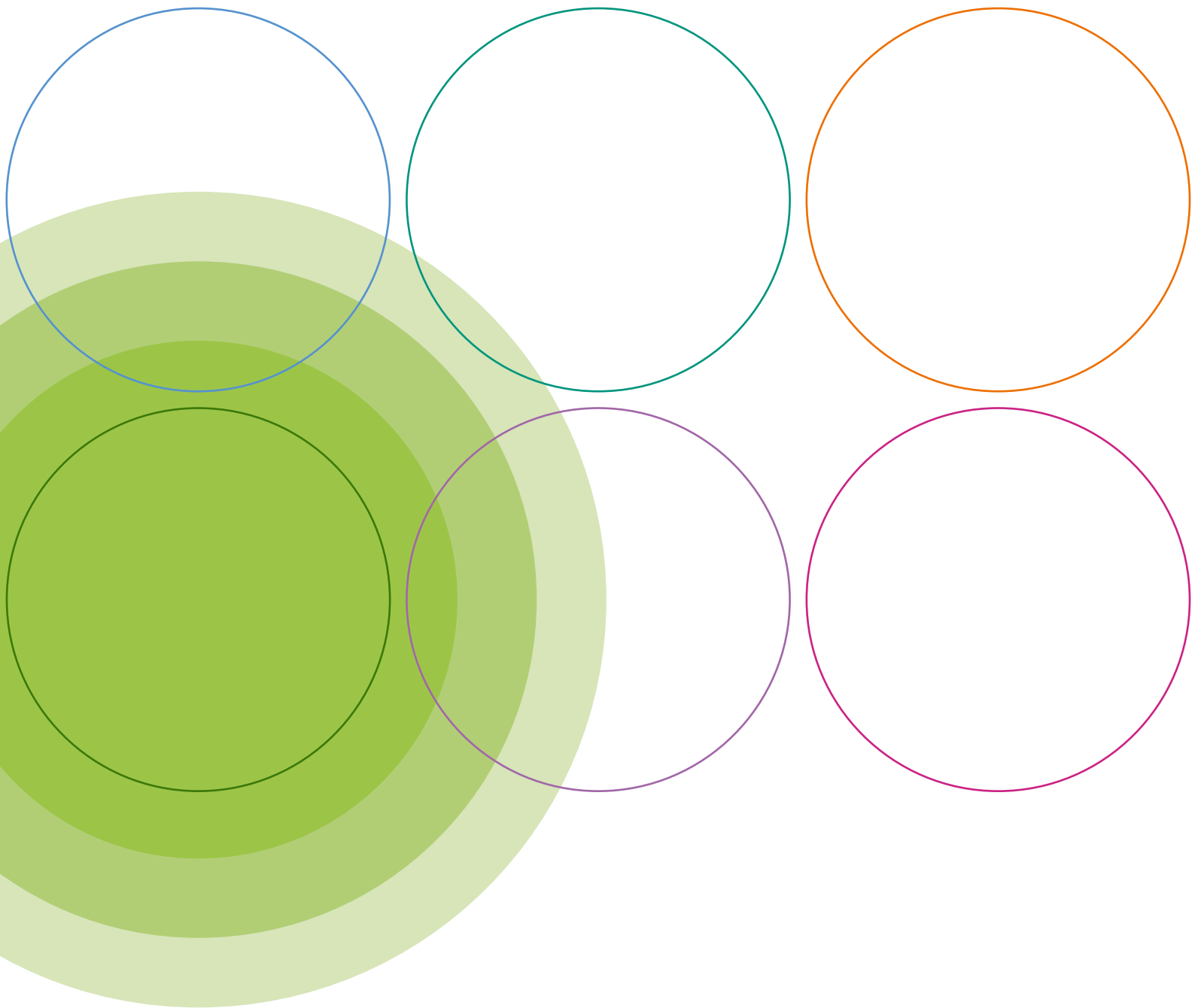


BY US, FOR US:

THE POWER OF CO-DESIGN
AND CO-DELIVERY



People
Powered
Health



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About the series

By us, For us: the power of co-design and co-delivery is one in a series of learning products which explain why People Powered Health works, what it looks like and the key features needed to replicate success elsewhere. It draws on the experience of the six teams who took part in People Powered Health, which was led by Nesta and Innovation Unit from summer 2011 to winter 2012.

The series includes:

- **People Powered Health**, health for people, by people and with people, foreword by the King's Fund
- **The Business Case for People Powered Health**: building the business case, foreword by the NHS Confederation
- **By us, For us: the power of co-design and co-delivery**, foreword by National Voices
- **More than Medicine**: new services for People Powered Health, foreword by Macmillan
- **Networks that Work**: partnerships for integrated care services, foreword by ACEVO
- **People Helping People**: peer support that changes lives, foreword by MIND
- **People Powered Commissioning**: embedding innovation in practice, foreword by NAPC
- **Redefining Consultations**: changing relationships at the heart of health, foreword by the Royal College of GP's

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Calderdale

Lambeth

Newcastle

Earl's Court

Leeds

Stockport

You can find out more about their work and about People Powered Health at www.nesta.org.uk.

Foreword

Just before I sat down to write this, I received an email from a GP commissioner who argued passionately that his “greatest successes are achieved through co-production and multi-stakeholder developments”.

‘By us, For us’ takes us inside some key case studies to find out how and why the People Powered Health approach – people and community groups working as equals with commissioner and providers – works.

In Lambeth (p6) it worked because all stakeholders in mental health discovered and cemented their joint interest in moving from a crisis service to one that offers prevention, early intervention and enablement to keep people well.

That is not just a local issue. It speaks to the challenges facing the whole NHS. The People Powered Health approach demonstrates that a radically different, sustainable NHS is possible if you draw on all the ‘assets’ available – including the knowledge and experience of the service users themselves.

National Voices, as a coalition of around 130 health and social care charities in England, has been delighted to be involved with the People Powered Health advisory panel because the programme’s investigation and exploration of the practices of co-production and co-design speak to the daily concerns of our member charities and their beneficiaries.

We know that services designed with their users, where personal experience of managing our lives with our condition(s) is as valued as clinical or managerial health knowledge, work better, support us more and are more likely to achieve the outcomes we want and need.

In our manifesto for changes to the government reforms in 2011 – the ‘9 big shouts’ – we demanded that:

- service users should have real involvement, with genuine influence
- we should be seen as ‘expert commissioners’
- care should be moved to the right place, at the right time, and
- paternalism should end.

Co-production and co-design help to address and encourage these necessary changes to the culture of healthcare.

Don Redding is Director of Policy of National Voices

Why is it important that service users help to design and deliver the People Powered Health approach?

At the core of the People Powered Health approach is collective ownership of health and wellbeing. Creating a health system driven by the people within it, not by the institutions that provide care, requires a focus on the interactions between people and providers at all stages; in designing, delivering, using, and evaluating services.

Putting the people who make up the community of health – patients and service users, carers, practitioners, providers and commissioners – at the centre of its design from the start is essential to creating, fostering and leveraging collective ownership. It requires going beyond ‘engagement’,

“User-centred design is the way forward – a universal commitment and a new culture of how we do things. We’ve seen it a bit in the past but not at this level. We recognise that it might be tough for those who live in the old system, but if we want to make a system for those using it then co-production is the only way forward.”

Dr Adrian McLachlan,
GP and Chair of Lambeth Living Well Collaborative Board

‘involvement’ and ‘person-centred’ towards real co-design and co-delivery at every level of the health service – design, provision, delivery, commissioning and strategy.

There are many definitions, and many facets, of co-design and co-delivery – including user-led and user-centred design, engagement and involvement,

and co-production and co-creation of services. What all of them have in common is an ethos and recognition that those who provide and experience services should have an equal say and role in how such services are designed and delivered.

Co-design and co-delivery involves rethinking who, when and how services are designed – moving from a top-down, one-off, ‘professional experts’ approach that may or may not include wider consultation, towards an iterative, structured process that includes a broad range of people, at every stage, and is built on a community of relationships and trust. These approaches are features of ‘service design’, a process more traditionally used in the private and corporate sectors but many components of which are applicable to public services.

In this document you will encounter examples of co-design and co-delivery that the teams have developed as part of their commitment to a People Powered Health approach. These processes and practices represent a long-term investment in organisational change, rather than a ‘quick win’. But the returns can be extraordinary, including significantly improved services and transformed relationships within and between organisations.

“Service design helps to generate a shared, single view of system priorities that connects actual experiences with the setting of those priorities. [It] focuses minds on the deeper purpose of service. And it builds the capacity of organisations and groups of organisations to adapt and morph as people’s needs change. In these terms, service design can offer a vision for transformation, as well as a set of tools and a model of change for bringing it about.”¹

Co-design and co-delivery help to:

- uncover and leverage existing assets, resources and networks
- identify opportunities for co-delivered support, taking account of both professional and user perspectives
- better identify opportunities for recovery and independence
- focus on the aspirations of service users, breaking down barriers between services and sectors
- share responsibility for outcomes and a move away from over-dependency on particular services and methods of care
- facilitate a conversation around the possibilities of experience-based evidence

Co-design and co-delivery are not:

- a move towards a system in which patients and service users self-manage without medical care and guidance
- a devaluing of clinical and professional input and expertise
- a rebranding of community and patient involvement or engagement – which remain a necessary but far from sufficient part of the process

Between them, the six People Powered Health locality teams are using co-design and co-delivery at every level of the health and social care system:

- **Individual service users** co-designing personalised care and wellbeing pathways.
- **Whole services** mobilising the skills and capacity of service users.
- **Local healthcare systems** co-creating the system conditions for People Powered Health.

“If you’re taking it seriously it’s not about engagement, not about communication, it’s about genuine production.”

Joseph Harrington,
Service Designer working
with the Lambeth Living
Well Collaborative



Co-designing individual care and wellbeing pathways

Care planning, pathway planning and wellbeing planning enable patients to identify their own goals and aspirations, and to navigate the services that will help to achieve them.

Care planning, at its best, is a process and a product. It results in both an action plan and a consistent framework for conversations between the patient, clinicians and services. When used in consultations, care planning sits at the heart of a partnership of collaborative working between patients and practitioners. However, existing care planning practice can neglect the true involvement of patients, consisting of as little as written instructions from the clinician to the patient – reinforcing existing power dynamics and not effectively engaging patients in their own care.

At a system level, care planning should feed into the commissioning process, using the collation of individuals' needs to plan community services. This relies, however, on agile and collaborative networks of providers, services and commissioners that can adapt provision as the needs of the population change.

For more on new forms of care and wellbeing pathways, see [Redefining Consultations](#)



“There’s been a cultural and professional change in attitude, mindset and behaviour...when I did my training as a clinician some years ago, it was very much the professional or the clinician who knew best, knew most – led the conversation. Now the person, patient, service user knows best and often they lead that relationship and that conversation.”

Paul Morrin,

Director of Integration, Adult Health and Social Care, Leeds Community Healthcare Trust



Focus on People Powered Health in Stockport: prevention and personalisation and prevention

In the People Powered Health Stockport team, collaborative commissioning and a network of providers underpins a new Prevention and Personalisation Service, the aim of which is for service users to co-create care pathways based on identifying their own goals and ambitions and the barriers to achieving them.

Users are supported by a wellbeing pathway planner and have access to a wide range of services from a variety of networked providers, ranging from peer support, debt and housing advice, volunteering and traditional clinical support. Stockport has put in place prototype alliance contracts and is building capacity for community-based support through initiatives such as timebanking. Though early days, the new pathways are expected ultimately to reduce referrals and re-presentation to secondary care by at least 60 per cent, and increase discharge rates by 25 per cent.

Owen's story

"I used to look at my future in a really negative way, 'cause I just thought there's no chance of getting a job but this [becoming a psychiatric nurse] is what I wanted to do as well. I thought, I just don't think I'm going to pass uni, but this [volunteer training] is a step to it without uni, or some parts of it. I'm looking forward to it."

Owen has a history of drug-induced psychosis, which at one point was so severe that he was sectioned and hospitalised for two months. Prior to being sectioned he'd regularly be so "out of it" that he'd walk out into the street in front of cars, and hallucinate that he could hear people arguing and fighting. He found hospital a particularly "grim" experience and ended up downplaying his symptoms so that he would be let out. Having been discharged from hospital, he was working with the recovery and inclusion team, and with an occupational therapist, Brenda. When Brenda first met Owen, his life was still chaotic - he lacked any structure to his days, he didn't have a job, and didn't know what benefits he could claim.

Brenda recommended that Owen see Barry Tildsley, a prevention and personalisation coordinator - a specialist mental health pathway planner and advisor. He aims to help people not by focusing on their medical history, their condition or their

drug regimen, but by finding out what that person wants to achieve in life and what's important to them.

Barry worked with Owen to help him figure out what he wanted to do in the future and how he could achieve this. For Owen, his main goal is to become a psychiatric nurse or work in social services, to help other people who are going through bad times like he did. His experience in hospital had a lasting impact on him, making him want to support others and improve care. Owen and Barry decided together that starting at college could be a bit too much for Owen at the moment. However, as a first step towards his goal, Barry suggested Owen sign up to volunteer training run by Mind. Having undergone the volunteer training, Owen has now started supervised volunteering at a wellbeing centre in Stockport, helping other young people who have experienced mental health problems.

Co-designing and co-delivering whole services

Users, practitioners and communities co-creating services is not a new phenomenon. The challenge is to harness this collaborative working culture and spread and embed it in new settings, including it as standard in primary care and acute services and in service governance.

Where co-design and co-delivery have worked in the People Powered Health teams and wider afield, a core set of elements have been in place:



- A co-design process that includes people from every sector and group at every stage, right from the beginning of the process – and with the input of all valued equally.
- A co-delivery process that gives those involved genuine autonomy underpinned by solid training and support.
- Significant time and real energy set aside by management, clinicians and practitioners to build relationships and trust with one another, patients and communities.
- Commitment by professionals to ‘not knowing the answer’. Co-design processes cannot work if there are entrenched pre-determined ideas of what the solution needs to be. This is a significant shift in approach for most professionals.
- A genuine commitment to real, quick, practical, visible and impactful change being made – and being seen to be made – according to the outcomes of work done together.

Co-design and co-delivery around the country



Service User Network (SUN), Croydon²

The SUN project in Croydon is a mental health service designed and co-run by its members, all of whom have a diagnosis of personality disorder or long-standing emotional and behavioural problems. SUN runs several groups a week focusing on emotional and practical support, including a Crisis and Support Plan group in which service users jointly create individual care plans. SUN is designed and delivered in close partnership with its members, with the continual development of the service shaped through forums and conversations.

<http://www.hear-us.org/aboutthem/croydonslam/slamsservices/touchstoneansthesunproject/thesunproject.html>

See [Redefining Consultations](#) for a more detailed case study of the SUN model.



Richmond Users Independent Living Scheme (RUILS)³

RUILS is a user-run and user-led organisation providing adult social care services in Richmond, London to older people and people with learning difficulties and mental health challenges, helping them to live independent lives in their communities. It has a tiered membership structure that enables people to help shape the development of the organisation. Over 70 per cent of the board of directors is made up of service users. Full members have voting rights and can be elected onto the board of directors. Associate membership is available to members' relatives, friends and advocates.

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



Pennine Care Trust⁴

An NHS Foundation Trust aiming to build the capacity of local people to take part in deciding health service provision. Pennine's Members Council has 12,600 members with elected governors, and uses informal roadshows to provide advice, information and guidance in an informal setting.

<http://www.cdf.org.uk/wp-content/uploads/2011/12/Building-healthy-communities-A-community-empowerment-approach.pdf>



Focus on

People Powered Health in Earl's Court: creating and delivering services based on community research

Earl's Court Health and Wellbeing Centre is a primary care centre developed with an ethos of community-led design and delivery.

Run by a consortia of Turning Point, Greenbrook Healthcare, NHS Dentists and the Terrence Higgins Trust, the centre integrates GP, dentist and sexual health services with a range of community and social value services including peer support groups, a timebank, exercise and diet classes, a job club and space for community-run groups. Health and wellbeing coaches help provide support and build social networks, while multi-lingual patient navigators help users explore the services on offer.

The centre was established following a campaign from local people for more primary care services and community space. Through its Connected Care Team, its approach to designing and delivering services is to involve its users and the community at every stage - including in research, commissioning and building up community skill and capacity to develop services from the bottom up. Key to this is the use of Community Researchers, a team of service users who provide a link between the centre, patients and the wider community by researching local need, identifying gaps in provision, gathering feedback and disseminating information. Researchers are given training and support to fulfil this role, which includes:

- Building on local people's knowledge of the community and feeding that into the design and delivery of services. Researchers use existing networks such as libraries, schools, neighbourhood centres and children's centres as well as visiting people in their homes.
- Harnessing capacity in the community, including local third sector providers and volunteers, and connecting that resource to the centre.
- Creating volunteering opportunities with local people so they have a way of building their skills and experience. For some this can be a move towards employment.
- Facilitating peer support and networks and enabling people to give something back.



Gemma Bruce,
Development Manager,
Turning Point

“You start with something quite simple and straightforward which is just a research project. And actually what you get is a group of people who are able to make a massive contribution to helping you achieve your aims as a service delivery organisation.”



Noni Beasley, Community Researcher, Earl's Court Health and Wellbeing Centre

Community Researchers sit on the social value steering group to share their findings from the research, and are included on interview panels for the centre's staff.

Services that have come out of the research programme include:

- A peer mentoring scheme helping people with long-term conditions to better manage their health.
- Activities focused on those with long-term conditions, including a weekly walking group.
- The timebank, allowing community members to share and exchange time, skills and support at the rate of one hour to one credit.
- A weekly coffee morning, run by researchers, which provides a social space to find out what's on offer.
- A patient participation group which feeds into board level.
- The job club, linked to peer mentoring, volunteering and the timebank and including support for getting back into work, CV advice and applications.
- Longer opening hours, flexible session times and use of community rooms.

“This is an on-going process of tailoring services according to changing community need. It's not something that has been thought by high-up people in the primary care trust or politicians who think 'they might need something like'.”

Learn more

To learn more about how to use community researchers see:

Turning Point – Connected Care.

<http://www.turning-point.co.uk/community-commissioning/connected-care.aspx>

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<http://www.reallifemethods.ac.uk/events/workshops/localities/localities-salway-harriss.pdf>

Mubarak, I., Salway, S. and Chowbey, P. (2006) 'Community Researchers: Methodological Issues and Challenges.' Sheffield: Sheffield Hallam University.

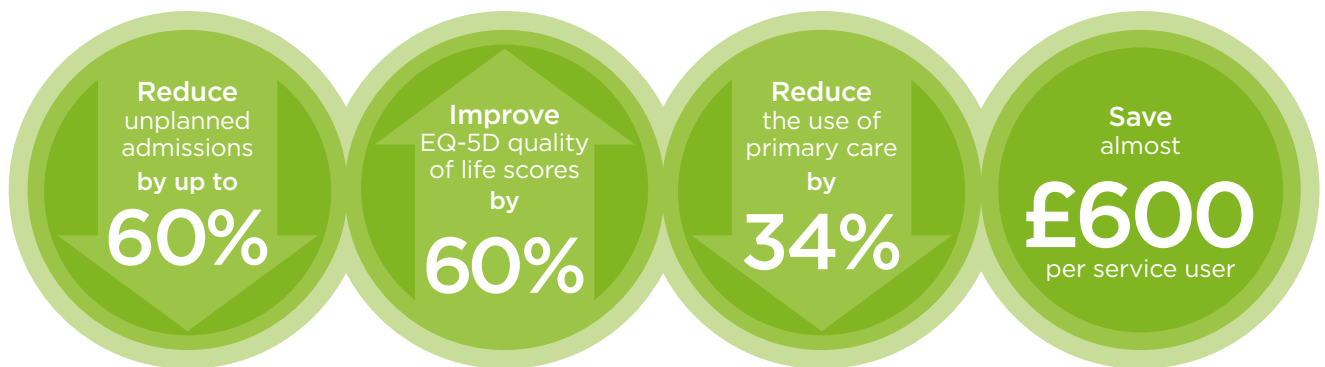
<http://www.methods.manchester.ac.uk/events/2011-03-11/slides/ismail.pdf>



Benefits of community research

- Researchers are credible in talking to local people – living locally, they are able to connect and engage in a way a professional researcher would not. This is particularly useful in engaging traditionally hard-to-reach communities and cohorts in an area with, for example, over 50 local languages.
- Researchers are committed to making the centre and services a success, as they belong to the community it serves and feel they own the space. They want it to work and for it to be a resource for local people. This both gives a clear purpose to the research and makes the researchers themselves a key resource in implementing the findings.
- The services produced as a result, particularly the timebank and peer mentoring scheme, really help those with long-term conditions to better manage their condition because they have been designed with that cohort. This impacts positively both on individuals' health and in terms of the costs of services further down the line.

Expected benefits of the Health and Wellbeing Centre's co-designed and co-delivered social value services



For more on these benefits see [The Business Case for People Powered Health](#).

Read more about Earl's Court's approach to partnership working in [Networks That Work](#).

For more examples of services that are co-designed and co-delivered by patients, see [People Helping People](#) and [More Than Medicine](#).



Practical tips for community research

Drawing on the insights of the communities that use services can contribute to building better, more responsive services and systems. The key elements to a successful community research programme are:

- Give in-depth training and support right from the beginning. It's important that the researchers know they have backing to do what they're doing and that it's purposeful.
- Don't limit what you think people are capable of - both researchers and members of the community - people grow and you need to expand your expectations of them. This is a methodology that can be used to expand capacity in the community to play a big role in the delivery of services.
- Though researchers are initially used to diagnose problems, they can become a resource in implementing solutions - so be ready to provide them with more training at this point and make sure this commitment is leveraged for maximum value.

“Whatever your aims are as a service provider, there's capacity out there in the community that can help achieve those aims.”

Gemma Bruce,
Turning Point

Prototyping in practice

Prototyping is an approach to developing and testing ideas at an early stage before large-scale resources are committed to implementation. It is a quick way to evaluate and validate impact and manage risk.

Prototyping is generally used in the early stages of service design and development, to experiment with new approaches quickly under real conditions. It supports a learning process that generates new thinking to understand design challenges, and provides an ability to test compliance, usability and feasibility while carefully managing risk. As well as testing current ideas, prototyping encourages new ideas and alternatives to grow out of the experience of testing.⁶

Prototyping is often described as a phase of the design process, but should be something that happens all the way through – from initial conception to the iterative reconfiguration of services to adapt to changing need, and at both small and large cohort scale. It is a key way of collaborative working – a culture, rather than a process. It provides a structure for thinking about innovation challenges and evaluating, replicating and validating ideas.

Prototyping is not new to health and social care, in which a process of discovery and trial-and-error are core to finding what works best for each individual. Yet a large barrier to using prototyping more widely is the perceived risks of such an approach. In reality, prototyping affords more controlled, structured and detailed ways of managing and stratifying this risk, thereby minimising the effects of any failure, as it supports much more agile and nuanced working with small groups of people. While traditional piloting of new services might take a number of months or years and the results not analysed until after the pilot's completion, a prototyped service can contain many iterations of varying risk levels and be constantly monitored with immediate adjustments made if necessary. Involving patients directly in the design of prototypes allows for much more valuable and swift feedback if things go wrong.

“There will be heads shaking saying [making the system more simple] is not possible. We have shown that it can be done.”

Peer supporter, quoted in Lambeth's prototyping evaluation⁵



The evidence

A comprehensive review of design in public services concluded that:

“... a formalised service design development methodology mitigates the risk of failure by managing incremental levels of service prototyping. Involving users at every stage also enables service designers to spot flaws not just in terms of operational systems, but also in terms of the experience of users.”⁷

Prototyping – how to get started

How should healthcare professionals, service managers and researchers start to prototype?

- **Start small** – start with a small cohort of people and build up from there.
- **Capture evidence** – capture both quantitative and qualitative evidence throughout the prototyping process.
- **Manage risk** – have procedures in place for dealing with risks including detailed monitoring throughout and an in-depth action plan to deal with any issues that arise.
- **Don't be afraid of failure** – many ideas will fail, the key is to fail quickly when the impact is negligible, and any process that results in a new idea will be valuable.

For more information, see Nesta's report on [Prototyping in public services](#).





Focus on **People Powered Health in Lambeth: prototyping assessment and planning**

Lambeth have used prototyping to create an evolving structure for pathways in mental health. Previous work highlighted a time lag between people's changing needs and changing the services they receive, meaning that crises were not averted and individuals' mental health was allowed to deteriorate while waiting for support to begin.

The project involved a small cohort of 12 people over a six-week period who were long-term users of services, isolated from support networks and at high risk of moving back into secondary care service. The cohort was referred to the prototype by GPs and Community Mental Health Teams and focused on those with a history of multiple agency use and of being trapped in the 'revolving door' of the primary/secondary care interface.

The prototype put together teams of professionals from Community Mental Health Teams (CMHTs), the Community Options Team, social care, psychiatric nurses, peer support groups and GPs. It looked at each person's route through services and the effects of every aspect of their lives and interactions with services, including housing, personal budgets, peer support, Improving Access to Psychological Therapies (IAPT) services, employment, home treatment teams and the wider voluntary sector. Applying an 'Assess, Plan, Act' model, it explored new ways of teams and services working together, including:

- How patients in primary care are assessed and by whom.
- How each person's care is planned, and who is involved in the conversations.
- How people are supported in primary care and in the community.

Central to this was a system of shared referrals within the team (rather than case loads) with support provided on a task basis. It also made extensive use of peer supporters to help reach patients that clinicians could not, and utilised new systems of referrals, time-limited support, regular team



meetings, complete recovery and support plans accessible online and fast access to personal health budgets.

The prototype was successful for peer supporters and clinicians, both in terms of better care provided to service users and the number of new ideas, problems and questions it generated. It also made a case for the need to keep trying out new ideas and the ability to do so in a productive way.

Rethinking evidence

“Seeing service as a delivery mechanism rather than a transformative experience has led to a particular form of information gathering and system measurement. Existing targets have tended to focus energy on underperformance in operational efficiency, at the expense of underperformance in the transformation of people’s lives.”⁸

Service co-design and co-delivery shine a light explicitly on patients’ experience of services – before, during and after points of interaction. This process of experience-based design, looking both at the overall path of patients’ care (not just the ‘cure’ at the end of it) and the process of designing these pathways, requires collecting, using and valuing different forms of evidence at every stage of the design and delivery process:

- As evidence for how successful services currently are from the point of view of those who interact with them.
- In researching what other services/methods might work better – generating very different stories about what these should look like.
- In measuring the results/impacts of new ways of working and the value of the process in and of itself – in particular, in areas that are difficult to measure in other ways, such as culture, capabilities and wellbeing.

Crucial among these is narrative-based evidence – stories, testimony, user journeys, service maps, video and ethnographies that show the interactions between patients and services as on-going experiences, not a set of disjointed outputs and measures from institutions. The co-design process is a route to support people in gathering, telling and sharing these stories, and prototyping can be a key way of quickly demonstrating the value and veracity of this evidence.

This type of evidence is often thought of as being less valuable than data sets from large cohorts of patients, but in fact these stories provide more nuanced and powerful information about what really does, and doesn’t, work. Evidence from patients that services really make a difference to their lives is difficult to argue with.

For more information on the evidence base for People Powered Health, see [The Business Case for People Powered Health](#).

“We realised there was a lot at fault with the service. The balance of resources was skewed towards clinical, crisis, acute, statutory, and skewed towards evidence-based practice. In itself this is a very good thing but it had become dogma. There was a disconnect between doing the expert work, the people being ‘done to’, and their carers – who were unhappy and dissatisfied with the service.

Getting involved with values-based awareness to go alongside evidence-based practice was what was needed. It was about getting clinicians back in touch with why they were doing the job – to make a difference to people’s lives. Not just to keep them safe or address a symptom or do some therapy with. The gap between a patient and clinician was too big. Value-based awareness training meant starting to see the person within the patient. As soon as you start to see what those people wanted with their lives beyond symptom management they went naturally into adopting the recovery approach.”

Nick Dixon,
Joint Commissioning
Manager (Mental Health),
Stockport Council

Redesigning local healthcare systems

“Just as outcomes need to be co-produced, so does transformation: how service design principles can be applied at every level of the system, from local authorities and policy-makers to politicians.”⁹



It is much easier to design a service than design a system. But designing a radically different service often requires redesigning the system – to provide the spaces, opportunities, capabilities and support for new services to be possible.

Many of the sorts of services which make up the People Powered Health approach already exist; what does not is the opportunity for them to scale and have real impact. A natural assumption would be that take-up by existing systems could be an efficient route to scaling radical new approaches. But new approaches are often not the right shape or size to accommodate the existing approaches to accountability, regulation, forecasting and so on demanded by the system, to the extent that their radical goals and the features that make them innovative become compromised. Over time the

pressure to demonstrate success in the existing arrangements makes the practice less radical, and like more of the same.¹⁰

Commissioners and system leaders shouldn't be in the position of designing services directly; rather, they should create and safeguard the conditions in which services can be designed and delivered by those who know what's needed. This includes changing the way in which services are commissioned by encouraging patients and communities to play an active role in the process; supporting changes in workforce culture through training and mobilising clinical leadership; changing financial incentives and outcome metrics; and utilising new uses of technology to support integrated and multi-team care.

Co-design of systems and services – it’s all about trust

Co-design projects stand or fall on whether the people involved trust the relationships within them. So the co-design community needs to meet purposefully and regularly in order to build up mutual respect, trust and confidence.

In **Lambeth**, this takes two forms. At the large scale, regular co-design workshops are held with up to 200 members of stakeholder groups who come together to learn about the aims of the programme, test out research and prototyping methods, and generate new ideas through collaborative working. Through these, the core vision is protected, disseminated and enhanced across as wide a range of people as possible and distributing the responsibility of engagement and idea generation.

At the small scale, the Lambeth Collaborative holds fortnightly breakfasts for commissioners and heads of services to discuss and problem-solve as a joined-up group. Peer supporters, community options teams, users and their advocates are also round the table, resulting in direct access and conversations to those with decision-making power. **Stockport**, too, has launched a regular Co-Design Forum to bring together service user and carer representatives, providers, commissioners and front-line workers.

People who, from the professional’s perspective, seem difficult to reach, engage with or are defensive are as valuable as those who are enthusiastic – they are representative of the genuine resistance that others might have. Finding and initially engaging members of the new community requires actively going out and bringing in intelligence. At the Health and Wellbeing Centre in **Earl’s Court**, this first part of the process was undertaken by Community Researchers.



Dr Adrian McLachlan,
GP and Chair of
Lambeth Living Well
Collaborative Board

“Co-produced decisions mean there’s no one person who’s the boss. We work by consensus. This only works because we put a lot of time and effort into laying a foundation of trust and understanding.”



Focus on

People Powered Health in Lambeth: co-designing acute mental health provision



Jessica Agudelo,
Project Co-Ordinator for Solidarity
in a Crisis, Lambeth

“A conventional pathway is driven by other people dictating what they think should happen. We want to get away from dictating what services are like and put users in charge of what services could be like. There is a wealth of knowledge and resources within the community of service users and carers. They know what works best for them and their peers.”

The Lambeth Living Well Collaborative was formed at the beginning of 2010 and brings together clinicians, service users, carers, secondary mental health services, voluntary sector providers, primary care practices, public health and commissioners to radically improve the way mental health services work in Lambeth.¹¹

It is focusing on a different way of understanding citizens, based on assets, needs and aspirations, and aims to harness and deploy the knowledge of providers and service users as a systematic part of the commissioning process.

Faced with a dramatic reduction in resources and increase in need, Lambeth embarked on an ambitious programme of service redesign to move from a crisis-dominated system of support to one focused on prevention, early intervention and enablement. Core to this is a process of co-design involving everyone who comes into contact with mental health services – including users, carers, volunteers, community groups and local businesses.

The Collaborative recognised the need to engage the mental health community as soon and as consistently as possible. A key initial step was the development of Vital Link, a body acting as a representative group of service users, carers and the wider mental health community. It has the mandate both to feed in views at commissioning level and to relay back any changes and questions. Together, the Collaborative and Vital Link designed Missing Link, a peer service that supports the difficult transition from intensive in-patient care to lower levels of community support.

Lambeth’s structured design process follows a system of ‘monitor, insight, co-design, co-delivery’, referred to respectively as the ‘ears, brain, hands and legs’ of the system. Each phase encompasses different tools, approaches and aims, providing a rigour to the work and a clear set of progress measures. Central to every stage has been the use of co-design workshops – large-scale events at which

Learn more



To learn more about the Lambeth Living Well Collaborative visit their [website](#).



What's new?

representatives from every group come together to refine the vision, generate ideas, create networks and tackle problems. The events are explicitly productive, rather than discursive, and incorporate prototyping, user journey mapping and analysis of narrative-based research. Having begun with 30 people, the workshops now attract upwards of 160, with about 1,600 people attending a workshop in the first two and a half years.

The results have been a shift of primary care support to building a 'safety net' of social support that prevents people falling into secondary care. New initiatives include more empowered Community Mental Health Teams, a structured programme of peer support, timebanking, a Community Options Team and networks between GPs, social care and mental health primary care. There has been a deeper change, too, towards an ethos of collaborative working and a collective reframing of what the challenges are. Eligibility criteria for services have been reviewed, with the aim being an 'easy in, easy out' system that supports fast access to care and a simplified discharge process.

"It's a different way of thinking about recovery. There's an assumption that you can only be discharged into other services that monitor you: 'monitoring and risk assessment' pretty much forever. There are many people for whom that's disempowering, creates dependence and gets in the way of recovery."

Dr Jonathan Bindman,
Clinical Director for Mood, Anxiety and Personality, Lambeth CAG

What sets Lambeth's approach apart is the inclusion of practitioners, commissioners, clinicians and senior managers in mental health and the local authority in the workshops themselves – not as experts, but as co-designers and facilitators of ideas. This has both brought in a wider range of ideas and skills, and begun a process of culture change through those traditionally in charge of care learning from patients directly the ways in which the system is failing them. It has also raised awareness of what provision is currently available – signposting for practitioners, not just patients – and built networks and trust between clinicians and services.

Lambeth's Co-Production Academy

Lambeth recognises the need to actively grow, foster and invest in the capabilities needed to work collaboratively. Leaders in Lambeth are developing a Co-Production Academy, which will introduce a range of interventions to shape the skills and capabilities needed to co-design and deliver services.

Programmes currently being explored by the Academy include:

- Peer Support: to develop and scale peer support through engagement, training and supervision.
- Enterprise: to support pioneers in the system to develop and scale new enterprises that grow co-production and collaborative working.
- Personalised health budgets: working to support personalised recovery planning across Community Mental Health Teams (CMHTs) as part of a national pilot to develop personal health budgets.

For more on system redesign, see [People Powered Health: Health for People by People and with People](#)

Endnotes

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