Working Well Together

Evidence and tools to
enable co-production in
mental health commissioning

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Contents

1   Introduction

1.1 Background

One of the key recommendations of The Five Year Forward View for Mental Health[1] called for the development of evidence-based approaches to co-production in commissioning (see Box 1).

Since then, the NHS Long Term Plan[2] has also committed to 'doing things differently' throughout the healthcare system, backed up by increased funding for mental health care. It encourages collaboration among people, primary care and community services, commissioners and clinical commissioning groups (CCGs), and between services and trusts. The NHS also promotes co-production in mental health care through personalised care plans, which give people more control over their health and care. Overall, the NHS Long Term Plan's pledge to 'do more to develop and embed cultures of compassion, inclusion and collaboration across the NHS' means that co-production in mental health care commissioning is vital and achievable.

The National Collaborating Centre for Mental Health (NCCMH) was commissioned by NHS England to build an evidence base for co-production in mental health commissioning using both documented and undocumented case studies.

Box 1: The Five Year Forward View for Mental Health – recommendation 8

'NHS England should work with NHS Improvement to run pilots to develop evidence-based approaches to co-production in commissioning.'

1.2 Purpose and scope of this document

By setting out the evidence, including examples of positive practice, this document aims to improve local strategic decisions about, and the provision of, current and future mental health services for children, young people, adults and older adults. This includes people who are not in contact with mental health services, because of existing barriers to access or for other reasons. This document also talks about co-production with people who are in at-risk populations, including those who have an increased risk of being detained under the Mental Health Act 1983[3] (amended 2007[4] and by the Policing and Crime

Positive practice examples are accompanied by the positive practice star. See Section 5 for full information on the positive practice examples in mental health commissioning.

Act 2017[5]) and people who may face discrimination because of their protected characteristics (see Section 1.5 for more information on protected characteristics and inequalities).

The recommendations from this document are aimed at commissioners of mental health services, and will also be relevant for the following in mental health:

- drug and alcohol (addiction) services
- health professionals and other staff in contact with people with mental health problems within healthcare settings
- physical health services including acute, primary and secondary care
- people who need mental health support, and their families, friends and carers[a]
- service providers
- voluntary, community and social enterprise (VCSE) organisations.

This document will support commissioners in end-to-end co-production, providing guidance and tools for co-produced commissioning, practical recommendations for each step and ways of measuring the effectiveness of the process. It includes key co-production principles for creating measurable standards, describes the existing evidence gaps and identifies examples of positive practice.

1.3 Current context for co-production

Public involvement has been central to NHS ambitions for many years.[6] The NHS Constitution for England holds public ownership in high esteem, declaring that the NHS is accountable to the public and that those who may need to use NHS services should be involved in their development and improvement.[7] In addition, the Children Act 2004,[8] Health and Social Care Act 2012,[9] Care Act 2014[10] and NHS England's Patient and Public Participation Policy[11] all require CCGs, local authorities and NHS England to embed public involvement and

[a] Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and includes those who care for people with mental health problems, long-term physical health conditions and disabilities.

consultation in the commissioning of health services. Section 3.2 discusses levels of participation in co-production in England; although these efforts rarely reach the level of genuine co-production, they provide a strong foundation and tradition on which to build.

1.3.1 Current levels of public engagement

A review of patient and public involvement showed that many clinicians consider patient satisfaction questionnaires part of co-production,[12] and that these kinds of consultation exercises are the most commonly reported method of engagement.[12,13] However, such consultation represents a low level of involvement and does not constitute a co-production partnership (see Section 3.2). Also, this method does not allow organisations or commissioning bodies to explore ways to modify their practice. Using this method alone also excludes people with unmet needs, especially those who are not in contact with mental health services. These different understandings of engagement and co-production may have contributed to the development of different co-production models (see the helpful resources in Section 6), which in turn may have caused confusion around what constitutes best practice. This document uses existing models and available literature to clarify the key aspects of best practice and to provide the basis for a common understanding.

Helpful resource

Ladder of Co-production

Think Local Act Personal

1.4 Co-production: terminology and language

1.4.1 The importance of language

Language is the first step to creating the potential for a transformative co-production journey. Using terms that are not understood can be off-putting and limiting for many participants and some terms may even unintentionally exclude people, so the language used during the process is crucially important to successful co-production.

1.4.2 Agreeing on preferred terminology

It is a valuable exercise to explore preferred terminology at the beginning of any co-production process and develop a shared understanding among the group.

People's contributions add up to be like a jigsaw. Each person is like an equal-sized piece but they all have to come together to form a whole and meaningful picture.

Expert by Experience

Although using jargon and acronyms is often discouraged, it must also be recognised that there may be a breadth of experience within the group you engage with. Some people may already be familiar with many commissioning terms, so it is important to identify terms that are understood by everyone. Use of commonly understood language in the group can empower people and help everyone feel like they have the same platform to share, be heard and make valuable contributions. See Box 2 for more about preferred terminology.

1.4.3 Definition of co-production in mental health commissioning

For the purposes of this guidance, the Co-production Working Group (see Appendix A for members), which included people who have used mental health services, carers, and commissioners and providers of mental health services, co-produced the following definition:

> Co-production is an **ongoing partnership** between people who design, deliver and commission services, people who use the services and people who need them.

The Co-production Working Group also agreed on the following wider definition of co-production:

Box 2: Talking with people

People may have different feelings about being called 'service users', 'survivors', 'experts by experience', 'citizens', 'people with lived experience' and so on – all of these terms can make some people or groups feel excluded. Using 'person' or 'people' is more inclusive but does not distinguish what makes their contribution important and unique.

Any co-production process should therefore include discussion of labels and agreement around the terms that participants prefer.

Wider definition of co-production

Co-production should **flatten hierarchies** and **promote respect**, while acknowledging and **making the most of the experiences and skills** of people with mental health problems, and of their families, friends and carers.

Everyone should have an **equal opportunity** to contribute value to **decision-making** throughout the co-production process. Positive outcomes in co-production need a **culture change** in which people no longer perceive each other as 'us and them', but as **us together**. Everyone involved should have the **same level of control and choice**, throughout the process, where appropriate and required.

Co-production should be a **continuous journey** over which the successes and mistakes of individuals and the whole group lead to **learning**. Co-production needs to **take a flexible approach** when **engaging people** and **working together as a team**.

Everyone involved in the co-production project should continue to be involved in its **evaluation**. Ongoing **improvements and adaptations** can then be made based on the feedback. All of the people involved should have access to **support**, **training**, **resources**, and **recognition and reward**.

1.5 Advancing mental health equality

There are inequalities in access to and outcomes of mental health support, care and treatment, particularly for people who have one or more protected characteristic (see Box 3).

Tackling and reducing mental health inequalities should always be at the heart of service planning, including explicit strategies to learn about local communities, engage with them and encourage their participation. Any strategy should be regularly revisited and reviewed, then updated, to ensure there are no gaps.

1.6 How this document was developed

1.6.1 Background

NHS England asked the NCCMH to co-produce this document with a Co-production Working Group. This included national advisers from around England with a breadth of personal and professional experiences in mental health care, healthcare, mental health commissioning and co-production.

1.6.2 Gathering the evidence

The Co-production Working Group reviewed the existing evidence on co-production in statutory and VCSE organisations, and contributed to the writing of this document. They developed a survey (survey questions can be found in Appendix B) to gather examples of positive practice. The survey responses included international entries as well as responses from around England. Responses were screened for relevance and applicability against the principles of genuine co-production. They were then used to generate the solutions to challenges in co-produced commissioning, and describe what those solutions are intended to achieve (see Section 2). From all responses, eight positive practice examples were identified and asked to provide more detail (the additional survey questions can also be found in Appendix B). Four commissioners responded with more information, and Section 5 contains information on those positive practice examples.

Box 3: Some characteristics that may increase the risk of experiencing inequalities

The nine protected characteristics (Equality Act 2010)

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- gender
- sexual orientation

Other characteristics

- socioeconomic status, including social exclusion and deprivation
- refugees and asylum seekers
- migrants
- looked-after children
- homeless people
- prisoners and young offenders
- traveller communities
- veterans.

1.7 The key principles of co-production

The six principles in Table 1 were developed by the Co-production Working Group, including experts by experience, carers, commissioners and providers. These principles were selected as fundamental to supporting co-production in mental health commissioning, based on people's views and experiences.

Table 1: The six key principles of co-produced commissioning

C	**Celebrate involvement** – All types of involvement are important and fundamental to the process, and should be celebrated at each stage and be received with an open and fair approach. Co-production is a continuous process rather than an aim or event and there should be ownership, understanding and support of the process from everyone involved throughout.
A	**Adaptable** – The approach to co-produced commissioning should be adapted to ensure that the community of interest's* voice is heard at every level, ensuring that inequalities are identified and addressed throughout.
R	**Resources** – Co-production should be built into every level of work programmes and business plans and resourced as a fundamental integrated part of the whole commissioning process. There should be a dedicated member of staff to champion co-production in practice.
I	**Influence of power** – There should be a collective understanding that acknowledges the power of individuals and organisations, the influence it can have and the perceptions it can lead to. A culture of honesty, value and respect should be fostered, with each person being committed to sharing power and taking responsibility for the decision-making they take part in.
N	**Needs-led** – Accessibility is fundamental to co-production, so people's needs should be considered and any barriers minimised. This includes consideration of the location of meetings and events, travel to and from venues, and preferred methods of communication. Terminology should be discussed and agreed at the start, and communication should always be clear and available in agreed formats. The environment and space must also be accessible, inviting and supportive of the overall values of co-production. The environment needs to foster creativity, courage and curiosity, so that everyone present has an equal opportunity to be involved.
G	**Growth** – Quality assurance needs to take place to maintain, improve and grow the co-produced commissioning process as well as the quality of services. This should be evidenced through outcome measures.

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* A community of interest is a network or group of people who share the same interest and aim – in this case, to create good quality mental health provision. This shared interest may not extend into other areas of their lives, but they will be focused on working together towards the commissioning of mental health services.

2 Solutions to the challenges of co-production

The journey of genuine co-production requires **effort, planning and resources**. At the start, co-production can be perceived as a risk, which may overshadow the potential of its positive impact. Therefore, it is essential to map out internal and external challenges and barriers, and to talk about overcoming them together. For example, co-production in rural areas will likely require people to travel greater distances to participate. Therefore, travel, hotels and other relevant expenses should be paid where possible – this requires planning, communication and action.[14,15]

Before exploring how to do co-production in mental health commissioning, Table 2 outlines solutions to challenges that everyone involved in co-production may face. It then describes the outcomes that are expected to result from acting on the solutions. The 11 solutions in the table are referenced at relevant points throughout this document.

The content of Table 2 was derived from the feedback of 39 commissioners who had responded to this project's survey (as described in Section 1.6.2). The commissioners described challenges they had encountered, the solutions they had used to overcome them and what happened as a result. The Co-production Working Group analysed this information alongside existing research and generated the following table. The items in the table are numbered for reference purposes and are not in order of importance or the time point at which they would occur.

> **Helpful resources**
>
> The Fifteen Steps Challenge: Quality from a Patient's Perspective – A Guide for Commissioners
>
> *NHS England*
>
> How to Estimate the Costs of Public Involvement
>
> *East Midlands Academic Health Science Network*
>
> Commissioning for Outcomes and Co-production
>
> *New Economics Foundation*

Table 2: Solutions to challenges and barriers in co-produced mental health commissioning

	Challenge	Possible solution	What will this achieve?
1	Lack of sign-up at system-level for genuine co-production and working together	Discuss co-production widely and encourage the whole system to adopt a recognised co-production approach that best meets the needs of the task at hand. Use the chosen approach to develop a shared message and goal that all people can subscribe to.	The organisation will have a clear and consistent message about what co-production is and will have core co-production development processes in place.
2	There is not enough time to dedicate to co-production	Encourage all stakeholders to recognise the value of co-production, particularly in saving time later down the line. If something is commissioned properly the first time and truly meets the needs of the community, it will prevent all stakeholders having to go back to the drawing board.	Even if more time could have been dedicated to co-production, starting early and continuing throughout will ensure that some value is derived from the process and that it is not tokenistic.
3	Difficulty in making the case for co-production to staff in environments that haven't embedded it yet or are resistant to change	Educate people on the value and benefits of co-production using the evidence and tools available. If co-production is not embedded, a first step in the right direction would be to obtain commitment from all parties, particularly from senior leaders.	All people who enter the co-production process will come with an open mind, ready to welcome ideas and innovations from all members. The culture will begin to move towards one that embraces co-production and values partnerships and equality of opinion.
4	Confusion about what contributions are expected of people	Be clear from the outset about the parameters of co-production (and the reasons for them), what type of co-production is being practised, and how you would like people to engage with the project. Engage in some preparatory work with people, if appropriate, to ensure that everyone comes to the meeting feeling informed and able to contribute.	People will have a clear idea of how best to voice their opinions and how these views might be used and taken forward. This will contribute to a greater feeling of being heard.

Table 2: Continued

5	Difficulty encouraging people with different complexities of mental health need to participate together	Support various methods for contributing, such as one-to-one feedback sessions, providing interpreters or advocates, or allowing for submissions in writing. Encourage several methods of contribution at every meeting and embed these into the group principles. In one-to-one sessions, be prepared and willing to openly discuss individual wellbeing and any barriers.	Everyone will be given the opportunity to contribute in the way that feels most comfortable to them, ensuring that the process has been inclusive.
6	The same people are involved every time, meaning that new voices might be seldom heard, or newcomers may find it difficult to contribute	Have an open recruitment process that has been co-produced and is advertised across as many channels as possible, including local community groups and voluntary and community sector services to broaden the range of people involved. Collaboratively review the recruitment process to identify ways to widen the reach of recruitment. Celebrating every stage of co-production widely and openly, especially using social media, can help to encourage those who might be seldom heard to engage.	Provides an opportunity to those who may never have been involved in co-production before but would like to be. Encourages new ways of thinking for each project and ensures a freshness of approach.
7	The lines of accountability for co-production and commissioning are not clear	Ensure that governance is co-produced at every level, from board to service level, with representation from every stakeholder within each governance structure. All individuals need a role description and will be treated in the same way as other members of staff or trustees.	Will allow people to develop an accountability structure they feel comfortable with, encouraging them to take positive risks and contribute more freely.
8	Feelings of unequal power, or inability to share power within meeting spaces	Recognise the power imbalances that currently exist and encourage all people who are involved in the co-production process to acknowledge the power they have. Promote open discussions about power and encourage all people to enter the room with differing views and experiences, rather than with views of differing weight. Embed this into the group principles.	Builds trust, respect and openness within the group and fosters a comfortable atmosphere in which people can express views, knowing they will be valued and heard.

Table 2: Continued

9	Previous experiences of feeling unheard or ignored when voicing opinions can prevent people from engaging	Demonstrate real commitment and desire to getting co-production right this time around. Admit where things are not working perfectly and be open and honest with the group. Create time and space for people to acknowledge their previous experiences and listen to them, demonstrating a commitment to learn from them. Commissioners should be prepared to accommodate negative emotions to build trust. Commissioners should also be committed to ensuring there are clear lines of communication and that every outcome is communicated to all stakeholders.	Builds trust with the group, promotes openness and inclusion, and helps people to feel that you are dedicated to learning and changing historical processes, and to embedding co-production into future commissioning structures.
10	Meeting locations that are difficult to access (because of the physical structure, the safety of the area, accessibility to public transport and so on)	Consider moving meetings into the community, in spaces that are safe and accessible for all people. Consider providing transport for people or remuneration for transport if geography poses problems.	Better engagement with the community and more opportunity to engage with people who might not typically engage in co-production.
11	Lack of financial resources to be able to co-produce properly (for example, remuneration for time, travel and other areas for support and so on)	The improvements that co-production brings are becoming increasingly evident for both the community and commissioners. Commissioners could consider taking a top slice of their budgets to cover the relatively small costs related to establishing and sustaining co-production.	All participants will feel that their presence and contributions are valued. This builds more trust and respect among all members.

3   Approaching and planning co-produced commissioning

3.1   Benefits of co-production

A service that has been commissioned based on the principles of co-production is more likely to be cost effective, responsive and have high satisfaction and health outcome rates from the people who use it. This section will concentrate on the available evidence to outline key potential benefits of co-production. As part of the process, we looked for relevant NICE guidance and identified nine NICE guidelines, two NICE quality standards and six quality statements (see Appendix C).

3.1.1 Benefits for the service and commissioning process

Co-production is based on the idea that people who use services and those who work in them are the best people to suggest better ways of working.[16,17] In a review of different levels of NHS patient and public engagement,[18] it was found that co-produced commissioning leads to new and improved services, as described in Box 4.

Box 4: Benefits for services designed with co-produced commissioning

- Development and delivery of additional resources[19]
- Development of holistic approaches[19]
- Development of peer support groups[19]
- Improved access to care, including adapting services to better meet the needs of the community[20]
- Improved outcomes for the service or project[21]
- Improved communication and connection between staff and the community[21]
- Increased responsiveness and efficiency in delivery of care[22]
- Long-term sustainability of services and programmes[18,19]
- Mobilisation of community resources and energy
- More efficient use of resources[22]
- Reduced inequalities in care[22]
- Prioritisation and re-organisation of existing services[19]
- Quality assurance of commissioned services[19]
- Utilisation of local intelligence to create better services[19]

A literature review by the New Economics Foundation identified key themes related to co-production outcomes, including wellbeing, prevention, social connectedness, stigma, inclusion and personal competences and skills. They found wellbeing to be the strongest theme, including physical and mental health.[17]

3.1.2 Benefits for those involved in co-production

There is strong evidence that taking part in co-production, as well as being part of a community of peers, is a positive experience both for people with experience of mental health problems and those involved in mental health commissioning and provision. Co-production contributes to a sense of shared identity and purpose among all involved,[21] as well as other benefits described in Box 5.

Box 5: Benefits for people involved in co-production

- Confidence to develop new peer relationships[23]
- Development and enhancement of skills and employability[24]
- Empowered professionals in frontline practice who are confident in positive risk-taking and have more empathy[25]
- Improved confidence and self-esteem[26]
- Improvement in own individual health and wellbeing[26,27]
- Improved recognition of working group members' expertise, leading to an exchange of skills[14,28]
- Improved relationships, understanding and power balance between people who use the service and service providers[29]
- Increased social connectedness[24] and new peer relationships[30]

3.1.3 Cost and time efficiencies

In many instances, co-production has been found to improve the efficiency of mental health services and demonstrated potential reductions of long-term costs.[24] Cost and time efficiencies are outlined in Box 6.

Box 6: Cost and time efficiencies from co-produced commissioning:

- In the initial stages of co-production in commissioning, the costs attached to practising co-production (time, effort, resource) can increase, but **significant cost savings can be made in the long run**[14,17,25,32]
- Reductions in avoidable costs and other **long-term financial benefits have been found to be sustained when the co-production process continues and is embedded** into the commissioning working strategy, for example in evaluation and assurance processes[16,33]
- Other evidence focusing on improving practice (through peer support, joint design and delivery of services with people with long-term health conditions) indicated a **7% financial savings and predicted future growth of up to 20%**[23,34]

Cambridge and Peterborough CCG reported positive outcomes from the co-produced commissioning of two services for time efficiency, positive patient outcomes and financial gains, as can be seen in Box 7. For more information about this positive practice example, see Section 5.

Box 7: Positive practice example: outcomes of co-produced commissioning

Cambridge and Peterborough CCG

- **First response services**: the community-based 24/7 first response crisis mental health service has had positive outcomes, including financial gains that enabled recurrent funding of the service and:
  - 19% reduction in mental health hospital admissions
  - 26% reduction in mental health A&E attendances
  - overall reduction in A&E presentation for self-harm.
- **Patient outcomes and experience**: feedback on the experience of the PRISM service was 100% positive.
- **Improved time effectiveness** – establishing the **first response** and **PRISM services** have proved highly effective, saving time on further commissioning and transformation initiatives.
- **Cost** – the **first response** and **PRISM services** have proven to be highly effective, and are currently both **saving money**:
  - First response service saved about £4 million
  - PRISM service cost was £3.2 million and shows savings of £650,000.

3.2 Levels of co-production

Broadly speaking, services can be designed while working together in three ways, two of which involve participation while the third does not. When planning a commissioning project, it's important to consider what level of co-production can be used and aim for as much collaboration and co-production as possible. The following series of steps lead from 'doing to' to co-production's 'doing with'. Sometimes services and commissioners find themselves stuck at a certain level of the ladder, but the aim will be towards 'doing with'.

The three levels shown here can be read alongside the National Co-production Advisory Group's ladder of co-production, which shows seven levels of involvement from coercion at the lowest to co-production at the top of the ladder.

Helpful resource

Practical Things that You Can Do to Get Better at Co-production (Moving Up the Spectrum of Practice)

Think Local Act Personal

Start on the ladder of co-production. Don't be put off by not getting it right straight away.

Co-production in Mental Health:
Not Just Another Guide

'Doing with' means everyone involved is equal and has the same decision-making power, where people's voices are heard, valued, debated and then acted on. In reality this will take many forms, but what matters is that people share equal roles and responsibilities, and that everyone's unique experiences and contributions are valued.

'Doing for' requires participation. The involvement includes some engagement and consultation with people, but it will take place within boundaries and the decision-making will not be shared by citizens and providers/commissioners. While these service designers have people's best interests in mind, in truth people's ideas and opinions are heard but will only be part of the decision-making process, not fully shape it.

'Doing to' does not seek participation or input from people but aims to educate them and have them conform to norms and standards. The resulting service 'happens to them'.

3.2.1 Current co-production in England

Mental health commissioning in England is generally in the middle – 'doing for'[24] – and may entail focus groups, consultation around topics, community feedback and so on.

One of the biggest barriers to effective co-production is people feeling they cannot do co-production well enough, and they cannot reach the top of the ladder straight away. This can lead to people not even trying.[24]

> **Helpful resource**
>
> Co-production in Mental Health: Not Just Another Guide
>
> *Skills for Care*

3.2.2 Choosing the level of co-production that is most appropriate

Commissioners should always ensure that the level of co-production that is chosen is appropriate and necessary for the task at hand. It is not always necessary for every aspect of the commissioning process to be co-produced, but the decision to not co-produce a task needs to be collaborative and shared with those who would normally be involved. Otherwise the mental health service that is being commissioned is unlikely to reach its full potential.[17,35]

3.3 Co-production: 'It's messy'

Co-production at the NCCMH

At the NCCMH, we have worked hard to improve our approach to co-production over the last 3 years. Now, people consistently tell us they feel welcomed as equal partners in our work, and we have adapted several processes to make it work even better.

However, we are also aware of the remaining barriers to some people's involvement: the application process we ask people to complete, the location of most of our meetings (geographically, and the cultural associations that come with our offices), and the forms we ask people to complete in order to be paid. All of these are likely to be factors that exclude people from the process. This particularly applies to people most excluded from society, whom mental health services most need to serve.

Once in the room, the fast pace of some meetings, the language and jargon occasionally used (despite our best efforts), and the unfamiliarity of the environment are further barriers to people feeling equal partners.

Co-production can be difficult, and sometimes feels a little bit messy, but we always try to adapt. It is a continual process of examining how we could do it better. As a result, it helps us to improve the quality of our work, our understanding and our enjoyment of the process beyond measure.

Co-production can add enormous value to mental health provision, but the process will take different paths and will not be linear. But this is not to be feared. When it's done right, it will involve spontaneity and creativity, and it is likely to feel messy at times because of the amount of communication and negotiation involved, and the need to 'rock the boat without getting rocked out of it'.[b] To harness this, commissioners should welcome the different approach to working and encourage system-level sign-up to co-production. Commissioners will need to ensure that their processes give sufficient time and flexibility to plan the project and allow for this way of working. There is significant expertise that can be accessed by working in this way, particularly in the VCSE sector, as well as in local authorities and CCGs, which should be utilised.

See **item 1** in Table 2 for solutions to challenges around **sign-up to co-production**, and potential outcomes.

See **item 2** in Table 2 for solutions to challenges around the **time needed to carry out co-production**, and potential outcomes.

3.3.1 Taking positive risks

Working co-productively can take unexpected turns, involve positive risk-taking and bring everyone involved together in the pursuit of shared aims and goals. Each person will be faced with different obstacles on their journey but will also celebrate different, and at times unexpected, successes.

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[b] McGrath J, Co-production: an inconvenient truth? [blog], The King's Fund, 31 October 2016.

3.4 Culture change

Changing the culture in mental health provision may not be easy. Reportedly, and from positive practice examples, commissioners said they often struggle to implement changes at service level. When the new approach of co-production is being put into place, the professionals are often asked to take a 'risk' or step out of their comfort zone. This might happen when they are asked to deliver services based on different methods or while involving people who use mental health services. Professionals should be supported and prepared (for example with training and supervision) to learn and feel confident about changes and new approaches, to help them be more enthusiastic about the result of co-production and new changes. Staff should have a clear understanding of the aims and potential outcomes of the project, and how the new approach can improve their services in the short and long term.

See **item 3** in Table 2 for solutions to challenges to **staff engagement**, and potential outcomes.

Following the principles of co-production may also require a change in the balance of power and a broader culture shift.[36] This means genuine partnership supported by strong and decisive leadership to better overcome barriers.[28,37] It involves viewing interactions as reciprocal, by shifting the focus away from solely delivering services and towards facilitating and enabling people to access services and resources.[21,38] It also will involve acknowledging risks and creating a plan to manage them. Having a risk-management strategy makes it easier for partners to experiment, and to test and pilot new elements of service provision.

3.4.1 The skills needed to facilitate co-production

Some of the skills that could be required to facilitate co-production in commissioning include:

- ability to communicate clearly throughout the co-production process, including when giving feedback
- ability to make reasonable adjustments for people
- ability to support others to develop their own skills and be open to developing your own skills
- co-chairing skills, including the ability to keep conversations clear and honest
- knowledge and skills in planning, delivering and evaluating services collaboratively
- willingness and ability to share power, knowledge, skills and expertise.

The King's Fund report, Patients as Partners, recommends adapting styles, focusing on what works, knowing what questions to ask and being aware of assumptions so that they can be addressed.[39]

3.4.2 Prompts for thinking about the activity you want to co-produce

These 'Think about' and 'Suggested solutions' prompts, adapted from the National Development Team for Inclusion,[42] are useful for everyone involved in co-production to enable you to design services together by understanding and addressing practical issues that are likely to come up during the co-production process. You will find them at relevant points throughout this document.

Think about:

How will you as a group define the changes that are needed (what research methods are going to be used?) and agree on the process of achieving these changes?

If a problem or an issue arises between people, how will you make sure that there is a shared understanding and agreement of how it should be resolved?

How will the process of finding solutions to any conflicts and finding common ground be managed? Everyone involved needs to feel safe and empowered to tackle and resolve disagreements.

How will everyone be supported to express their professional and personal stories when developing a shared understanding of how conflict should be resolved?

Suggested solutions

Collate and understand the changes to be made and break them down into smaller elements. Discuss together how each can be resolved, what difficulties there may be, and how long it will take for the change to take place.

Discussion about processes should include common agreement and expectations about the timeframes, the issues that need to be addressed (including predicted and unforeseen issues) and how any issues will be managed. Discuss the framework or method that will be used (the groups should have an in-depth understanding of the pros and cons of each framework).

As a group, agree on a set of shared values, aims and ground rules, including how any disagreements will be worked through.

Build in time (whenever the group works together) and create a feeling of safety so that everyone feels able to talk about their experience of using and providing mental health services – this information can be used to increase understanding about what needs to change and why, and how it can be done.

4 Practising co-produced commissioning

4.1 The commissioning process

4.1.1 Before the project

Before starting recruitment for each project, the following questions could be considered:

1. At what stage of the commissioning process should co-production take place?
2. Is co-production the best strategy with this commissioning process?
3. How many people should be involved?
4. How will the people involved be recruited?
5. How do we ensure that everyone's contributions are included and actioned?
6. How will decisions be made?

Some co-production methods and models might be effective and applicable at one commissioning level, but not work at another. The approach to co-production in commissioning may need to be adjusted at:

• the individual level for specific population groups
• the team, service or practice level, or
• the whole community level.[40]

4.1.2 Planning co-production processes

Co-production processes should be planned in advance and reflected on throughout, to ensure that they continue to meet the aims of the group. This includes establishing whether there will be a need for any focus or special interest groups within the team, to work on certain aspects of the project.[32] It should be made clear to all group members what kind of co-production is being practised, how much time will be required and what input and outcome is expected.

See **item 4** in Table 2 for solutions to challenges around **expected contributions from people**, and potential outcomes.

4

4.1.3 Dedicated co-production roles and champions

To ensure that co-production is embedded into commissioning processes at every level, there should be a dedicated member of staff who champions co-production in practice, and encourages it and promotes it to all members. For example, the Bristol North Somerset and South Gloucestershire CCG have a dedicated post in commissioning (see Box 8). In addition, at least one board-level role should have a responsibility to ensure co-production happens.

Box 8: Positive practice example, in their own words: 'Designing together'

Bristol North Somerset and South Gloucestershire CCG

'We have a dedicated commissioning post, to ensure that co-production is embedded in all areas of the mental health commissioning cycle including transformation. This involvement supports the programme of quality assurance for all mental health contracts with a user-led independent mental health network which has been involved in several procurement processes and the monitoring of mental health providers.'

4.1.4 Identifying gaps while doing co-production

Working together will help identify existing assets and gaps that health and wellbeing initiatives can build on, for example:

- skills, knowledge, social competence and commitment of individual community members
- friendships, intergenerational solidarity, community cohesion and neighbourliness within a community
- local groups and community and VCSE associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources within a community
- assets provided by all public and private external agencies.

4.1.5 Improving co-production processes

The evaluations and outcomes of working together should be evaluated and evidenced wherever possible to understand the successes and challenges and destination of any future work and how it can be improved.[41] This information should be reported back to the community in accessible formats and languages.

4.1.6 The co-production commissioning cycle

This commissioning cycle and its principles were developed by the Co-production Working Group (see Figure 1 and Figure 2). It was agreed that the co-produced commissioning cycle should start with collaboration, to conceive and research ideas. However, it was acknowledged that this could be constrained by scope, budget and mandate.

Helpful resource

Commissioning Cycle

NHS England

Figure 1: Outline of the co-production commissioning cycle
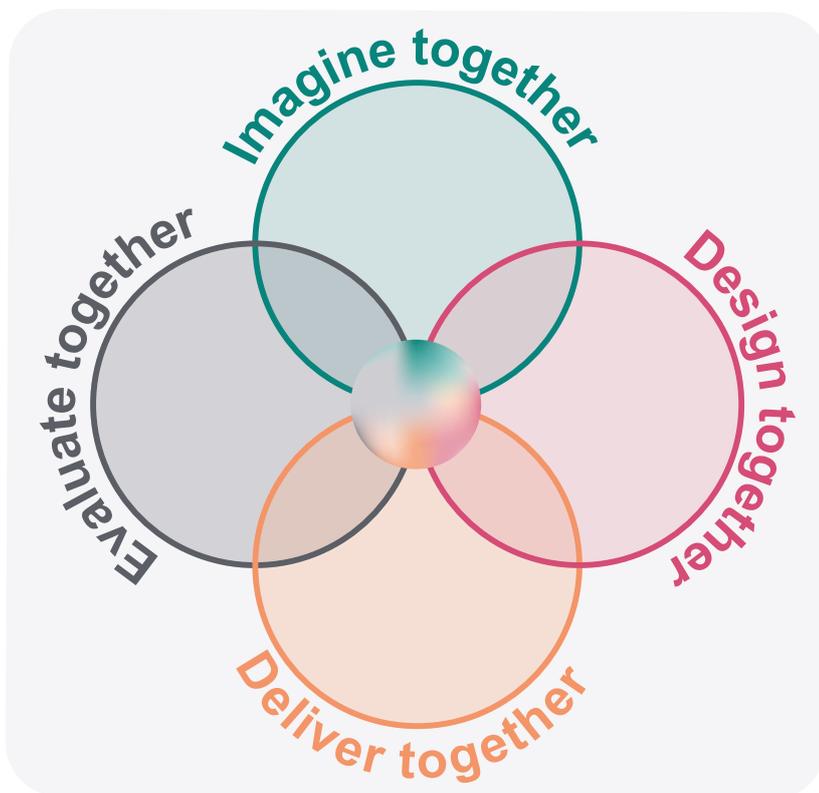
Figure 2: What happens in the co-production commissioning cycle?

Imagine together
- sharing thoughts and creating shared concepts
- narratives and viewpoints
- coming up with new ideas

Design together
- ways of working that ensure all stakeholders are fully involved

Deliver together
- work in equal partnership with stakeholders to determine what good mental health services look like, then work back from there
- work in partnership to develop quality standards for the contracts
- have stakeholders review the contract compliance and the implementation of quality standards (CQUINs)
- have a governance system that pays attention to all stakeholder groups, as part of the process

Evaluate together
Follow-up action plan based on the evaluation results, including:
- development of outcome measures
- interviews
- design of questionnaires
- quantitative and qualitative data collection and analysis.

The co-production commissioning cycle should **promote equality, diversity, accessibility, courage, curiosity and encourage joint ownership** by the people and partners involved to find solutions as a team. Co-production is a series of actions and a journey rather than an event, and for that reason co-production should embrace creativity.

Notwithstanding any unavoidable constraints or barriers, co-production will still be a key opportunity to identify local needs and inequalities as part of the Joint Strategic Needs Assessment process to select providers of services and evaluate existing contracts. See Box 9 for Cambridge and Peterborough CCG's own description of how they 'imagined' the first response service.

Helpful resource

Better Mental Health: JSNA Toolkit

Public Health England

Box 9: Positive practice example, in their own words: 'Imagining together'

Cambridge and Peterborough CCG

'We have worked with people before the idea has been even conceived and then through every step of the project including ongoing reviews, and evaluations.

When the community-based 24/7 first response crisis mental health service was set up, the service user network and a person with lived experience were represented on the delivery board, which developed and implemented this service. The service users' network has developed a "5 values framework" against which the service was then evaluated and then improved.'

Think about:

What are the problems that need to be defined and addressed within commissioned mental health provision?

Who is going to be the champion of co-production during your commissioning cycle/this co-production commissioning project?

What approach/model/framework are you going to propose for this co-production commissioning project and why? Have you used that approach/model/framework before? Can you reflect on previous approaches and think about what could have been improved?

What do you hope to achieved by using this approach/method/framework, in terms of goals and outcomes for your working group and mental health provision that you are commissioning?

What will be done to ensure that all the right people come together from the outset of the commissioning cycle and how can this be decided?

Suggested solutions

Define the problems and come up with solutions with everyone involved in co-production.

There should be a dedicated member of staff to champion co-production throughout the commissioning cycle – ideally at a senior level.

Discuss what can change as a result of co-production, based on previous experience and knowledge of all involved, and reflect on what has and has not worked before; try to identify case studies to help with that, too.

To help identify who needs to be involved, think about the short-term, long-term and overall goals of the project. For example, depending on the context, you may need:

- people with a range of experiences and different levels of professional and personal expertise

- people with a range of relevant backgrounds, to inform the project aims and outcomes.

Network and collaborate with voluntary and statutory sector services to identify and engage people for the project.

Always take time to build positive and trusting relationships among all involved, especially if people have had negative experiences of co-production in the past or do not have experience.

4.2 Recruitment and engagement of people in co-production

Throughout the commissioning cycle, engagement with people with whom the project is being co-produced needs to be considered and maintained. Monitoring engagement should be ongoing, to ensure that the community is adequately represented. Co-production should not only involve a range of people who have experienced mental health problems, but people from across the whole of the community, including families, friends and carers of those who need mental health care, as well as staff, clinicians and anyone else who will be affected by the outcome of the project.[33]

4.2.1 Reflecting the population

Co-production working groups should not only reflect the population receiving care within mental health services, but also people in the community who are currently unable to receive help for their mental health needs due to barriers to access or other related barriers (see Section 1.5 on inequalities, and the positive practice example in Box 10 below).

4.2.2 Addressing barriers to engagement

To successfully engage a wide group of individuals, barriers to engagement should be reviewed and addressed as much as possible with the levels of planning, engagement and skills adjusted as needed by the relevant population groups (see Section 1.5 on inequalities and where such barriers exist). Wherever possible, co-production should be used during engagement as well. Six Practices for Creative Engagement outlines six steps to consider to help ensure that people with diverse interests and perspectives are identified and engaged.[43] *The Framework for Community Mental Health Support, Care and Treatment for Adults* and Older Adults (forthcoming) provides more detail on community assets mapping. For more engagement tools, see Section 6.4.

See **item 5** in Table 2 for solutions to challenges in **recruiting people with different complexities of mental health need**, and potential outcomes.

See **item 6** in Table 2 for solutions to challenges in **recruiting new people to projects**, and potential outcomes.

Helpful resources

Engaging Local People

Engaging with Communities

NHS England

Acknowledging limitations of engagement

Commissioners should pay attention to local factors that may affect co-production or the engagement process. Some people may not wish to engage with co-production processes in their own local areas because of the likelihood of being identified by someone they know. These feelings and opinions must be respected, and no one should be forced to engage.

In Box 10, the Surrey-based Adult Social Care-led commissioning process describe how they involve people and engage with them.

4.2.3 Recruitment

Commissioners can recruit people to the co-produced commissioning process in several ways, including:

- working with existing local VCSE and local authority groups to ensure they build on existing participation
- advertise creatively, using social media and the community – for example, community centres, sports clubs and town halls
- commission VCSE groups to recruit from within their communities.

To support this, clear role descriptions and training and support packages should be in place before starting recruitment.

Box 10: Positive practice example, in their own words: 'Designing together'

Adult Social Care-led commissioning process in the South of England: Surrey County Council working with the Surrey mental health CCG collaboratives

'We are working with independent user-led mental health network and service providers, to involve people who use their services and support access for people with additional or multiple inequalities.

Engagement approaches include directly asking and talking to people who are using or in touch with mental health services, including on specific issues, and through other means, for example digital technologies such as Twitter, websites or blogs.'

Think about:

Who are your local population?

What are the mental health needs in this population?

What mental health services are available and what is missing?

Who is and who is not accessing mental health services?

What kinds of interventions are people receiving?

What kinds of experiences are people having?

What do the outcomes of mental health care look like for the local population?

How do our mental health and social care services work together?

How do our mental health services work with other public services (schools, universities, police and criminal justice system, young offender institutions and so on)?

Are there delays in accessing services and in receiving care and treatment?

4.3 Power dynamics when working together

4.3.1 Acknowledging power differences

Power and empowerment are key concepts in co-production, as outlined in 'Influence of power' in Table 1. Community empowerment is about 'shifting power, influence and responsibility away from existing centres of power and into the hands of communities and individual citizens'.[44] This means that power relationships should be acknowledged and addressed transparently, which can be a key factor that contributes to people feeling more confident and in control of services and communities, and of their own health and lives. Open acknowledgement of the power balance and how it is perceived it is not always comfortable, but it is important and should be made a priority (there is more on communication and building trust, in Section 4.4). Co-production strives for equality in decision-making, and intends to distribute power evenly among everybody involved. There should then be regular reminders that the people involved will be given support, respect, and appropriate ways to contribute based on need and preference. This can be achieved by actively encouraging and creating opportunities for everyone to contribute,[33] and by co-producing all levels of governance structure, making sure that they include a structure for accountability.

4.3.2 Marginalised groups

Some communities are more structurally marginalised and may not be in the room at all (see Box 3 in Section 1.5). This means that power can be transferred to the people who find it most easy to access the co-production process, but others may find themselves even more marginalised and disempowered by not being involved, meaning that co-production can increase the marginalisation of some groups if done in a less inclusive way. This may include people from Black, Asian and Ethnic Minority communities, people with lower socioeconomic status and people with more severe and disabling mental health problems. It can also include people based on their geographical location, such as those in rural versus urban areas of England. Commissioners should pay particular attention to ensuring that all communities are empowered through co-production.

See **item 7** in Table 2 for solutions to challenges around **accountability**, and potential outcomes.

4.4 Communication and relationships in co-production

Getting co-production right depends on the relationships between all the people involved. They will come from many different walks of life, have had different experiences, and have different perspectives and approaches. Because of this, some people may start their working relationship from a point of conflict, so consideration should be given to re-building trust from the very beginning of the process.

Everyone involved in the co-production process should be treated as equal partners. To achieve this, there are a number of things that can be done to support people's participation in and engagement with the process, and these are outlined in the sections below.

4.4.1 Building trust

Time and space are needed for people to discuss their experiences and emotions openly, using effective communication to build trust between people. It is important that everyone taking part makes an effort to be receptive to people's experiences, both positive and negative. Group members' positions, and any previous mistakes or problems, need to be heard and acknowledged. Such open, honest discussion can bring mutual understanding, an atmosphere of trust and pave the way to positive collaborative relationships.

To maintain trust and positive relationships it is important to communicate about contributions and decisions that are not ultimately actioned, explaining why the decision has been made. Listening to and acknowledging the views and feelings of everyone involved needs to also be maintained throughout the process.

8

4.4.2 Communicating clearly

Communication should be clear and accessible to everyone, adapted according to need and available in different formats (see Table 3). Communication methods should be planned, and then reviewed throughout the process. There should be ground rules for everyone, covering issues such as confidentiality, respect and what will happen if those rules are not honoured.

9

4.4.3 Accessibility

As well as communication, accessibility is one of the most crucial elements of facilitating co-production. The physical space as well as the process itself should be accessible to everyone,[42,46,47] allowing all participants to participate and contribute fully.[14]

The following elements should be considered:

- Providing training to people so that they are prepared to engage fully in all meetings.
- Ensuring that all individuals have timely access to all the relevant resources and support to prepare for meetings,[47] tasks and discussions.
- Ensuring that all people can access buildings, receptions, rooms, toilets and other facilities easily. This includes ensuring there is disabled access, accommodation for guide dogs, induction loops for the hearing impaired, and other adjustments.

Helpful resource

Making Events Accessible

Social Care Institute for Excellence

- Meetings should be scheduled to account for the needs of the people involved. Meeting agendas should allow time for people to build relationships and for dynamics to develop.

In addition to the resources referred to above, see Box 11 on Pathfinder's practice of making projects accessible.

4.4.4 Recognition and reward

All people taking part in co-production should be valued and rewarded. Often the simplest ways of recognising and acknowledging people's input and contributions have the greatest impact, so expressing appreciation can positively improve confidence and self-esteem.[17] At a minimum, every person's contribution should be openly recognised; however, people should also be remunerated for their contributions. Case studies show that remuneration can be the most difficult part of the co-production process, mainly due to lack of additional resources within the commissioning budget or uncertainties around how to pay people, particularly those who might also be receiving benefit payments.[14,49] Nevertheless, all participants should be treated and financially rewarded in the same way as any other employees involved in the process.

The following items are examples of what could be remunerated, where appropriate; for example, time, travel, childcare expenses, replacement carer, support worker, interpreter, accommodation, subsistence, stationery and telephone use. This list is not exhaustive, and expenses will depend on each person's circumstances.

> **Helpful resource**
>
> Paying People who Receive Benefits – Co-production and Participation for Further Guidance
>
> *Social Care Institute for Excellence*

Table 3: Examples of communication formats and platforms

Formats
•   easy read
•   Braille
•   flash cards
•   different languages (including sign language)
•   interpreters
Platforms
•   meeting venues
•   telephone conversations
•   online interactions
•   digital technologies

4.5 Measuring, monitoring and evaluating co-production

4.5.1 Quality assurance

Quality assurance of the co-production process and its effectiveness needs to be ongoing, taking on board positive and negative feedback, as well as understanding the dynamics of all involved. This will ensure that there is ongoing reflection and learning on how to improve co-production processes.

See **item 10** in Table 2 for solutions to challenges around **physical accessibility of meetings**, and potential outcomes.

Box 11: Positive practice example, in their own words: Planning ahead

Pathfinder West Sussex Co-production

'When working with people we plan ahead to ensure we work within agreed framework, so people are informed well in advance about the timelines of the project including **meetings**, **activities** and **tasks**.'

4.5.2 Measuring progress

Progress should be measured to monitor, evaluate and reflect (as a team) on everybody's involvement. There are various frameworks that can be used to facilitate that process (see Section 6.9 for further resources). The choice of method or evaluation tool should be decided on by the working group, as different tools will suit different groups. Some of what is learned will lead to solutions that can be implemented immediately to improve the processes or the way the group is working on a task. However, some challenges may require more discussion and planning, and might be more difficult to overcome – sometimes not at all. As part of the evaluation the groups should consider different aspects, including:

- changes in relationships
- the need to develop additional skills to continue with co-production
- openness and capacity for challenge
- people's skills
- recognition of individual assets and expertise
- trust and confidence.

See **item 11** in Table 2 for solutions to challenges around **lack of financial resources to co-produce**, and potential outcomes.

Helpful resource
Budgeting for Participation
NHS England

4.5.3 Evaluating outcomes

When evaluating the outcomes of co-production, they should be communicated to all those involved after the project is finished. This ensures that everyone involved knows the impact of their contributions and feels that they are a valued and integral part of the decision-making process.

Think about:

How will the knowledge, expertise, assets, strengths and contributions of everyone involved be fully utilised throughout the process to generate a better understanding of mental health provision?

How will challenges, including people's emotional expressions, be integrated into learning about what needs to change and how?

How will everyone be supported and encouraged to be honest about their own personal and frontline experiences?

Will people be expected to conform to formal meeting rules and use a particular language to be heard?

How will other practical issues including access, payment and expense be addressed?

Suggested solutions

Ensure that everyone has an equal opportunity to express their thoughts and experiences around topics, including in different languages, written and spoken formats, by digital technologies, and so on. Consider taking minutes during meetings and activities to record everyone's views accurately and check that everything is captured.

Establish rules of confidentiality and respect, and continually remind people that it is a non-judgmental and safe space. Outline and keep on reminding people how decisions based on their experiences can positively influence mental health provision.

Always use plain language and agree on the preferred language and terminology with everybody involved.

Always prioritise budgets to pay people for their time and expertise.

4.5.4 Evidence that commissioners can show

Commissioners should be able to show evidence of how they have involved members of the local community when they were setting priorities for mental health provision, to demonstrate how they have reflected on what has and has not worked. The quality measures should include evidence about monitoring and evaluation, which should have been agreed by everyone involved in the co-production process. Mental health provision should be evaluated using the measures that were derived from agreed priorities, and their outcomes and impact, both positive and negative, should be fed back to the working group.

4.5.5 Community involvement in evaluation frameworks

As part of the co-production commissioning cycle, members of the community should be involved in planning, designing and implementing the evaluation frameworks for community engagement approaches. They should also be involved in deciding on the outcomes that have been derived from co-production.

As part of this, commissioners should regularly evaluate community engagement approaches to advance mental health equalities. The evaluation should also include evidence of what has been done to develop the local community, such as skills, knowledge, networks, relationships, facilities and community assets. Reporting changes, including acknowledging improvements and gaps, is likely to be appreciated by everyone involved in co-production and is a way of recognising everyone's efforts.

4.6 Research recommendations

There is a lack of formal published evidence focusing on the impact of co-production specifically in mental health commissioning, or even in wider health and social care commissioning. Most of the available evidence looks at co-production at a service level. However, there is a wealth of literature based on experiences of co-production.[14,24]

The available evidence focuses on the improvements that a service has made as a result of co-production and the individual experiences of those involved. While much of the evidence indicates that savings have been likely, there is a need for more published economic evaluations to support this case.[17,21,50,51]

Key research areas for future development are the **outcomes** and **benefits** of co-production, particularly in commissioning.

5   Positive practice examples

Positive practice example: Coastal West Sussex CCG – Pathfinder
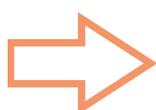
Overview

Co-production is central to everything we commission, from the outset to the ongoing development of mental health services, including planning, procurement and mobilisation. We use models recommended to us by people who use our services and their carers, including those produced by third sector providers such as Rethink and Mind. We complete an equality impact assessment for every service we commission and identify other groups of people who may be at risk of being underrepresented.

Process and quality assurance

In our recruitment process, we ensure that we concentrate on diversity so that we represent everyone from our local community and get an accurate view of what is needed. We work in partnership with Capital to help us facilitate those roles throughout the co-production process. People with lived experience are members of all key **Pathfinder** boards and workstreams; their title is 'Independent Non-Executive Director'.

When working together, we work within an agreed framework and make sure that people are informed well in advance about the timelines of the project including meetings, activities and tasks. Minutes are taken throughout the process and shared within workstreams. As an alliance, we develop regular updates on our work and processes, and look at what works and what could be improved, including feedback to the Pathfinder Strategic Board. We then make changes accordingly.

Outcomes (what people have found effective)

Because co-production is central to the work of Pathfinder, we have a workstream in place to facilitate this process and agreed terms of reference. The terms of reference have enabled us to have an agreed definition of co-production, develop then review recommendations and structures (including on how to measure and evaluate the effectiveness of co-production), and recommend how we can share and learn from each other. Overall, we act as champions by facilitating the implementation of co-production across the Pathfinder Alliance.

Reflections

We have faced some barriers when seeking to improve mental health services, because some of our statutory providers do not automatically engage service users and carers from the outset. This has caused a number of problems further down the line, and there is still plenty room for improvement in that area.

Find out more

Neil Johnson Senior Manager, Mental Health Commissioning Team, Coastal West Sussex CCG
E: neil.johnson6@nhs.net   W: https://www.coastalwestsussexccg.nhs.uk/
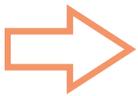
Overview

We have a dedicated commissioning post, to ensure that co-production is embedded in all areas of the mental health commissioning cycle, including transformation. This involvement supports the programme of quality assurance for all mental health contracts with a user-led independent mental health network, which has been involved in several procurement processes and the monitoring of mental health providers.

We have **two CCG-funded mental health crisis houses and a Sanctuary service** (with another similar service planned for North Somerset). Local people who use or have used services had been asking for these services, and they continue to be involved in service specifications and procurement.

Process and quality assurance

People from the community are also trained to be involved in managing the service contracts, including quality assurance visits to all services including inpatient services. For example, we did a user-led review of the crisis houses recently to inform our future plans. This gave us a detailed independent assessment. It also showed that service quality had improved (our main aim), and that our services are more effective.

We also have a wider partnership, engagement and communications team that are working with wider population and community groups to ensure it reflects the local community we strive to serve. In our process there are successes and challenges: in our monitoring of services, we try to engage with people (for example, using National Involvement Standards and other frameworks that we have co-produced within our networks), but there are ongoing challenges, such as engaging excluded people and communities. In the past, we commissioned a community access service to help address equalities issues, but we also know we need to do more to follow up on and demonstrate the value of contributions.

Outcomes (what people have found effective)

As part of the co-production process, we continue to train staff to build their confidence in embracing new approaches. We also make sure that we build trust and relationships with the people we work with who are using the services. We advocate buy-in and support at all levels of the organisation, along with resources, but we also want to be honest and manage expectations of all involved.

Reflections

We have noted improvements in the quality of services by seeking more detailed and independent views on how the services are doing. We have found that co-production in commissioning has certainly helped us to do things differently and more efficiently, which has been cost effective.

Positive practice example: Adult social care-led commissioning process in the South of England: Surrey County Council and Surrey mental health CCG collaborative
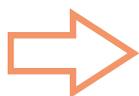
Overview

People have long played a critical role in our commissioning processes, to help us understand how the services could be best delivered and to aim for the right outcomes. As a result, we set up **Community Connections Surrey** to bridge the gap between primary and secondary care mental health, and to support people to stay well in their communities. Community Connections Surrey comprises three lead voluntary sector providers (Mary Frances Trust, Richmond Fellowship and The Welcome Project) covering the six CCGs and 11 districts and boroughs in Surrey.

For our engagement processes, we work with an independent user-led mental health network and service providers, to involve people who use their services. Their approaches to engagement broaden our reach and help to support access for people with additional or multiple inequalities. Both are very good with directly approaching people, more generally and on specific issues, through Facebook, Twitter, websites, blogs and other means.

Support during the process and quality assurance

When engaging with people, we always ensure provision of an accessible environment for people to be able to contribute in a meaningful way. This includes providing hearing loops, speech-to-text typing, large-font text and wheelchair-accessible venues. We aim to work with people in ways that suit them through formal and informal events, and to communicate in ways that they choose such as by email, teleconference, phone call or text message if they find it difficult to attend a meeting or workshop in person. We continually feed back outcomes to people working with us and let them know what changes have been made. The performance of all services is monitored on a quarterly basis, and the data is shared with the independent mental health network so that they can comment, challenge and have a say in how the services are going.

Outcomes (what people have found effective)

In a survey of the five sites covered by Community Connections Surrey, 89% to 100% of respondents said that the services have very much or moderately improved their life. The survey revealed that people have been enabled to maintain a network of support, to help themselves and to maintain their recovery. This has been through accessing appropriate courses, groups and activities, which give them a reason to get out and about. Respondents also reported that they received the help and advice they needed.

Community Connections Surrey were also found to contribute to the improved management of crises and a reduced dependence on statutory services. Overall, Community Connections Surrey demonstrate positive impact and are cost effective, meaning they are of key strategic importance in the mental health pathway and are valued by stakeholders.

Reflections

We have committed time, resources and organisational commitment to co-production in commissioning. However, during the process our main barriers and challenges involved challenges with resources, because co-production can be time intensive and expensive. Despite this, we have always used our work as a platform to encourage and inform other senior leaders by illustrating the value and benefits – and therefore the necessity – of involving people in commissioning.

Find out more

Jane Bremner Senior Commissioning Manager, Adult Social Care
E: jane.bremner@surreycc.gov.uk   W: http://communityconnectionssurrey.com
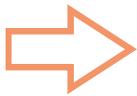
Overview

When we were setting up a new community-based 24/7 first response crisis mental health service, **The Sun Network**, we had worked with people before the idea was even conceived. We started by getting to know the local population using public health data and by setting up a service user network that included people with lived experience.

Process and quality assurance

Getting people 'into the room' was the first challenge – when we advertised for participants we made it clear that no one would be refused, and that we would provide individualised support. Whenever we needed to hear from certain groups, we would specify, so no one felt like they had been turned away.

We offered as many choices around participation and platforms as possible, so that people could join in in the way that best suited them. For example, the premises were always accessible for in-person events like meetings, workshops and forums, and we utilised IT to include people in co-production via emails, social media, a website, online polls, text messages and training videos. Everyone was always provided with suitable training, which was delivered in different forms such as Braille, larger print, audio support, language translation and so on.

We ensured that everyone had the opportunity to contribute fully and started with a group contract – a 'respect agreement', to address power imbalances so no one felt unimportant. People could engage in ways comfortable for them, such as table discussions, writing ideas on Post-it notes, voting on yes/no questions, holding up cards that said yes/no/speak up, working in smaller groups, Skype, teleconferences, working in pairs, and so on. As a result, the group has put together a '5 values framework' that informed the new service. The '5 values framework' was subsequently used to evaluate the service and to drive needed changes.

To ensure that people knew how valuable their work was, we paid them an hourly rate and offered a shopping gift card, free lunch and provided training on 'attending meetings' and 'confidence and assertiveness'. We also continually encouraged, reassured and provided emotional support to them.

Outcomes (what people have found effective)

As a part of our ongoing improvement, we asked everyone involved a number of questions. We asked how the experience worked for them, if they felt valued, if they felt like an equal part of the process, if the service user network helped them being part of the process, and more.

Our work contributed to our local community's improvement: we noted a 19% reduction in hospital admissions for mental health reasons, a 26% reduction in mental health-related A&E visits, a reduction in A&E presentations for self-harm, and cost savings of around £4 million as well as time savings that could be used for further commissioning and transformation initiatives.

Reflections

Challenges and barriers were part of the process. They included having restrictive timescales, which imposed a feeling of pressure, and limiting the use of jargon in services where culture change and the attitude towards new approaches had to change.

Find out more
Lois Sidney Executive Director, The Sun Network
E: lois.sidney@sunnetwork.org.uk   W: www.sunnetwork.org.uk

6   Helpful resources and tools for co-production in mental health commissioning

The following resources can be referred to when taking part in co-production of all levels and variations. For older resources, please bear in mind that their age may add some limitations to their applicability today, but each resource included below includes information of value.

6.1   Commissioning

Commissioning Cycle [web page] – NHS England, 2016.

Commissioning Independent Advocacy [web page] – Social Care Institute for Excellence, 2014.

Delivering Public Services [web page] – NCVO Knowhow, updated 2017. Includes these useful web pages:

- Social Values in Commissioning and Procurement – in 'Procurement' section
- Co-production and User Involvement in Commissioning – in 'Commissioning' section.

The Fifteen Steps Challenge: Quality from a Patient's Perspective – A Guide for Commissioners [PDF document] – NHS England, 2017.

Patient and Public Participation in Commissioning Health and Care: Statutory Guidance for CCGs and NHS England [PDF document] – NHS England, 2017.

People not Process – Co-production in Commissioning – Think Local Act Personal, 2015. Includes these useful web pages:

- Commissioning Co-production – 'Stories and resources' section
- Co-production in Commissioning and Market Shaping
  - 'In more detail': Practical Things that You can do to Get Better at Co-production (Moving up the Spectrum of Practice).

Values-based Commissioning [web page] – National Survivor User Network, 2017.

6.2   Methods, models and frameworks

Commissioning for Better Health Outcomes [PDF document] – Local Government Association, 2016. Includes this useful web page, which requires login:

- Commissioning for Better Outcomes: a route map (updated edition) [PDF document].

Commissioning for Outcomes and Co-production [web page] – New Economics Foundation, 2014.

Coproduction in Mental Health Commissioning [web page] – Rethink Mental Illness, 2016.

A Co-production Model: Five Values and Seven Steps to Make this Happen in Reality [web page] – Coalition for Collaborative Care, 2016.

Co-production in Social Care: What it is and How to do it [web page and PDF document] – Social Care Institute for Excellence, 2015.

A Guide to Co-production with Older People. Personalisation – Don't just do it – Co-produce and Live it! [PDF document] – National Development Team for Inclusion, 2010.

Integrated Commissioning for Better Outcomes: A Commissioning Framework 2018 [web page and PDF document] – Local Government Association, 2018.

Joint Commissioning Panel for Mental Health: Guidance for Commissioners [web page and PDF documents] – Joint Commissioning Panel for Mental Health, 2017.

Ladder of Co-production [web page, PDF document and video] – Think Local Act Personal, 2016.

Model Collaborative Commissioning Agreement: Multiple Contract Option [PDF document] – NHS England, 2017.

What is Commissioning and How is it Changing? [web page] – The King's Fund, 2017.

6.3 Tools

Better Mental Health: JSNA Toolkit [PDF documents] – Public Health England, 2017.

Budgeting for Participation [PDF document] – NHS England, 2015.

Co-production Training Courses [web page] – in house training for 25 or more – Social Care Institute for Excellence, 2017.

Documents to Support Participation [web page and PDF documents] – NHS England, 2017.

EBCD: Experience-based Co-design Toolkit [web page] – The Point of Care Foundation, 2018.

How to Estimate the Costs of Public Involvement [PDF document] – East Midlands Academic Health Science Network, 2015.

The Influence and Participation Toolkit [web pages] – Mind, 2013.

Stakeholder Mapping Tool [web page] – The Health Foundation, 2013.

6.4 Engagement

Bite size Guides to Participation [PDF documents] – NHS England, 2014–17. Includes:

- Engaging with Communities, 2017
- Planning for Participation, 2015.

Engaging Local People – A Guide for Local Areas Developing Sustainability and Transformation Plans [PDF document] – NHS England, 2016.

Social Care Institute for Excellence [web pages] on co-production with different groups:

- Co-production with Black And Minority Ethnic People, 2016
- Co-production with Different Groups Of People, 2016
- Co-production and LGBTQI+, 2017
- Co-production and Participation: Older People with High Support Needs, 2012
- Co-production with Seldom Heard Groups, 2016
- Co-production with Young People, 2016.

Independent Mental Health Advocacy [web page] – Social Care Institute for Excellence, 2015.

The NHS Youth Forum's Top Tips to Involve Young People in Healthcare Planning [PDF document] – British Youth Council and NHS England Youth forum, 2016.

Participation in Development of Dementia Care [video] – Social Care Institute for Excellence, 2012.

Patient and Public Participation Equality and Health Inequalities [PDF document] – NHS England, 2017.

Patient and Public Participation Policy [PDF document] – NHS England, 2017.

Six Practices for Creative Engagement [PDF document] – Think Local Act Personal, 2011.

Top Tips for Good CCG Engagement with Patient Participation Groups (PPG) [PDF document] – National Association for Patient Participation, 2017.

6.5 Recruitment

Recruiting New Staff [web page] – Think Local Act Personal, undated.

6.6 Accessibility

Making Events Accessible [web page] – Social Care Institute
for Excellence, 2012.

6.7 Payments

Paying People who Receive Benefits – Co-production and
Participation [web page] – Social Care Institute for Excellence, 2019.

Working with our Patient and Public Voice (PPV) Partners –
Reimbursing expenses and paying involvement payments (v2)
[PDF document] – NHS England, 2017.

6.8 Collaboration

The Compact: The Coalition Government and Civil Society
Organisations Working Effectively in Partnership for the Benefit
of Communities and Citizens in England [PDF document] –
HM Government, 2010.

What is Collaborative Practice? [web page] – Altogether Better, 2018.

Altogether Better Working Together to Create Healthier People
and Communities: Bringing Citizens and Services Together in New
Conversations [PDF document] – Altogether Better, 2018.

6.9 Monitoring, evaluation and outcomes

4Pi National Involvement Standards [web page] – National Survivor
User Network, 2013.

Co-production: How are You Doing? [PDF document] – Think Local
Act Personal, 2015.

A Guide to: Annual Reporting on the Legal Duty to Involve Patients
and the Public in Commissioning [PDF document] – NHS England,
2016.

The Point of Care Foundation [website] – The Point of Care
Foundation's 'Evidence and Resources' library (2006–19) is a library
with links to various evidence and practical resources.

7   Abbreviations

Abbreviation	Definition
CCG	Clinical commissioning group
FRS	First Response Service
GP	General practitioner
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
QS	Quality statement
STP	Sustainability and Transformation Partnership

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Special acknowledgements

The Advancing Mental Health Equality Expert Reference Group, NCCMH

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Appendix B: Positive practice examples: survey for mental health commissioners

Q1. In practical terms, what does co-production mean to you in the context of your own mental health commissioning? Do you follow any particular guidance or framework? If so, please describe

Q1a. Give an example of working alongside people to commission mental health care provision for your population

Q2. How have you involved people, service users, carers and others with direct experience of mental health problems in commissioning mental health provision?

Q3. How do you ensure you work with people who reflect the population you are trying to serve?

Q4. Tell us what you have done to engage with people who experience additional inequalities?[c] How do you know you are doing this well?

Q5. In the context of commissioning local mental health provision, please give examples of the different approaches you have used when working with people (for example, consultation, co-development, co-design and co-delivery)

Q6. How have you found out whether the people you work with feel that their contributions have been valued and heard? What do you do to communicate that they are valued and heard?

Q6a. What do you see as barriers to everyone involved being heard and acknowledged? What steps do you take to help remove these?

Q7. How have you enabled people to have an active role in the co-produced commissioning of services? Do you have arrangements for remuneration, training, supervision and support that you can describe?

Q8. What language do you use to describe the people involved in co-production?

Q9. What barriers and challenges do you face in making co-production a mainstream approach in commissioning?

Q10. Did you feel, or can you evidence, the benefits[d] of co-production in mental health commissioning?

Additional questions:

Q1. How does the post promote co-production more widely in the CCG

Q2. How does this process fit into the overall governance framework?

Q3. How did you identify the people who were involved? (For example, in a citizen's panel)

Q5. How did you meet the more excluded communities/people?

Q6. How is your commissioning process quality assured?

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[c] This refers to any inequalities in access to and experience of mental health care that exist in addition to having a mental health problem.

[d] Benefits to include: (1) improvements in patient outcomes; (2) improvements in patient experience from involvement; (3) time effectiveness; and (4) cost.

Appendix C: NICE quality statements and recommendations

Nine NICE guidelines were identified (listed in Section C.2) as being relevant to working with local communities to improve mental health services and advance mental health equality. Searches of those guidelines focused on the involvement of people in service design and redesign rather than in the delivery of care.

C.1   NICE quality statements

Of the relevant NICE guidance, Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities (NICE guideline 44) was found to be the most relevant, and from this guideline two quality standards were derived:

- Community Engagement: Improving Health and Wellbeing (NICE quality standard 148)
- Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (NICE quality standard 167).

From these quality standards, the following quality statements (QS) were found to be the most relevant to co-production in the commissioning of mental health services.

These quality statements will mean different things to people approaching them from different perspectives. For example **health, public health and social care practitioners** in health and wellbeing initiatives should ensure that **from the start of the process, they involve members of local communities as equal partners** in all discussions so that the initiative reflects the priorities identified by those members.

Community Engagement: Improving Health and Wellbeing (quality standard 148)

QS1. Members of the local community are involved in setting priorities for health and wellbeing initiatives.

QS2. Members of the local community are involved in monitoring and evaluating health and wellbeing initiatives as soon as the priorities are agreed.

QS3. Members of the local community are involved in identifying the skills, knowledge, networks, relationships and facilities available to health and wellbeing initiatives.

QS4. Members of the local community are actively recruited to take on peer and lay roles for health and wellbeing initiatives.

Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (quality standard 167)

QS1. People from black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local health and wellbeing programmes.

QS2. People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

C.2   NICE guidelines

The following nine NICE guidelines contain recommendations relevant to co-production in the commissioning of mental health services in England:

- Care and Support of People Growing Older with Learning Disabilities (NICE guideline 96)
- Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services (NICE guideline 58)
- Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities (NICE guideline 44)
- Decision-making and Mental Capacity (NICE guideline 108)
- Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management (NICE guideline 54)
- Older People: Independence and Mental Wellbeing (NICE guideline 32)
- Preventing Suicide in Community and Custodial Settings (NICE guideline 105)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE guideline 136)
- Transition from Children's to Adults' Services for Young People Using Health or Social Care Services (NICE guideline 43)

Please start your co-production journey with this blank page...