ImROC

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13. Co-Production – Sharing Our Experiences, Reflecting On Our Learning

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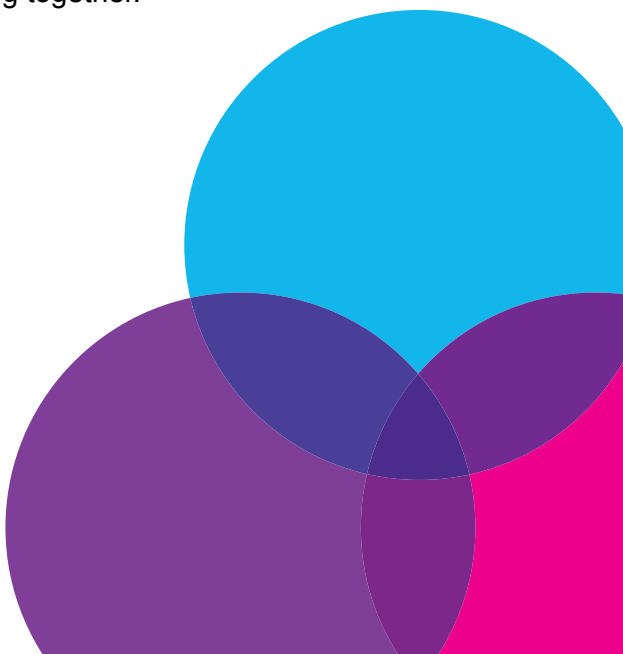
INTRODUCTION

There can be little doubt that the term 'co-production' has a growing profile in public services, and particularly within the mental health sector. Look at any conference programme, recent policy document, training event or even your Twitter feed, and it is likely that you will find mention of it. It features in the Five Year Forward View for Mental Health (2016), Prudent Health Care for Wales (Bradley & Willson 2014), the Scottish Co-Production Network and Learn to Lead in schools (Frost & Stenton 2010). The NHS is talking about it. Local Government is talking about it. Education is talking about it. Many have been working diligently and authentically to do it over many years. Others are just embarking on their journey and may feel overwhelmed by the challenges lying ahead.

So what is 'it' and why does it matter? Co-production offers a unique approach through which to interpret and address the challenges faced in our communities. It opens up opportunities we haven't yet spotted. It represents something fundamentally different in the way that relationships between services and communities are understood and developed. And yet this has not happened suddenly or dramatically. Slowly, people, communities, partnerships, groups are responding to shared challenges by evolving new ways of problem solving together.



The principles and values which have guided ImROC's work from inception are built around recovery and co-production. In every aspect of our mission, we continue to amass experience and learning by working in partnerships that both facilitate and value the contribution that every individual makes. In this paper, we attempt to bring co-production to life through a series of case studies of collaborative work undertaken with ImROC. Our intention is to curate a space in which narrative accounts are shared. We do not seek to critique the experiences – they are recounted just as they were told to the authors of the paper. Instead we seek to draw out common themes and explore their relevance to others, so that we all learn and strengthen our efforts to work more effectively amongst our communities.

The case studies are not unique, yet each represents something extraordinary and special and new for those involved in them. They illustrate the reality, the value, the challenges and the learning that we continue to gain in every aspect of our work. They allow us to explore the themes that characterise the work, and think about our aspirations for the future. They give us hope in turbulent times.

Intentionally, we have not examined at length the theoretical basis or principles for co-production. That has been ably achieved by many before us, not least Cahn (2001), Ostrom (1996), NEF (Stephens, Ryan-Collins & Boyle 2008), NESTA (Boyle & Harris 2009) and more. Here we provide the theory only to the extent that is necessary to contextualise the case studies. We work on the basis that authentic co-production is something for which we strive, in which we make mistakes as well as strides. We hope that these real life examples will inspire others to try too.

THE WIDER CONTEXT

While the notion of co-production aligns so naturally with the strengths-based, life-oriented ideas around personal recovery, its origins lie well beyond the mental health arena. Boyle, Slay & Stephens (2011) set out the wider context in which co-production has evolved, citing issues such as escalating demand for public services, advances in technology, and the changing nature of family networks, approaches to which are bound up in the mindset of the deficits-based welfare economy. The scope of these approaches to nurture health and wellbeing in communities is largely exhausted. Co-production seeks to re-imagine a future in which other resources, hitherto overlooked and untapped, are identified, valued and utilised.

The scope for this real change lies in the 'core economy' (Cahn 2001) of family, friends and neighbours – those individuals who make up each local community. It is this unseen & unrecognised context that determines the impact of every public service over time. The infinite talents and resources of those for whom public services exist are largely overlooked, diminished by the professional tendency to see what's wrong, not what's strong, alongside the unconscious willingness of participants to slip into a passive role as recipients of services. Yet it is likely that any future state-funded health and social care provision will rely on this hidden capacity and capability to thrive, and it will need to re-frame its own role and relationship with this untapped and rich resource.

Some will feel pulled towards the values-based reasons for a vision for co-production. Others may feel pushed towards that vision because other more traditional options are rapidly rendered redundant. Whether an idealist or a pragmatist, there is something within co-production that offers hope and opportunity.

SO WHAT DOES CO-PRODUCTION MEAN TO US IN IMROC?

One of the difficulties that besets our field of work, and many others, is the ease with which accessible language and terminology can be picked up, used and abused. One person's shorthand is another person's source of confusion, disagreement or even indignation. Ideas borne out of mutual appreciation and belief in the potential and power of people have been overtaken by less laudable agendas, often driven by powerful players such as large organisations or government. We encounter this in relation to recovery. Whilst the appeal of co-production tends to grow when times are tough, it too easily becomes conflated with the politics of austerity and cuts (Bovaird, 2007). How easy it is to re-label an existing activity or approach, acquiring the new language and outward expression, yet missing the opportunity to reflect honestly upon its challenges and internalise a fundamentally different vision for the future.

Hence finding a single definition of co-production to act as a benchmark for authenticity & fidelity feels less important than being able to articulate a set of principles that have common meaning, are easily accessible, and act as a guiding light for those treading the path of co-production. In turn, these principles are interpreted and brought to life by those most involved within the unique context of each activity, goal or set of assets. Like recovery, co-production is a personal experience and one best understood through the shared narrative that evolves when people find ways of working together towards new solutions.

Within ImROC we have come to this realisation over a period of time, as our understanding and experience have evolved and our willingness to test out new ideas has grown. We value this discovery as an important aspect of the process of our own co-production journey, and one we would not choose to leapfrog if we had our time again. Experiencing co-production first hand is at the heart of that process of internalisation and authenticity.

We first defined the principles which underpin our ImROC approach in our briefing paper The Team Recovery Implementation Plan: a framework for creating recovery-focused services (Repper and Perkins) in 2013. These are drawn from the literature, including Cahn (2001), Boyle et al. (2010), Slay et al (2013).

- We recognise people as having human **assets**, strengths, resources and networks that reach beyond the labels we use to describe their 'position' within a system or hierarchy.
- We build **mutual and reciprocal relationships** in which expertise is recognised amongst all parties, no longer the exclusive domain of the professional. Looking beyond these conventional labels, we strive to break down barriers, blur boundaries, share responsibility in both the design, delivery and improvement of services.
- We nurture and mobilise peer, personal and professional **networks** around a diverse community of interest, in order to share learning, build understanding, generate ideas and explore possibilities.
- We seek to **catalyse change**, and we have that vision for services too. We believe that it is for the individual to define and lead their journey, with services acting as supporters and facilitators of resources, expertise and networks that help both in the short and longer term.

Those core principles characterise transformative co-production across the globe, and bind us together with the efforts of thousands of others who have a vision for a fairer and more inclusive world in which all talents are valued and nurtured. Co-production is appreciative, collaborative, respectful and active. It is based on a belief that every one of us has something to offer for the greater good. It goes hand in hand with the values of recovery by locating both problems and solutions within a shared rather than individual context, and it facilitates personal agency.

POWER PLAY

These principles, brought to life through collaborative effort, form the foundations of co-production. However, there is one more essential factor in relation to co-productive impact. That relates to power. More specifically, the re-distribution of decision-making power within the relationship between provider and consumer, professional and person with lived experience of mental health conditions, practitioner and client. Three levels of co-production have been identified (Needham & Carr, 2009) – descriptive, intermediate and transformative. It is the balance of power between professionals and patient (sic) that determines and defines each of these levels, and it is the transformative potential of co-production on which ImROC is focused. We return to the theme of power later in the paper.

POLICY VS PRACTICE

So what of the practice in healthcare? Is this a passing fad? Is it really starting to happen?

The terminology is straightforward enough to adopt. The reality - changing the conversation, sharing power, recognising the limits of professional expertise, embracing diverse experiences and views, developing a shared narrative, and blurring the boundaries between those who provide and those who use services, and doing all of this through good times and bad - is as challenging as it is rewarding. Rarely does it slot harmoniously into well-established organisational practice and beliefs, which tend to be rooted in a deference towards professional status, knowledge and expertise, passivity and even gratitude. Rather, it unravels the order of things at a time of unpredictability and change when we all crave some kind of stability. Adding yet another layer of uncertainty, asking for some professional 'letting go' to happen when so much is already beyond our control feels as if it is too great a leap. Familiar chaos seems preferable to the unfamiliar, even if that does offer the possibility of something better. Despite ample good intention, co-production in public services, consistently, competently and committedly deployed to its full transformative potential, remains an aspiration for most of us.

Yet mental health communities across the UK and beyond are rising to this challenge and leading the way. The following case studies have been put together by people who are striving to co-produce in their local area, working within their local context. While we want to celebrate the good practice and commitment that the case studies represent, that is not our main aim in sharing them. Instead, we seek to illustrate the wide range of possibilities and challenges that co-production presents in real and living ways. The accounts that the authors share are about the realities of working differently, working against the prevailing norm, re-setting values and focus, unlearning and relearning. In current organisational language, being 'disruptive'. As in recovery, there is no end point. We value the journey and what we have yet to discover. This spirit of adventure and curiosity is at the heart of any co-production effort.

The case studies are broadly grouped according to scale, ranging from team to system-wide levels. As you read them, it may be helpful to reflect on the scale of the impact that each is having, and in particular the extent to which power is distributed amongst the people involved.

We begin by exploring a contentious issue about the feasibility of co-production at an individual level.

CAN YOU CO-PRODUCE WITHIN INDIVIDUAL WORK?

In the development of this paper, a debate emerged amongst the authors about whether co-production could take place within a therapeutic relationship between two people.

Many practitioners work in a person-centred and collaborative way during 1:1 sessions in their day to day practice. Those with recovery principles at the core of their work will be used to drawing on strengths, building hopes and shared solutions. Co-production may sound like business as usual. SCIE (2013) describes this as a descriptive level of co-production. Here, at a minimum, there is a degree of collaboration in order to achieve an outcome for the person in receipt of the service, and at its most successful, individuals are engaged in an active role or leading their own recovery.

Yet in our own work we all experienced 'co-production' at an individual level as very different from co-production at a group level. This led us to ask - is this really co-production? There are three theoretical principles which highlight why this may be debated.

1. Cahn's original work identifies the development of **social capital** as a primary outcome of co-production. It creates a community in which "people are valued for their contributions and discover they can rely on one another" (Rowe 1997). In this way, the outcome of co-production is of benefit to more people than those directly involved.

   In comparison, it might be argued that in a typical therapeutic encounter, the goals will focus on resolving problems and generating solutions for the individual. Certainly, this would have been the case in traditional psychiatry services. However, in a recovery-focused relationship, aspirations are not limited to symptom reduction but to the development of contributing roles and valued relationships within communities – thus increasing social capital.

2. The principle of **reciprocity and mutuality** is essential in co-production. All involved will learn and create something together which could not be discovered or achieved individually. The experience of sparking off one another, someone else's viewpoint revealing new truths and options and this being equally shared regardless of status, health or training. It might be argued that the limited nature of a relationship involving only two parties can hinder this possibility. It could equally be the case that a recovery focused relationship, in which boundaries between helper and helpee are more permeable, shared experience and common humanity are recognised and decisions are made together, each contributing a very different kind of expertise, is co-produced. Indeed, mutuality and reciprocity are founding characteristics, and essential for the full benefits, of peer support.

3. The corner stone of **building on assets** can be easily and visibly achieved as a group or team forms around a project. As the team witness others' contributions being needed and valued, a transformational process begins. Identities shift and people experiment with sharing ideas, questioning assumptions and taking on tasks. It might be argued that this process cannot be emulated in a dyadic relationship. Alternatively, the more equal relationship that takes place in a recovery focused encounter, where both the helper and the helpee put forward ideas, draw on different kinds of evidence, and share personal views in an open and evolving conversation, then solutions can be developed, refined and shared in a co-productive manner.

So perhaps in individual work, there is potential for a descriptive level of co-production to take place. However, we need to be sure to distinguish it as something more than a compassionate or fundamentally respectful human interaction. There is an active and generative quality to co-production which makes it distinct, recognisable and beneficial beyond those involved.

We are keen to stress that we see collaborative and shared decision making as key to any recovery-oriented therapeutic relationship. The question here is not whether there is value in working collaboratively, but rather whether work at this individual level is true to the nature of transformative co-production.

Case Study One: Co-Producing Within A Team – Developing a Training Package

Sue Barton, Deputy Director of Strategy and Change,
South West Yorkshire Partnership NHS Foundation Trust

In South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) we decided that we needed to really understand co-production if we were going to establish our four Recovery Colleges with co-production at their heart. So, we set out to co-design some co-production training that we could co-deliver to service users, carers and staff as part of our Recovery College curriculum.

We started by inviting a range of people to a workshop. This included service users, carers and staff (both from services and from our learning & development team). In the workshop we heard from colleagues who had been working co-productively for some time. They encouraged us to consider what strengths we each brought to the development of the training and how we might bring them together to help others understand what co-production was all about. We had some surprises when we identified our assets, and a sense of amazement at the wide range of skills and experience that we had at our disposal. We also lost our way a bit when we forgot to use all our talents, such as leadership and training design. A small group of people from the session volunteered to go away and pull together a plan for how the co-production training might look. We then invited the whole group back and delivered it to them, asking for comments and feedback which were incorporated into the training that went into the prospectuses. One key feature of this was that, as facilitators of the course (who were a combination of people with lived experience and people with professional experience), we removed our badges and asked the participants to do the same. We wanted people to bring all their assets to the learning, not just their expertise derived from living with a condition or professional training. Since then, we have delivered the training to both staff, students and partners within the Colleges. Each College has taken the training and developed it further as part of their overall offer.

We learnt a lot from this experience, including:

- We bring individual assets and some of these do not directly linked to our role e.g. a service user, as a teacher, had considerable experience of delivering training; a staff member had many creative ideas for how we might engage people even though this wasn't part of their current job role.
- Co-production is very different from service user-led approaches and for it to be successful we need to respect all types of experience and expertise equally.
- There are so many resources in the room when we intentionally identify them and collect them together, and that makes this work exciting and stimulating and the end product much better.

Case Study Two: Co-Producing Within A Service Line – Establishing a Recovery College

Lesley Herbert, Consumer Advisor - Adult Mental Health & Southern Health NHS Foundation Trust
Anna Lewis, Senior ImROC Consultant

Co-producing the Recovery College in Hampshire was a natural next step in a journey that had begun several years previously. Building on solid foundations (such as co-facilitated WRAP training, service user involvement and development of a 'consumer advisor' role as part of the management team), we drew together disparate strands of activity and established the College. With a modest additional budget and a few months to achieve it, we designed and recruited the workforce to reflect both 'lived' and 'professional' experience, secured premises, co-designed the curriculum and all aspects of its operation. We gave the work a high profile within the Division and organisation, and put it at the centre of our recovery effort as one of the six national pilot sites for ImROC. A group of people with diverse professional and lived experience, crossing several layers of organisational hierarchy, worked in partnership to lead the process and modelled the values and principles they sought to inspire in others.

The work was underpinned by our commitment to recovery, which we had brought into the mainstream of our Division's strategy and ethos. The longstanding passion and vision previously held by a small number of champions was now boosted by support from service leaders who had the authority to act. The sharing of power implicit within this new relationship was what made the possibility of co-production real. At every opportunity we spoke about our role in services in different ways. We used the language of strengths, assets, education, partnership and collaboration such that we reframed the concept of expertise to extend beyond the professional voice and the traditional treatment model. We began to redefine what it meant to provide good care.

We sought to 'walk the talk' in the College's development, at the heart of which was the employment of peer trainers within the team. While there had been routine service user involvement in recovery training previously, offering substantive peer employment opportunities to individuals was a significant step forward. Where people had previously been invited to share their story within professionally led and oriented training, the role of lived experience was elevated. Peers became equal partners with professionals in the design, development, delivery and evaluation of courses. They were recognised and valued as members of staff, subject to the same expectations and responsibilities as each other. Everyone took a courageous step into the unknown.

This was our first attempt at real co-production both individually and organisationally, and unsurprisingly it wasn't always easy. It was difficult to work in ways that were not the cultural norm, and it was hard work to reach a functional level of understanding of the goal amongst the organisation's leaders and other key influencers. We struggled at times to find a good balance in the new relationships. We were trying to bring the very best of our collective expertise and wisdom to catalyse new relationships and better outcomes, but it took time for us to learn what that really meant in practice. Indirectly we were also breaking down traditional hierarchical boundaries between us by taking an inclusive and mutually respectful approach. The work acted as springboard for many other co-productive efforts that have been pursued since.

We learnt so many things about ourselves and our services along the way. Here are three of them:

- Be ready to learn things about yourself and others that you could never anticipate. There are predictable challenges, and then there are subtleties about the dynamics in human relationships, intentionally constrained by the divides between 'professional' and 'patient', that are new, real, raw yet ultimately rewarding. This has a very real impact on the pace at which you can achieve cultural change. Making mistakes is part of the experience.
- Feeling OK that co-production doesn't equate to consensus, and that differences of views need to be accommodated just as in any other aspect of life. Having to make and be accountable for difficult decisions in ways which don't rely on falling back on positional power and honour the essence of co-production is way beyond the comfort zone of NHS convention and skill.
- We noticed that sometimes we were at risk of replacing one dominant power structure with another. Professionals took too many steps back initially and risked tipping the balance in the other direction. We learnt through experience that it is much harder to find equality in the relationship than it is for one to dominate the other.

Case Study Three: Co-Producing Within A System – Redesigning A Pathway of Care

Becky Aldridge, Chief Executive, Dorset Mental Health Forum &
Kath Florey-Saunders, Head of Mental Health and Learning Disabilities, Dorset CCG

In Dorset people had made us very aware that changes are needed within our mental health acute care pathway and we were keen to address this. Dorset has a mixed urban and rural population of approximately 750,000, with a diverse range of need. We wanted to approach the review of the current acute care pathway differently, and at every stage to co-produce options for a new model of care that would improve experience and equity of outcomes across the county.

The project, facilitated by ImROC and NDTi, started with co-production at its heart, by working with people with lived experience and other partners to design the first stage engagement plan and materials. Previous engagement work to gather views around mental health service provision had not been based on co-production principles. Co-producing the engagement process ensured that we would be able to connect with people in a way that was meaningful and resonated with them. Our engagement on this occasion was very successful and delivered over 3000 views from over 750 people. These views informed the work of the co-production modelling groups and the objectives that any new models of service needed to meet.

The co-production modelling groups included people with lived experience, their carers, statutory partner organisations and local NGOs, all working together sharing their knowledge, experience and expertise to build options that might address everyone's issues as far as possible within the financial constraints. The groups recognised the differences in experience and knowledge, without focusing on people's specific roles, ensuring together that there was an innovative and supportive environment for people to start sharing their power and taking responsibility as a collective group, for developing ideas that might work across Dorset.

During the modelling stage, the groups have looked at innovation across the world, considered significant issues in rural and urban areas and listened to challenges from both people who deliver services and people who access services.

This approach has helped everyone to learn and understand the whole picture in Dorset together, including experienced clinicians and people who have been accessing services for a long time. The co-production process has enabled people to consider and accept different viewpoints and to understand the broader picture and challenges.

During the process of co-producing options, people have become more confident in the commissioning process, provider organisations have been able to propose how they could deliver potential models of care and people who access services and their families have become active stakeholders in the design of future services in Dorset.

We have a long way to go, but co-production will be central to all mental health service reviews in Dorset moving forward. We are enriched as a result of this process and we will continue with this ethos and approach well beyond the end of this project.

We are continuing to learn throughout this experience. These are our reflections so far:

- Be willing to take more time at the beginning than you might think necessary. The foundation work with everyone who wants to get involved is essential to define what co-production is, what we want from it, and what skills we need to achieve it. This includes finding a common language in which everyone can participate.
- Establish a common understanding of the process, and the 'give and take' that it is bound to involve. This isn't about a single agenda triumphing over others. It's about working together, using the best of each other's talents, to find a constructive solution, and one that you probably can't envisage at the outset.
- It's empowering to work with empowered people! Sharing power can feel uncomfortable and unfamiliar, but it can also be liberating and hugely rewarding.

Case Study Four: Co-Producing Beyond Service Delivery – Audit & Evaluation at Sussex Recovery College

Louise Patmore, Patient Lead to Clinical Strategy SPFT
Senior Peer Trainer Sussex Recovery College & Sara Meddings, Psychology and Psychological Therapies Consultant Lead for Recovery and Wellbeing

At Sussex Recovery College we have developed a process for co-producing research, audit and evaluation. During the early development of the College, service users were keen that we demonstrate its effectiveness, so we asked how we would know if the college was successful. We drew together suggestions from people using mental health services, professionals and managers. We formed a task group to take this forward. Psychologists and researchers scoped methods of measuring what had been suggested. Service users then looked at the measures and advised about what to use drawing on their expertise about how people might experience them. One peer used her wider network to advise about language and readability. Having agreed the measures, we organised a workshop with student reps, peer trainers, professionals and administrators to decide what processes and systems to use. We decided to integrate the evaluation with the Individual Learning Plans so that the process was intrinsically useful rather than an additional task.

As the group and College expanded, pressures for efficiency increased. The co-production process slipped. This resulted in reduced engagement and incomplete audits. In response, we created a monthly meeting of students, peer trainers, professionals, researchers and College managers to focus on research and evaluation. We decide

together what research projects to suggest and what we would like to audit and evaluate. This group then oversees the research process. For example, students, commissioners and managers were keen that we look at whether attending the College reduced service use. A trainee psychologist is currently analysing this. They attend the co-production meetings, are guided by peers on how to go about evaluation sensitively, by researchers on robust statistics and methodologies, and by staff and managers on capacity and what is possible. The researchers gain supervision from the group and in turn provide what the stakeholders require.

We are not there yet but here are the lessons we are learning:

- We need to prioritise, critically review and strive to improve co-production. In a busy environment with multiple pressures, co-production and teamwork can slide. We have experienced this and the quality of what we have done has suffered.
- We need to invest adequate time in co-production and an infrastructure to support it. When we allow space, build relationships and invest time listening and including people, utilising everyone's assets, we have better suggestions for evaluation, achieve higher quality, shared ownership and increased participation.
- We need to acknowledge differences in power, try to build equality and redress the power imbalance. Genuinely appreciating the assets people bring is a start. We need to be prepared to accept decisions that leads do not initially want. Reasonable adjustments may be needed for equal participation. We need to be flexible, accessible and thoughtful about participants' experience of co-productive efforts so that we continually strive to improve it.

Case Study Five: Co-producing Throughout An Organisation – Developing Training for Central & North West London Corporate Services

Valerie Morrow, Recovery Programme Lead & Interim Head Occupational Therapist for Offender Care & Veronica Kamerling, Experienced Carer/Trainer

As part of CNWL's commitment to creating and sustaining a context of more equal 'partnerships in care' with our service users and carers, the Trust's Recovery Programme Lead worked together with a carer Peer Trainer to co-produce and co-deliver workshops for corporate colleagues entitled 'Redefining "user involvement"; co-production and partnership working'.

Initial thoughts around what might be included emerged from discussions in an ImROC-led 'What is co-production?' workshop. This led the facilitators to draw on further literature, in order that the workshop would enable a discussion focusing on strategic co-production within and external to the Trust.

The workshop aims were:

- To reach an understanding of what is meant by co-production, the challenges & the benefits.
- To adopt an approach which differs from more traditional involvement and engagement.
- To identify the processes & the structures that are needed to support co-production.
- To outline action plans which achieve effective shared decision-making.

We scoped the corporate services we wished to target. Time was one of the main challenges. We worked with

managers and their teams to understand their constraints, as well as emphasise the importance of the workshop, and we were flexible about how and when it was delivered to maximise participation.

A range of corporate services were included: Human Resource Managers & Recruitment Team, Occupational Health, Quality & Audit; including the Patient Support Service, Communications & Marketing, Programme Management Team, Trust Employment Services, Information Governance and the Serious Incidents Investigation Team.

Services were encouraged to identify areas already underpinned by "service user and/or carer involvement" before thinking together about how co-production could create new possibilities.

Participants were given an opportunity to identify the challenges of this way of working and how these concerns should be taken seriously. The inclusion of an action plan enabled participants to have clarity regarding the task they considered would be best co-produced and what skills and expertise they would be looking for in those who would co-produce. Teams were also invited to think about how peers would be recruited, selected, prepared, rewarded and supported.

Once this project gained momentum, requests for bespoke workshops started to emerge from operational, clinical and corporate teams across the Trust.

Lessons we have learned:

- Roll with resistance, try not to judge, and prepare to be surprised!

One of the most positive outcomes of this project was a greater understanding of how some individuals working in corporate services often feel far removed from the service users and families/carers we all seek to serve. The workshops offered staff a safe place to explore some of their own attitudes and prejudices about mental health issues and there was the sense of a new conversation beginning to emerge. This included honest conversations about concerns and anxieties, for example reliability of service users to engage consistently, confidentiality, and accountability for decision-making. Challenge and self-expression are vital for transformative co-production, as is broad engagement from a diverse range of people.

- Lay the groundwork, ensure "buy in" from senior management and invest realistic time in training and follow up.

We had not anticipated how difficult it would be for some services to come together for two hours. Investing time with Team Managers in an attempt to secure their "buy in" for the workshops paid dividends in some services. If the Team Manager was not perceived to be engaged and committed, staff members voted with their feet. It was essential to have the support of the Trust Recovery Lead and the Chief Operating Officer in engaging with senior managers and prioritising the training.

- Carers and families back on the agenda.

Co-delivering the workshops with a carer proved to be a very effective way of putting families and carers back into the consciousness of both corporate services and clinical teams. Veronica encouraged an open and frank discussion about the challenges of working with carers through her non-defensive delivery and excellent sense of humour. This facilitated teams to acknowledge how they often struggle to work with families and carers and seemed to inspire them to try a different approach. Through providing a space for a genuinely collaborative approach, participants were able to see that carers and service users bring a new perspective and may offer new ways of working.

Case Study Six: (Re) Building Lives in Rushcliffe – Co-Producing a system wide response to a key challenge in primary care

Julie Repper, ImROC Director and Liz Walker, Peer Support Lead, Nottinghamshire Healthcare NHS Foundation Trust

This project began when we were approached by a commissioner and a GP/psychiatrist from a local primary care Vanguard site to consider ways of supporting people with 'chronic' depression to rebuild their lives in their communities. We responded by turning to the local community for solutions. We arranged a meeting with more than 30 people representing different local community groups, services, mainstream resources, ambulance service, police, churches, carers …. We presented the challenge to the group and everyone volunteered some way in which they could help by drawing on their own expertise, resources and experience. We built on this by presenting some innovative service delivery models that had been shown effective in research on community development (social prescribing, community cafes, asset based community development, peer navigators, sports hubs…) and participants discussed each of these, then fed back ideas of how they might work in the local community. By the end of the meeting we had coproduced a 'framework' that everyone from the local community volunteering service, to dementia friendly communities, the Baptist church and the local fire brigade could sign up to: they could see a role for themselves and could imagine it working. This entailed peer workers employed within GP surgeries to link people with roles, relationships and activities in their communities; and the development of community cafes (funded by the church and staffed largely by volunteers) as a central hub for self management workshops, peer meetings, activities and mental health advice to take place.

This plan was successfully submitted for pilot funding and is now in the early stages of implementation. The model is strongly supported by the co-production group who are now meeting fortnightly to oversee the ongoing development, implementation and evaluation of the service. Numbers of participants are ever increasing as local communities see the benefits for individuals and for their overall community capital. This really is a triumph of co-production that demonstrates the huge rewards of working together. However, the challenges facing us as we all move forward together include:

- Inequality in contributions and rewards. Some participants give voluntarily and generously of their time and others receive payment (either working on the project as part of their salaried employment, or directly paid out of the project). Whilst successful co-production depends on contributions from all parts of our communities, paid and unpaid, rewarded and unrewarded, this does not make it acceptable or right. As our project progresses we will bring this topic up for careful consideration and debate by the co-production group.
- Sustainability. For as long as there is funding available then someone can be held accountable for co-ordination of the project, trouble shooting, ensuring proper governance, supervision and consistency of service. If funding ceases, then despite the majority of the service being provided voluntarily, it will not be viable. Evaluation of the service will need to focus clearly on cost effectiveness and return on investment to justify funding beyond the pilot stage.

Case Study Seven: Co-producing A New Urgent Care Pathway, West London Collaborative

Jane McGrath, Chief Executive, West London Collaborative

West London Collaborative (WLC) is an independent Community Interest Company (CIC) that uses authentic co-production to create and sustain meaningful working partnerships between the providers and commissioners of health & social care services, academic institutions and the communities they serve. Our partnerships utilise authentic co-production and disruptive innovation in operational and strategic areas of transformational change. In our work, all stakeholders learn how to share power and responsibility to solve difficult problems together. We use an assets-based community development model with the broader ambition that communities will become more healthy and empowered through becoming active citizens. WLC acts as a consultancy rather than a service provider, providing tools and frameworks that support local relationship building and networking. We expect our partners to be true partners - accepting mutual responsibility for ideas, solutions, success and failure. WLC was formed by service users, carers and staff of West London Mental Health NHS Trust after an event hosted by ImROC in 2013 – "From Service Users to Coproducers".

We work with the Trust both operationally and strategically. Projects are wide-ranging, examples including supported decision making in medication, through to local services transformation.

We have coproduced the urgent care pathway across three London boroughs, using social media to really reach out to the community and to staff that could not get to our event because of shift work. We used Twitter and built a micro-website 'Test My Story' where the whole community built complex scenarios to test the proposed urgent care model. We then hosted a forum theatre event where we live re-played the coproduced scenarios using digital technology and voted collectively on preferred responses. Police, ambulance, commissioners, liaison psychiatrists, GPs, front line staff, three NHS trusts and the wider community, attended the event. The day was broken into sections and stories so that busy staff could attend the sessions that interested them and we have since won an NHS England community grant to make a short film about the work.

We have identified some key learning since we set up. A horizontal model can be tricky in a vertical hierarchical organisation. The two models can butt up against each other and we can get stuck or meet pockets of resistance. Yet the value we bring beyond solving the complex problem is the process itself – reflective space, time to pause and new thinking and techniques for problem solving. As much as we meet resistance, we also meet amazing, passionate staff who are refreshed and encouraged by this new way of working. When in full flow and at its best, co-production is joyful. At its most challenging, there is pain and tears. As co-producers we strive to work collaboratively, moving away from 'them and us' positions, we use critical reflection, appreciative inquiry, dialogue and Argyris's Ladder of Inference (1990) to debunk assumptions. However, the fine line between critique and challenge is easily crossed, sometimes leading to conflict. People bring baggage. People want to challenge what is hurting them, much of which is happening in the context of austerity.

Challenging questions about poor data and unreliable evidence is uncomfortable. Before we can truly coproduce we need transparency and trust and to collectively distinguish signal from noise. This aspiration is still a work in progress for the NHS.

Co-production work often happens in disjointed silos, and behind doors in

selected phases. Local landscapes are vast and the systems complex, and staff churn at all levels is a recurring problem. To counter this, WLC now aspire to stay coproducing through the life cycle of a project, from the very first conversation where we establish what question we are exploring together, to the potential co-delivery of the service. We collectively accept when things were not perfect (for whatever reason) - but we absolutely name what could have been better… and we also celebrate our success loudly, making films, poems and hosting community events. It is progress we seek, not perfection.

DISCUSSION/THEMES

The case studies illustrate well our broader ImROC experience of co-production in mental health improvement work. What might these individual experiences, each encountered in their own unique context, offer us in terms of thematic learning that might be applied elsewhere? We now attempt to draw out an answer to this question, building on the principles of co-production outlined above. It is not our intention to advocate a 'lift and shift' approach to such learning. In other words, the learning is there to inspire, be thought-provoking and give rise to new conversations in your own unique setting and circumstances. It is not offered as any kind of short circuit or quick fix to the application or experience of co-production. The notion of a 'journey', while much over-used, is nevertheless an essential metaphor in the understanding and experience of co-production. Making mistakes is part of the experience, and in the long term has the potential to strengthen and mature relationships and their effectiveness.

Every co-production journey begins with a leap into the unknown. While our case study authors may not explicitly articulate this, there can be little doubt that each entailed a courageous step into something unfamiliar, unexperienced, and untested, working against the well-established norms in the culture of the organisation and its ways of working. These steps were taken in times of significant pressure, in which the scope to make a mistake or fail is very limited for organisations and therefore their workforce. This requires a kind of **leadership** that is underpinned by a set of values and beliefs that are not typically nurtured in a professionally-dominated culture. Often that leadership departs from the hierarchical definition and comes from the grassroots. The pioneers of this work show courage, tenacity and resilience on a daily basis, spurred on by a belief that working in equal partnership is at the heart of any recovery-oriented mental health service. Living with the discomfort of ambiguity and uncertainty is a necessity.

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*"**Living** with the discomfort of ambiguity and uncertainty is a necessity."*

Thus 'holding the space' for effective co-production to take place, safely and without fear of reprisals, within an environment or culture which unknowingly can work against it, is a vital responsibility for the leaders of the work. There is value in having a leader or ally who can build the bridge between the prevailing and desired cultural norms, in ways which seek to include others in that task. For example, if someone brings positional power in aid of a more distributed vision for leadership, then that is their asset to value and nurture in the co-productive relationship.

"Learning through co-production complemented the notion of learning or improvement in the end result"

On a related theme, the process of co-production is **strengths-based**. The values and techniques are appreciative, inclusive, assets based, and ambitious. They recognise the unique contribution and worth of every individual. They give voice and focus to ideas, creativity and passion that have traditionally been excluded. Yet as our case studies illustrate, this is not always an easy path to tread. The baggage gets in the way, causes pain and conflict, and can leave people feeling anything but appreciative. This is the cue not to desert the approach but to reinforce it. The way in which the space is shaped is vital to the resilience of the effort to do something better. So the process of co-production is at least as valuable as the outcomes it delivers or problems it solves.

Time is a recurring theme. In highly pressured working environments, in which it is faster, and arguably more predictable, to do what you have always done than it is to try something new, carving out the time and space is difficult. Permission to do so may also be difficult to achieve when the desire for rapid results is pressing from above. The fast pace requirement for 'delivery', amongst multiple competing demands, creates an impatience which is understandable yet not conducive to innovation. Developing new skills, forming new habits and testing out new approaches take time and are exposed to threats from the daily grind and very well-entrenched ways of thinking and working. Co-producers identify time, and implicit within that a tolerance for making reasonable mistakes and needing to repeat stages of an improvement process, as key to their progress and impact.

*"The preparedness to share power and responsibility, or even to nurture the environment in which **power** can be taken, is requisite in every co-production experience."*

Breaking down barriers between providers and consumers of services, which have served all kinds of purposes in the past, is an essential endeavour within co-production. The preparedness to share **power** and responsibility, or even to nurture the environment in which power can be taken, is requisite in every co-production experience. It can be particularly challenging in the early stages when the new relationship and patterns of behaviour have not yet matured. This is a common experience through ImROC's work. Dedicated professionals, confronted with the realisation that aspects of their training, practice and culture have been at odds with a more inclusive and appreciative approach, may 'back off', feel invalidated and even become apologetic for their role. The latent holding of power in a relationship may in itself be difficult to identify and then confront in oneself, especially when intentions are honest and come from a place of care and compassion. Intellectually the professional may have that 'light bulb moment' but the emergence of new behaviours, attitudes and practice comes as a result of a series of trial and error, success and failure, unlearning and relearning over time. This reinforces the importance of safe space in which people can explore their journey together and individually, in ways which enhance and validate the new practices, rather than work against them.

*"**Leadership** that is underpinned by a set of values and beliefs that are not typically nurtured in a professionally-dominated culture"*

For those with lived experience, there may also be challenges in engaging in this new kind of relationship. The vivid and intensely personal story of each individual has the power to engender change for the better, and it is an act of courageous generosity to share it. That is not to say that the story alone will make the difference. Co-production is not about swapping one dominant power base (that of the professional) for another (that of the person with lived experience), although we see this in our work as a common misconception. While of course there is a place for user-led services, this negates the value of equal partnership that comes about when diverse experience gained through professional training and through life is respected, pooled and put to work. This notion of collective wisdom, underpinned by a shared humility and humanity, and with it collective responsibility for outcomes, provide the foundation for co-production.

In a similar vein, the basis on which co-producers engage with each other needs to be fair, honest and transparent. In seeking equality, it is important to generate a shared understanding of individual contributions, and avoid drawing distinctions on the basis of traditional labels of 'professional' and 'patient'. It is incumbent upon all concerned to hold each other to account for the contributions expected and made, making 'reasonable adjustments' without straying into 'making allowances'. Implicit within co-production is the avoidance of 'othering' – labelling difference between individuals as a legitimate basis for exclusion, separation or special treatment. Each person, regardless of their label or status, is treated equally. That means taking the rough with the smooth. To do otherwise simply reinforces the othering that divides and labels people on the basis of deficits rather than assets. In short, we have mutual expectations and we hold each other to account for those in the pursuit of fair and equal partnership.

The shifting dynamics in a co-productive relationship may feel harder to achieve when there is an established relationship akin to traditional engagement or involvement of service users, that has long been popular in mental health services. While the track record of user involvement may offer a useful building block for a more sophisticated relationship between different constituencies within services, co-production represents a step change in the way we work together and should not be perceived as anything less. The legacy of traditional engagement can be a barrier as much as an enabler.

"To stay coproducing through the life cycle of a project, from the very first conversation where we establish what question we are exploring together, to the potential co-delivery of the service."

A common hindrance to this sense of equality is the differential terms and conditions, and particularly remuneration, that remain amongst those traditionally distinct cohorts of contributors. The differences in remuneration between 'professional' and 'patient', and sometimes the difference in contractual employment status or tenure, do not speak to an equal valuing of expertise. This is a barrier that is likely to take some time to resolve, as lived experience grows its prominence in the mainstream workforce.

> *"Co-production doesn't equate to consensus, and that differences of views need to be accommodated just as in any other aspect of life. Making mistakes is part of the experience"*

The process of co-production is a **voyage of discovery** and thus is embarked upon in a spirit of adventure. While people come together around a common intent, the nature of the journey you will take, and even the destination you may reach, are yet to be discovered. It is an **emergent** process full of possibilities, guided not by a highly-specified goal but by a willingness and commitment to try something different in the interests of a common desire. The process is revelatory, drawing out strengths and resources we didn't know we had or couldn't recognise in ourselves. It helps us to understand our individual and collective contributions with much greater clarity and purpose. This feels quite distinct from the more conventional means by which we pursue goals or activities in services.

All of the case studies featured examples that involved doing something new or innovative, in which the notion of **learning** through co-production complemented the notion of learning or improvement in the end result – such as developing a Recovery College or redesigning a care pathway. In other words, the idea that we can achieve something better together wasn't limited to the design of a new initiative, but it carried on through into implementation, delivery and evaluation.

These ripple effects are often described in the process of cultural transformation that we witness in ImROC. Contrast this, however, with a common frustration that scaling up the impact can be very difficult to achieve.

As well as the many positives illustrated by our case studies, they show equally that our aspirations are not yet fulfilled. ImROC's work has been grounded, purposefully and intentionally, within the realms of mental health service delivery in large organisations. Recovery Colleges, in particular, have been at the heart of our co-production work. Over the last couple of years, we have been taking deliberate steps to broaden our focus. Cahn's 'core economy' includes families, friends, neighbours and local communities - all assets which are not universally visible in the activity that the case studies describe. That is not to say that what we are witnessing is not co-production, rather it is an acknowledgement of the potential scope for strengthening our **community impact**, moving beyond a service to a community focus, as WLC has done from the outset – from seeing people as defined by their relationship to services to seeing them as citizens first. Just as co-production is a journey of exploration and discovery, so ImROC as a community of practice reflects this. It is timely that we consider our role and contribution and that we increase our focus ever more on supporting people to have lives rather than services. In order to achieve this, we are actively developing new partnerships and stepping beyond health and social care into citizen spaces.

OTHER OBSERVATIONS IN IMROC'S CO-PRODUCTION WORK

Co-production can achieve **outcomes** that spread beyond the core brief of a project or other effort. It creates and taps into communities of engaged and active participants. Boyle (2006) identified 'clear links between involvement in time banks and reduced levels of medication and hospitalisation' and (in 2010) suggested "savings of up to six times the investment made in new approaches". People attending Recovery Colleges form peer support networks and become more active community participants. The extent to which these individual benefits can be measured and aggregated across groups, and then attributed in terms of cause and effect is problematic, however. As such, the scope to predict and quantify outcomes is limited, at least within the prevailing narrative that revolves around narrow commissioning briefs and funding flows which fail to capture the rich and diverse ways in which lives are improved. Making the co-production case to sceptics is made more difficult as a result. ImROC is supporting RECOLLECT, a three-site study in 2017 investigating key components and change processes supported by Recovery Colleges, and understanding who uses them. Co-production is emerging as a central and influential component of Recovery Colleges. More information on the RECOLLECT Study is at researchintorecovery.com/recollect.

Retaining **fidelity** to the principles of co-production while embedding or scaling up co-productive efforts is a common challenge. It can become a victim of its own success, rendering itself invisible through its normalisation and business as usual. At the outset of the journey, there is a deliberate and mindful focus on this new way of working, accompanied by an understanding that it takes investment of time and attention to succeed. As it becomes less new and more familiar, it is easy to assume that it will take care of itself. Instead it becomes vulnerable to an unconscious neglect and degradation. In our experience, this is felt as a loss of enthusiasm, direction, priority or connection. Being able to pre-empt this risk, or at least identify it quickly, is key to limiting its negative impact. Co-production is all about relationships, and so like any other, it requires nurturing attention to remain healthy and effective.

It is also the case that many decision-makers will actively choose to hold specific co-produced projects on the safe periphery of an organisation's operations, pursuing low key efforts that have no major consequence if they slip or fail, and that pose no great challenge to the prevailing power dynamics. There is no intention to allow this ethos any closer to mainstream ways of working or organisational beliefs and value systems. Whilst we advocate starting small and working with what you have (which may well mean something around the edges initially), we see this as a tactical approach which creates a springboard into more substantial and transformative change that confronts traditional hierarchical power bases, rather than a glass ceiling of possibility. Co-production is neither a 'task and finish' endeavour, nor a fair weather pursuit. It should not be attempted in a 'start/stop' style. Its full potential is realised only through an absolute commitment to its principles and practice throughout an organisation, group or community, which means that it is there at every single stage of a project's life. That commitment is unlikely to emerge at the outset and champions on the ground shouldn't feel the need to wait for it, but it should be the goal and focus for any strategic effort, in order to reach into and discover the transformative realms of possibility that co-production offers.

Finally, there is a **celebratory** sense about co-production. The value achieved through co-production, to the individual, the team and ultimately to a community, brings hope and pride rarely seen in more traditional approaches to improvement. The 'feel good factor' associated with working through challenges, making errors and resolving them together using an assets-based mentality is energising for disillusioned professionals and people with lived experience of mental health conditions. Yes, it can be messy, frustrating, and exhausting. Yet the experience is ultimately validating, enriching and life-affirming. It offers opportunity for personal growth. The sense of discovery, helping each other to find out what we are really good at and then using that towards a common hope, energises us for the more testing aspects of co-production. To quote WLC, 'we seek progress, not perfection'.

TOP TEN TIPS FOR CO-PRODUCTION

1. **Gather the right people for the job**. Identify key stakeholders for an initial meeting to discuss the challenge and use this group to generate a network of peer, family member, personal and professional expertise offering a diverse co-production group with relevant skills, knowledge and experience. Identify all of the assets in the room (not only those related to their role). Be prepared to invite new individuals and/or ask for advice and contributions from other relevant groups. Allow free movement so that people can choose to join after it has started or choose to leave if they feel it is not for them. Make this an inclusive experience. It's important to avoid the perception of cliques often associated with conventional methods of 'involvement'.
2. **Just get started and build momentum around your shared purpose**. Don't wait for the perfect moment, or the perfect set of people but build momentum and expertise around your shared purpose and understanding of the process. This will act as an anchor when things get tough.
3. **Spend time agreeing the structure and the values of meetings**. This may involve assigning a leader or facilitator; discussing the rights and responsibilities of members and considering how everyone can both 'give' or contribute to the task as well as 'take' or benefit from their engagement. Ensure that everyone understands what decision making power lies within the group.
4. **Support every member to contribute to their full potential**. Nurture, support, offer learning opportunities, make necessary adjustments and enable everyone's voice to be heard. Take an even-handed approach across the group, adapting according to need, not label – avoid the temptation to 'other' those who may be less experienced or confident in the setting.
5. **Tackle the challenge in small steps**. This process will create new ideas, present new challenges, suggest new solutions which require further exploration. Test lots of ideas. Make it safe to fail. It is not possible to work to a predefined set of outcomes in a predetermined time frame.
6. **Listen, listen, listen**. Co-production will only achieve its full potential if every member is prepared to listen and learn, see different perspectives, try new ways of thinking and consider new ideas. It is important for everyone's voices to be heard, so members will need to gauge their input so that those who find it more difficult to speak up have that opportunity. However, the overall 'culture' of the group is one of valuing everyone's contributions and genuinely exploring their utility in the given context.
7. **Back up decisions with evidence**. One of the concerns about co-production is that any decisions will be based on personal experience rather than 'hard evidence'. The challenge for the co-production group is to back up personal experience with research that demonstrates this goes far beyond one individual. This does not need to be large scale statistical research; accumulated personal narratives, qualitative research and routinely collected data that can be used to demonstrate a level of need or the efficacy of a suggested approach. It is also possible to increase authenticity and credibility by 'sense checking' certain aspects with a wider audience.
8. **Beware the comfort zone.** Keep a watchful eye to avoid slipping back into old familiar ways, and be mindful of the triggers – such as challenging conversations, differences of opinion, or external pressure to deliver. Be willing to talk openly about this, and regroup around your shared purpose. This is a particular challenge when you increasing the scale of the project – this rarely happens easily or smoothly but needs careful attention.
9. **Look to the bigger picture**. Consider how your project can influence behaviour, attitudes and outcomes in the wider system. Grasp opportunities to lead others. Even better, create them!
10. **Cherish what you create**. Co-production comes from the heart. You are building a community like no other. Recognise and embrace its value, strength, wisdom, and potential. Nurture it, celebrate it, love it. It will reciprocate in spades.

CONCLUSION

Co-production, and the values and beliefs that underpin it, offers communities and individuals a sense of hope when many other sources of inspiration feel endlessly lacking. More than that, it offers real and achievable solutions to challenges which are increasingly proving too great for conventional means of problem-solving, orchestrated by and mobilised through professional expertise.

Our case studies cast a light on what is possible when people with diverse backgrounds and experiences come together with an open mind, and draw out expertise in each other towards a common vision or passion. The examples are easily accessible and we think anyone can give them a go. We have used tangible and routine outputs, like developing a training programme or evaluating a service, to frame a much more significant story of transformation. It is a story anchored in a belief that every person has something valuable to give, and that each derives value in return. This is the message that sets these stories apart from others. That is the ethos and expertise on which their success has been founded. We believe these stories are representative of a growing movement of grassroots change in communities around the UK and beyond. None of us believe this is a 'job done'. In fact, it is a job just started.

As we develop our contribution to this movement through ImROC, our focus is moving beyond our origins in the mental health community, to embrace the wider world of community wellbeing. Improving mental health has a far greater reach than improving mental health services, and it is in this mission that we seek to unlock the full potential of co-production, as yet unknown and undiscovered by any of us.

GET IN TOUCH

We hope this paper provokes conversations and we would love to hear what you think. If you would like to offer feedback, or would like to support us in our co-production journey, please email imroc@nottshc.nhs.uk or call 07392318188.

REFERENCES & RESOURCES

Alford 2002 Alford, J. (2009) Engaging public sector clients: From service-delivery to co-production, Basingstoke: Palgrave Macmillan

Bovaird, T. (2007) Beyond Engagement and Participation: User and Community Coproduction of Public Services. *Public Administration Review.* Volume 67, (Issue 5) 846–860

Boyle, D. (2004) Is this How to end Public Service Failure? *NewStatesman.* Feb 23 2004 accessed at: http://www.newstatesman.com/node/194958 on 2 Nov 2016

Boyle, D. and Harris, M.(2009) *The challenge of co-production: How equal partnerships between professionals and the public are crucial to improving public services,* London: National Endowment for Science, Technology and the Arts.

Boyle, D., Coote, A., Sherwood, C. and Slay, J. (2010) *Right here, right now: Taking co-production into the mainstream,* London: National Endowment for Science Technology and the Arts.

Boyle, D., Slay, J. and Stephens, L. (2011) *Public services inside out: Putting co-production into practice,* London: National Endowment for Science Technology and the Arts.

Bradley, P. & Willson, A. (2014) *Achieving prudent healthcare in NHS Wales (revised).* Cardiff: Public Health Wales

Cahn, E. (2001) *No more throwaway people: the co-production imperative* (Washington DC: Essential Books).

Frost, D. and Stenton, S. (2010) *Learning to Lead: The story so far.* Available at: http://www.learntolead.org.uk/wp-content/uploads/2013/11/learning-to-lead-the-story-sofar.pdf.

Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health.* London: NHS England.

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

Ostrom, E. (1996) Crossing the Great Divide: Coproduction, Synergy, and Development. *World Development,* Vol. 24, No. 6, pp. 1073-1087.1996

Repper, J and Perkins, R. (2013) The Team Recovery Implementation Plan: a framework for creating recovery-focused services ImROC Briefing Paper 6. London: Centre for Mental Health and Mental Health Network, NHS Confederation.

Rowe, J. (1997) Money with care built in YES!. *A Journal Of Positive Futures* Spring 20-25 accessed at http://www.yesmagazine.org/issues/money-print-your-own/the-basic-function-of-money 5.6.15

SCIE's Co-Production Strategy, accessed at http://www.scie.org.uk/coproductionnetwork

Scottish Co-Production Network, accessed at http://www.coproductionscotland.org.uk/ on 1 Nov 2016

Slay, J. & Stephens, L. (2013). Co-production in mental health: A literature review. London: new economics foundation

Social Care Institute for Excellence 2013. Co-production in social care:What it is and how to do it. Guide 51, London: SCIE

Stephens, L., Ryan-Collins, J. & Boyle, D. (2008) Co-production: A manifesto for growing the core economy, London: New Economics Foundation.

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Toni King is Trust Lead in Recovery & Peer Workers at Solent NHS Trust, Clinical Teaching Fellow at University of Southampton and an ImROC consultant. She is inspired to work in this area by the many people she knows who do difficult things and are brave enough to share their story. Some raise money, some raise hope, all have motivated her to keep learning and questioning her own practice and the systems in which she works.

Lesley Herbert has a track record of striving for the true essence of co-production within mental health, driven in no small part by her concurrent personal and professional relationship to services. She is continually struck by the parallels between her personal recovery and the processes of co-production. She would describe it thus: It's a hard slog, but there are moments of beauty and wonder along the way that make the effort seem, even if briefly, more than worthwhile....

Thanks to all contributors for sharing their experiences so willingly, and to the fantastic ImROC team from whom we learn every day.

And to Ostrom and Cahn for giving us a language, a set of principles and concepts which are helping mental health services the world over bring their values to life in ways that have never before been thought possible.

ImROC's Vision

For systems, services and cultures to support Recovery and wellbeing for all locally, nationally and internationally.

ImROC's Mission

ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. ImROC has been leading the way in recovery-oriented service and practice improvement since 2011.

Originally established on behalf of the Department of Health to champion its 'Supporting Recovery' initiative, through a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, ImROC is now hosted through Nottinghamshire Healthcare NHS Foundation Trust. This innovative new partnership allows us to cement our close working relationship with frontline providers of care, ensuring that our work remains relevant and useful to practitioners, managers, system leaders, local communities and ultimately, the people who access services.

Our role is about enabling people (who use services, work in services and live in communities) to unlock and pool the strengths and talents they take for granted, explore new ways to make use of them, share knowledge and learning, and facilitate recovery-oriented improvement in the outcomes and experience of health and social care. We rely on and embrace the expertise, experience and collective wisdom of everyone we work with, and encourage communities to develop as a result. Our job is about using our expert knowledge to inspire others to believe that change is possible; pursue their dreams, and most importantly to act: changing attitudes and behaviours. This ethos of working in co-production is at the heart of our organisational work, and role models what we seek to achieve at a practice level too.

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