

# Making Thrive Kingston



Draft for circulation to Health and Wellbeing Board

## Thrive Kingston

A Mental Health and Wellbeing Strategy

for the people of Kingston by the people of Kingston

2017 to 2021

This strategy covers

- Mental wellbeing for all ages
- Mental health services and support for adults

Lessons we learned from making Thrive Kingston - a new mental health strategy for Kingston Upon Thames



## Contents

Foreword .....	3
The purpose of this paper and who it is for .....	4
Background and Context .....	4
Co-Production and complementary methods .....	7
Process followed and governance employed .....	10
Constraints.....	10
Governance.....	10
Process (overview).....	11
Event 1 - Discovering Assets.....	13
Event 2 - Forming the Group .....	16
Co-Production .....	16
Behaviours .....	17
Common Terminology .....	17
Scoping Exercise.....	17
Event 3 - Understanding How Things Are Now.....	25
Event 4 - Deciding How the Future Should Be .....	30
Completing the Picture .....	37
Event 5 - Refining the Strategy .....	37
Feedback we received at Event 5 .....	43
Discovering Assets.....	43
Governance .....	43
Deciding How the Future Should Be .....	44
Learning .....	45
Make enough space to listen to all perspectives respectfully .....	45
Churn happens.....	45
Make sure all feedback is recorded and seen to be recorded .....	45
Ground everyone in the process at the start of every session and follow it up at the end .....	45
All plans are useless but planning is essential .....	46
An effective steering group is vital.....	46
Removing hierarchy is easier said than done .....	46
The power of self-disclosure .....	47
Know who's not there .....	47
Be the child of at least a medium sized God.....	47
Reflections on community empowerment .....	48
Arnstein's Ladder .....	48
Assessment of this process against Arnstein's Ladder .....	49
Conclusion .....	50

## Foreword

We're delighted to partner with the Royal Borough of Kingston Upon Thames and Kingston's Clinical Commissioning Group to co-produce a new mental health strategy for Kingston. Co-production is not consultation. Co-production challenges existing notions of leadership and ownership, with the promise of creating outcomes which are the best fit for all concerned. In the health and social care sector it involves dissolving traditional boundaries and building peer relationships between people who use services, their families and carers, professionals and deliverers of services, and anyone who is passionate about wellbeing. In co-production everyone is an expert; some in a clinical / professional field; others are experts in their own lives and experiences, including adversity. Many are both. We are all equal members of the same community.

The co-production phase to build the strategy has taken eight months, including five major day-long events averaging 60 people at each (a total of 200 people were involved throughout), backed up with an outreach programme and an on-line survey. It's been especially pleasing to see relationships build as the dialogue continues. Everyone has been open to listening to each other, as people. It's resulted in the assembly of an evidence log from all quarters of 80+ pages (in a small font!); countless flip-chart pages and over 50 case studies. These have contained wall-to-wall insights, many consistent and quite a few which are novel. Importantly, most of these insights have been exchanged first hand, face to face. It's also been fun, which was not a box everyone was expecting to tick.

Going forward we want to maintain these relationships into the phase of implementation and delivery; and ultimately into review. We need to make sure we get what we said we needed. To do this we want, together, to decide how we change the governance around mental health services and wellbeing in the borough so that it meets everyone's needs and enables us all to stay involved.

We've also built a record of our experiences of this process throughout 2016 -this document - so that we can offer a model for consideration by other partnerships starting out in co-production; and like everything, we did this together.

Last we'd like to thank everyone for the commitment they've shown to stick with the process throughout the year. We're pleased to say that we are largely the same 60 people we were in April. Except that we've all grown a bit and made some new friends.

Stephen Hardisty, Manager

Tony Williams, Chair, Mental Health  
Task Group

HealthWatch Kingston Upon Thames

## **The purpose of this paper and who it is for**

During 2016, a new strategy on mental health was developed for Kingston Upon Thames. It was decided from the beginning that the strategy would be informed by the views of people in the borough. In this way it was intended that the new strategy would meet people's needs better.

This paper describes how the strategy was developed, specifically how the process of gathering people's views and using them to shape the strategy was handled. This process is called "co-production". The co-production process did not finish when the strategy became a document: it will continue over the five years in which the strategy is delivered, and will be used ultimately to review it at the end.

The paper is intended to help others who want to develop new products and services and want to make them represent peoples' needs better. It:-

- Describes the background to the work and its context
- Describes co-production and other ideas we used
- Describes the process we followed and the governance we used to control it
- Reflects on what was critical to success
- Discusses what could have been done better
- Provides links to things we used to make the strategy in case they are useful to others.

No previous experience of co-production, of organisational change methods, or of the UK health and social care system, is assumed.

## **Background and Context**

Kingston is a borough in South West London. It is known as an affluent borough but contains areas where people live in poverty. About 173,500 people live there, and about 30,000 more come to the borough for various reasons. The demographics of mental health in Kingston are not significantly different to other parts of London, or the UK in general. Responsibility for managing the health of these 200,000 people falls to the public health section of the local authority, called the Royal Borough of Kingston Upon Thames (often shortened to RBK), and to the Clinical Commissioning Group (CCG), which between them try to understand the needs of the borough, both now and in the future, and use that understanding to buy (commission) products and services which meet them.

Currently most services which meet the borough's mental health needs are provided by South West London and St Georges' Mental Health Trust; some by Camden and Islington Mental Health Trust; and others from a range of smaller providers. Delivery of mental health services is planned and monitored by RBK public health and the CCG in a forum called the Mental Health Planning Board

(MHPB). Above this is a forum called the Health and Wellbeing Board, which is accountable for public health in the widest possible sense.

In December 2015 the Health and Wellbeing Board required the MHPB to develop strategic thinking in mental health over the coming five years. In January 2016, the MHPB considered this objective, and the direction of the Five Year Forward View for Mental Health<sup>1</sup>, which said “Co-production with clinicians and experts-by-experience should also be at the heart of commissioning and service design, and involve working in partnership with voluntary and community sector organisations.” In the light of this direction, the MHPB decided to co-produce the new strategy. It was decided that a product should be in draft in time to inform the commissioning cycle for 2017-18 - in other words, by the end of the calendar year 2016.

As we will see, co-production involves working with the community. So RBK public health and the CCG approached the HealthWatch Kingston Upon Thames (HWK) Mental Health Task Group (MHTG) to reach individuals with appropriate life experiences to inform the strategy. HealthWatch organisations provide a national framework of assurance in the health and social care systems in the UK, representing the “voice of the customer”<sup>2</sup>. To achieve this end, their continual engagement with individuals with lived experience of the local health and social care system is essential. HealthWatch delivery is almost entirely dependent on the work of volunteers, organised into “task groups” themed around aspects of the health and social care system. These factors made HWK a good partner for the co-production work, as will be discussed later. The proposition was debated at the February 2016 MHTG, and commitment to assist the council and the CCG in the co-production exercise was agreed amongst those present. HWK then started to promote the idea of a co-production community to their contacts.

While this work was going on, a small sub-group was assembled to start to devise a draft of the co-production process and to make sure that the resource needs of the co-production group could be met. This later became a regular forum called the Mental Health Strategy Steering Group (MHSSG).

A launch event was arranged, to convene the co-production community and to share the draft co-production process so that it could be refined by the community. This event marked the start of the co-production process. The co-production process was based on some existing methods which have been proven in the UK and elsewhere.

---

<sup>1</sup> The Five Year Forward View for Mental Health – a report from the independent Mental Health Taskforce to the NHS in England. February 2016 (p.25) <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

<sup>2</sup> <https://www.healthwatch-uk.org/images/Documents/Charitable-aims-and-research2.pdf>

As HWK had limited experience of co-production, a local social enterprise called RISE was asked to contribute their expertise, and that featured strongly at the beginning.

The next section in this paper discusses the methods which were used.

## Co-Production and complementary methods

Put simply, co-production is about involving the people who use products and services in their design, delivery and review, so that the outcomes meet their needs better. But it is more than that. In the UK, an authority on co-production is the New Economics Foundation (NEF). NEF published a manifesto on co-production in 2008 called “*Co-Production: A Manifesto for Growing the Core Economy June 2008*”.

Describing co-production, NEF says<sup>3</sup> “The point is not to consult more, or involve people more in decisions; it is to encourage them to use the human skills and experience they have to help deliver public or voluntary services.” This implies such human skills as emotional intelligence, insight and compassion will be utilised throughout the whole delivery cycle, from design through implementation to review, in order to achieve a better fit of outcome to need. Even more than *involving* community in shaping delivery, it seeks to *integrate* community with delivery:-

“The need is clear - how to recognise the hidden assets that public service clients represent, and make public services into engines that can release those assets into the neighbourhoods around them - and to do so even when public sector budgets are severely constrained whilst avoiding people becoming cynical about the role and motivation of the state.”

The Manifesto goes on to describe essential qualities of effective co-production as:-

“Public organisations and charities that set out to co-produce with clients, and their families and neighbours, will have a range of different characteristics. They will not necessarily all look the same, but similar processes will be in place, which incorporate the following:

- Provide opportunities for personal growth and development to people, so that they are treated as assets, not burdens on an overstretched system.
- Invest in strategies that develop the emotional intelligence and capacity of local communities.
- Use peer support networks instead of just professionals as the best means of transferring knowledge and capabilities.
- Reduce or blur the distinction between producers and consumers of services, by reconfiguring the ways in which services are developed and delivered: services can be most effective when people get to act in both roles - as providers as well as recipients.

---

<sup>3</sup> Co-Production: A Manifesto for Growing the Core Economy June 2008  
[http://www.thinklocalactpersonal.org.uk/assets/BCC/nef\\_Co-production\\_1.pdf](http://www.thinklocalactpersonal.org.uk/assets/BCC/nef_Co-production_1.pdf)

- Allow public service agencies to become catalysts and facilitators rather than simply providers.
- Devolve real responsibility, leadership and authority to ‘users’, and encourage self-organisation rather than direction from above
- Offer participants a range of incentives which help to embed the key elements of reciprocity and mutuality.”

In taking forward the Thrive Kingston co-production process we sought to adopt these principles. This paper will describe how we did this in a later section.

Complementary to co-production, which seeks to realise the value of community as an asset to service design and delivery is Asset Based Community Development, or ABCD. ABCD identifies freely available community assets in order to achieve outcomes rather than depending on the supply of external resources (usually this means money, or traditional services). It is an empowering methodology. Principles which are usually found in ABCD initiatives are<sup>4</sup>:-

- That it is "asset-based." That is, this community development strategy starts with what is present in the community, the capacities of its residents and workers, the associational and institutional base of the area - not with what is absent, or with what is problematic, or with what the community needs.
- Because this community development process is asset-based, it is by necessity "internally focused." That is, the development strategy concentrates first of all upon the agenda building and problem-solving capacities of local residents, local associations and local institutions. Again, this intense and self-conscious internal focus is not intended to minimize either the role external forces have played in helping to create the desperate conditions of lower income neighbourhoods, nor the need to attract additional resources to these communities. Rather this strong internal focus is intended simply to stress the primacy of local definition, investment, creativity, hope and control.
- If a community development process is to be asset-based and internally focused, then it will be in very important ways "relationship driven." Thus, one of the central challenges for asset-based community developers is to constantly build and rebuild the relationships between and among local residents, local associations and local institutions.

Another method complementary to co-production is Appreciative Inquiry (AI). AI “advocates collective inquiry into the best of what is, in order to imagine what

---

<sup>4</sup> Reprinted with permission of John P. Kretzmann and John L. McKnight, pp. 1-11, from Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, Evanston, IL: Institute for Policy Research (1993). <http://www.abcdinstitute.org/publications/basicmanual/index.html>

could be, followed by collective design of a desired future state that is compelling and thus, does not require the use of incentives, coercion or persuasion for planned change to occur”<sup>5</sup> AI focuses on change through exploration of strengths as opposed to the amelioration of weaknesses.

Appreciative inquiry attempts to use ways of asking questions and envisioning the future in order to foster positive relationships and build on the present potential of a given person, organization or situation. The most common model utilizes a cycle of four processes, which focus on what it calls:

1. DISCOVER: The identification of organizational processes that work well.
2. DREAM: The envisioning of processes that would work well in the future.
3. DESIGN: Planning and prioritizing processes that would work well.
4. DESTINY (or DEPLOY): The implementation (execution) of the proposed design.

The aim is to build - or rebuild - organisations around what works, rather than trying to fix what doesn't. AI practitioners try to convey this approach as the opposite of problem solving.

The following section describes the process we followed based on aspects of these methods.

---

<sup>5</sup> Bushe, G.R. (2013). Kessler, E., ed. [The Appreciative Inquiry Model](#) (PDF). *The Encyclopedia of Management Theory*. Sage Publications.

## Process followed and governance employed

### Constraints

Having described certain methods which we chose to develop Thrive Kingston it is necessary to recognise some limitations imposed by the context which caused the strategy to be pursued in the first place, as these were not negotiable. These limitations constrained the purity of the methods which could be employed and demanded compromise. They were to do with the drivers (causes).

The drivers for the strategy were “top down” (driven from the top) - that is to say, the Health and Wellbeing Board, MHPB, RBK and the CCG wanted to have a Mental Health Strategy; NHS England required that they follow a co-production process; and there were also national and regional demands that the strategy would have to fulfil which were not community-related - for example, things which were clinical decisions based on best practice, or commercial constraints which arose from the commissioning process, which is determined across government. The strategy also had to sit alongside other strategies whose boundaries were already defined and in some cases had already been developed / delivered, e.g. CAMHS (young people’s mental health) and dementia.

So the strategy would need to recognise a mixture of clinical and commercial best practice, national and regional strategy and policy drivers. But the co-production process would allow us to give the results a community focus so that the right *human factors* would be visible in the resulting system. In other words, there are certain things which the strategy will have to do, but the community can influence how it will be delivered and how it will feel.

Some of the methods just described are clearly at odds with a “top-down” approach - particularly ABCD. As an example, to accommodate that tension we chose to identify community assets to inform our ideas; but also to identify service options which could come to play. As another example, AI would have us disregard how things are and instead have us focus on how things should be; but many community members had a strong need to relate how the existing service had affected them, so it was not practical to adhere to a pure AI approach.

In short then, we blended a mixture of community-based approaches to obtain the person-based outcomes and values which the strategy should embody, with the clinical and commercial constraints, accommodating national and regional policy and within pre-defined strategic boundaries.

### Governance

As related in the background section to this paper, first we built a small steering group which would be responsible for development of the strategy to the MHPB

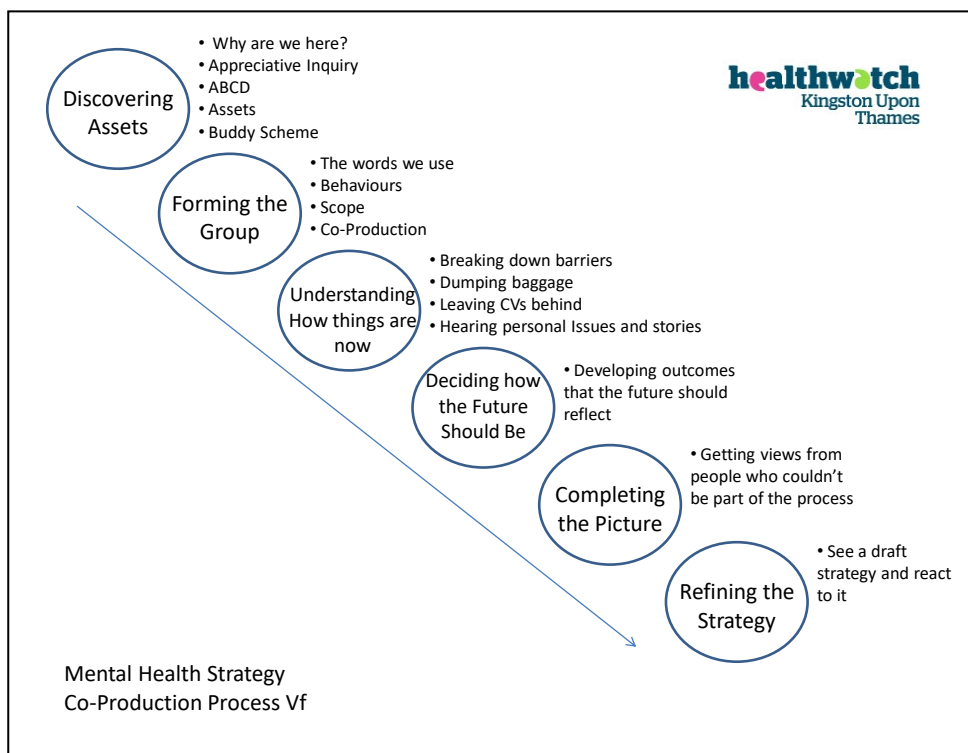
and the Health and Wellbeing Board. Terms of Reference for the Steering Group are available at appendix A to this paper.

HealthWatch then built a feedback log, into which all comments made by any party would be recorded. The feedback log was designed so that all feedback must show how that feedback has been used, either to inform the strategy or to shape the strategy development process. A sample page from the feedback log is at appendix B.

Next we started to build a heterogeneous community of diverse backgrounds and perspectives. Local peer-led community organisations were approached and their involvement elicited - for example, Fast Minds, an ADHD / ASD / PD support network, Kingston Environment Centre, RISE, a peer-led recovery group, Kingston Carers Network. Added to this were local examples of voluntary sector delivery, for example the Fircroft Trust, MIND in Kingston, Kingston Samaritans, the RNLI. Also individuals, not aligned to any organisation, their friends and carers; and finally representatives of statutory organisations and their commissioned services, RBK, the CCG, South West London and St George’s and Camden and Islington Mental Health Trusts. A full list of contributors is appended to this paper.

Process (overview)

We built a draft process and at the first (launch) event we checked the sense of the process with the community so that they not only became involved in the shaping of the process but came to own it. As the process developed we returned to its design and adjusted it with input from the community as we went along. A diagram was used to describe the process. Below is version F, the version we had



arrived at by the end of the process. As the letter F suggests, it is the 6<sup>th</sup> version of the process.

Each stage was to be achieved by a day-long workshop, with the exception of stage 5. The first workshop

took place in late May, the last in early December. The workshops are described in detail in the following pages. This section describes how the process was intended to work overall.

The early stages of the process (stages 1 and 2) were designed to build the co-production community, through a focus on the dynamics and qualities of the group. Two whole events were invested in issues such as equipping all present with a common view of scope and terminology, building a set of behaviours by which we would interact. They also provided overviews of AI, ABCD and co-production. Whilst these steps were necessary and worthy, the first two workshops were also the place where a mixed community of users of services, carers and professionals got to know each other first and foremost as *people*, rather than in the roles they were used to occupying. This was especially important as the third workshop tackled the shortcomings of the existing mental health system, and this session was seen as potentially the most difficult to handle as it dealt with issues of sensitivity and possibly of trauma.

The fourth event, in contrast, was focused on how the future should look. This took place in July, and was followed by the traditional holiday period. During this time the HWK personnel took the strategy process on the road to local organisations and individuals who were unable to participate in the events. An online form was also promoted to capture other individual feedback and case studies. RBK also used the time to circulate a questionnaire to professionals. A period of drafting then followed.

The last event in December was a chance for the community to see the developed content and to react to it; in effect, a chance either to contest the content or to fine polish it.

The strategy was then further refined by the Steering Group according to the feedback received, and a limited consultation process followed, in time for the strategy to be presented to the Health and Wellbeing Board in March 2017.

The section which follows describes the co-production process in more detail, including images from the events and examples of the outputs. From the second event onwards, session plans were developed for each event and these are included to describe the events better.

## Event 1 - Discovering Assets

About 60 people attended the first workshop (this number was sustained through the whole process, although the people in attendance were not always the same individuals). It took place on 27<sup>th</sup> May in the Quaker Centre in Kingston. The first event focused on exposing the community to some of the methods discussed earlier; co-production, AI and ABCD. A presentation was given and a discussion led by a representative from RISE on these subjects. Although these tools were explored and exercises completed, the purpose of the day was just as much if not more about the group forming together and getting used to working together as people; and, just as importantly, working in a different way to the way they were accustomed.

The day followed a pattern which was repeated throughout; the group was assembled and welcomed, objectives and an agenda for the day explained.

The group then identified the outcomes they wanted to achieve from the day. These were recorded for comparison at the close.

Then, a classic AI interview protocol was followed. In this exercise, the group formed into pairs. In each pair, one participant related a story from their experience which involved dealing with a difficult situation. During this exercise, the other participant listened and noted down not the narrative of the story, but the qualities and skills which the first participant must have exhibited to achieve their outcome. After 10 minutes the positions were reversed. At the conclusion, all participants introduced their opposite number, and related their skills and qualities. A facilitator recorded each new skill or quality on flipchart paper. At the conclusion of the exercise, three outcomes were apparent; first, that the group had started to get to know each other; second, that an air of positivity had started to grow in the room; and third, that exposure to a method had been achieved.

Next, a discussion on co-production was facilitated by an experienced practitioner. This amplified the difference between co-production and consultation exercises.

Then in groups around tables, each table played the ABCD Game. The ABCD Game demonstrates the power of social capital. Small cards, depicting a wide range of common skills (and a few not so common), are randomly dealt to the group. Three large cards are placed in the space between the participants: I CAN DO IT, I KNOW SOMEONE WHO CAN DO IT, and I CAN'T DO IT AND I DON'T KNOW ANYONE WHO CAN. A brief discussion is held on the subject of how many cards out of 100 may be expected to be found in the third pile. The participants then discuss each card in their hands in turn, identifying whether they themselves can do it or whether someone in the group knows someone who can. At the conclusion there are usually nearly no cards in the third pile. The message is; you can get most things done if you work together and call on your personal connections.

Last, an asset mapping exercise was conducted, another ABCD idea. Using flip chart pages and post-it notes, this started with the identification of personal assets, be they head (knowledge), heart (passion) or hands (skills). Using the same method, consideration of locally available assets came next, be they primary (under direct community control), secondary (not under community control but to which access can be negotiated) and external (in the world outside). These were then organised into domains (themes).



## Event 2 - Forming the Group

The second all-day workshop was again about preparing the community to undertake the co-production work. Within this overall aim there were objectives

- More exposure to what co-production is and some related ideas
- Agreeing how we wanted to work together by defining a set of behaviours for the group
- Making sure that everyone had roughly the same understanding of terms and language which would commonly be used in the rest of the exercise
- Making sure that everyone had a common view of what the scope of the strategy and what was outside - to prevent us spending lots of time discussing out of scope issues

This meant that the day was made up of four loosely related exercises, rather than one continuous process, which had been the feel of Event #1. Rather than the meeting room at the Kingston Quaker Centre, Event #2 was held at the Fircroft Trust in Surbiton. There were about 45 attendees at this workshop.

Following some feedback from the first event, a new session was introduced where one of the facilitators described the whole strategy development process in brief and explained the context of the day's work. This was reinforced by the mailshot calling attendees to the event, which carried the same message. The purpose of this activity was to make sure everyone understood the context of the work they were going to do and how it fitted into the overall process. This step was repeated at each of the subsequent workshops in the series.

We also understood from the first workshop that community members found it hard to get to events which started as early as 10:00am, for a variety of reasons. We therefore adjusted the start and finish times for all subsequent events to 11:00am - 4:00pm to accommodate this.

### *Co-Production*

Reinforcement of the idea of Co-Production was achieved by playing two short videos followed by a group discussion.

<https://www.youtube.com/watch?v=vugLEaEcBR0>

<https://www.youtube.com/watch?v=aKATrzUV2YI&t=3s>

## *Behaviours*

We asked the group what rules they wanted to impose on themselves about how they would make a respectful and inclusive working environment. Once each rule had been debated and clarified we recorded this on a flipchart. The behaviours were made available at all the subsequent workshops.

## *Common Terminology*

To work together effectively it was important to make sure that any commonly used terms were understood to have the same meaning(s) by everyone involved.

We also sought to eradicate jargon wherever possible as this could exclude people. One member of the community took on a role to challenge jargon wherever it was used - and everyone agreed that she should do this.

There is a balance to be struck here, obviously. On the one hand we didn't want to use exclusive language but on the other we did not want to use lots of people's time by constantly referring to a spade as a broad bladed entrenching tool.

So for terms which would be in very common usage we ran an exercise where "street" terms, terms in mental health service delivery and commissioning were written on pieces of A4 paper. The pieces of paper were stuck onto the walls around the workshop; the community were asked to augment them with any other terms they felt they had heard and did not understand. We then gave everyone 10 sticky voting buttons each and asked them to nominate the most significant / least understood words in the room.

We then asked if there was anyone in the room who could explain the most voted-for words to everyone else. In every case, there was.

## *Scoping Exercise*

A large landscape whiteboard was set up in the room where everyone could see it. A large oval was drawn on it. Things which were to be in-scope of the strategy were written inside; things out-of scope were written outside. One of the Mental Health Commissioners gave a brief description of the given constraints which applied to the remit given by the Health and Wellbeing Board; for example, that this was about everyone's wellbeing, but only about adult mental health services, as there was already a CAMHS (Children and Adolescents Mental Health Service) strategy in development; that functional, rather than organic mental health was in scope (and what this meant).

The community then explored what this meant in practice by raising observations or questions. These observations / questions were debated by those in the room and the results either written inside or outside the oval. The scoping diagram which resulted was made available at subsequent workshops.

At the close of the day the next steps were outlined.



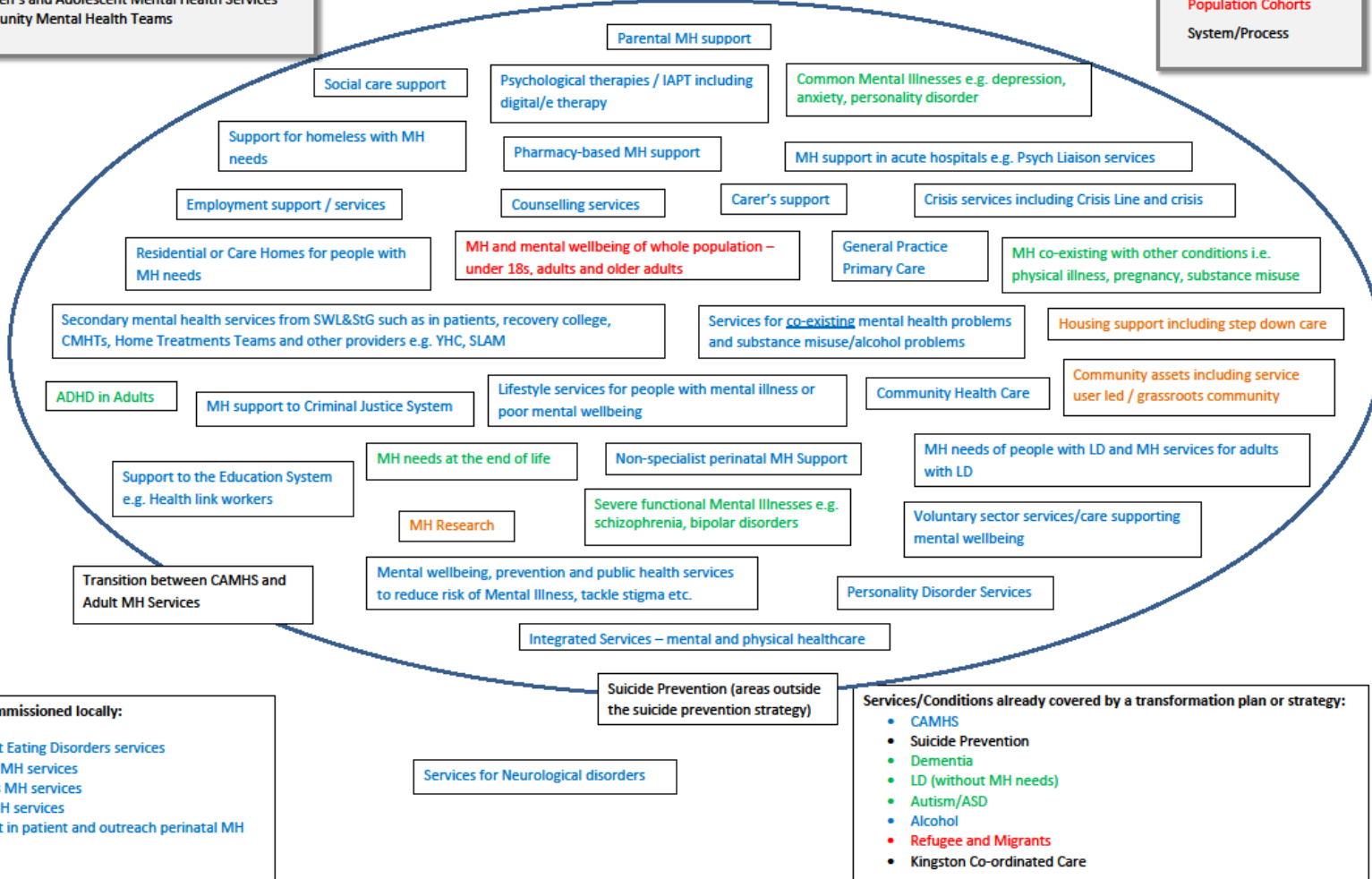
**Glossary:**

MH = Mental Health  
 SLAM = South London and Maudsley NHS Trust  
 SWL&StG = SWL and St George's MH Trust  
 LD = Learning Disabilities  
 YHC – Your Healthcare CIC  
 IAPT – Improving Access to Psychological Therapies  
 CAMHS – Children's and Adolescent Mental Health Services  
 CMHTs – Community Mental Health Teams

**Mental Health Strategy – What is in or out of scope**

**Key:**

Assets  
 Conditions  
 Services/Support  
 Population Cohorts  
 System/Process



# Behaviours Agreed in Workshop #2

- Listen to each other/ don't talk over the top of other people.
- Stay on topic
- Respecting each others opinions and ideas
- Respecting the confidentiality of what is shared
- Be constructive if you want to challenge something that has been said.
- No abbreviations or acronyms (use language that everyone will understand)
- Be kind to yourselves and others

## MH Strategy Session Plan - Event #2

<b>Facilitators:</b>	<b>S Hardisty / T Williams</b>	<b>Location:</b>	<b>Fircroft Trust</b>	<b>Date:</b>	<b>24<sup>th</sup> June 2016</b>
<b>Topic:</b>	<b>Forming the Group</b>	<b>Start Time:</b>	<b>11:00am</b>	<b>End Time :</b>	<b>16:00</b>
<b>Aim:</b>	Create a common understanding in the group				
<b>Objectives/Outcomes</b>	Agree standards of behaviour Understand co-production Understand and agree scope of the strategy Understand a common terminology				

<b>Timing</b>	<b>Learner Activities</b>	<b>Teacher Activities</b>	<b>Resources</b>	<b>Assessment</b>
11:00am - 11:05am	Absorb Ask questions	<b>Welcome and housekeeping</b> Introduce self Explain layout at Fircroft <ul style="list-style-type: none"> <li>• Toilets</li> <li>• Refreshments</li> <li>• Emergency procedures</li> </ul> Explain agenda	<b>Stephen Hardisty</b> 60 Name badges 60 Copies of agenda	Learner questions and feedback
11:05am - 11:20am	Absorb Ask questions Give feedback	<b>Where are we in the process?</b> Introduce self Explain strategy process Explain feedback document Demonstrate use of feedback	<b>Tony Williams</b> 1 Large copy of process diagram 60 Copies of process guide 5 Copies of feedback document 1 Copy of feedback on process so far	Learner questions and feedback

11:20am - 11:40am	Contribute behaviours	<b>How do we want to work with each other?</b> Elicit acceptable behaviours from group Record behaviours	<b>Denise Parry</b> Flipchart easel Flipchart Pad Pens	Learner contributions
11:40am - 12:30pm	Absorb Express opinions Give feedback	<b>What is co-production?</b> Ask for views from group Show video Co-Production by Spice (3.5 mins) <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Record Feedback</li> </ul> Show video No More Throw Away People (6 minutes) <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Record Feedback</li> </ul> Show video Stories of Co-Production (8 mins) <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Record Feedback</li> </ul>	<b>Tony Williams</b> Laptop Projector Screen Flipchart easel Flipchart pad Pens Copies of videos <ul style="list-style-type: none"> <li>• Co-Production by Spice</li> <li>• No More Throw Away People</li> <li>• Stories of Co-Production</li> </ul>	Formative assessment at start and after each video Summative assessment at end
12:30pm - 1:30pm	Eat and drink Complete buddy sheets	<b>Lunch</b> Explain buddy system Ask group to complete over lunch	<b>Tony Williams</b> Buddy scheme sheets Lunch Napkins Plates Cups	Completed buddy sheets
1:30pm - 2:30pm	Vote on terms Supply more terms	<b>The words we use (understanding terminology)</b> Explain process Invite completion of new terms	<b>Stephen Hardisty</b> 50 Terminology sheets Blu-tac Blank sheets	Completed terminology sheets

		Invite voting	60 x 10 Voting buttons	
2:30pm - 3:30pm	Contribute conditions, assets, services	<b>What is included in the strategy and what can't be</b> Explain process Record feedback Elicit clarifications	<b>Stephen Hardisty</b> <b>Tony Williams</b> Large (4' x 6') whiteboard 5 Copies of scoping document	Completed diagram
3:30pm - 4:00pm	Absorb Questions	<b>What happens next?</b> Explain next stage in process Ask for questions Record feedback	<b>Tony Williams</b> Large copy of process diagram Flip chart easel and flipchart pad Pens	

### Event 3 - Understanding How Things Are Now

The third workshop was held at the Kingsmeadow Conference Centre in July 2016. This was the start of co-production proper, with the single aim of hearing experiences of and opinions on the existing delivery of mental health services in the Borough.

To prepare the context for the workshop, presentations were given by the Clinical Commissioning Group and RBK Public Health on National, Regional and specialist strategy and policy. An exercise was conducted to elicit people's perspectives on budgetary issues in mental health commissioning, where blank pie charts were distributed to the community and estimates made of where and how much people thought was spent on which aspect of delivery.

The main exercise however was to identify a number of themes for discussion and to identify the most popular, again using voting buttons. For this purpose some sample themes were suggested, and the community asked to identify their own. These were written onto A4 sheets and posted onto pinboards. Voting buttons were distributed (12 to each individual) and the community asked to vote on the issues of most concern / relevance to them.

18 most popular themes for discussion were identified. These were put into a table projected onto a screen visible throughout the room.

The room was laid out as six large circular tables, 10 seats per table. A facilitator and a scribe sat at each table. The facilitators role was to facilitate conversations and to draw conclusions from them; the scribes recorded discussions and their conclusions on flip-chart paper.

The community were then split into 6 tables and each table debated three themes, each debate of 30 minutes duration. In this way all 18 themes were discussed in a 90 minute session (this is different from the session plan, which envisaged 12 sessions over 2 hours - a constraint imposed by the number of themes identified as a priority and the amount of time left in the day). Community members could move between the tables to discuss the subjects of most concern to them.

At the conclusion of the day the facilitators played back the conclusions to the whole group and additional feedback gained. Next steps were discussed.



### MH Strategy Session Plan - Workshop Event #3

Facilitators: S Hardisty / T Williams / S Ford / R Rowan / H Raison / D Parry / S Bird      Location: King Charles Centre      Date: 11<sup>th</sup> July 2016

Topic: Dissolving Barriers      Start Time: 11:00am      End Time : 16:00

Aim: Depict the current state and capturing perspectives on it

Objectives/Outcomes  
 Achieve a common understanding of the current state  
 Decide which aspects of the current state are most important to overhaul  
 Unpack lived experience and hearing views on the current state  
 Capture case studies

Timing	Learner Activities	Teacher Activities	Resources	Assessment
11:00am - 11:05am	Absorb Ask questions	<b>Welcome and housekeeping</b> Introduce self Explain layout at King Charles Centre <ul style="list-style-type: none"> <li>• Toilets</li> <li>• Refreshments</li> <li>• Emergency procedures</li> </ul> Explain agenda	<b>Stephen Hardisty</b> 60 Name badges 60 Copies of agenda	Learner questions and feedback
11:05am - 11:20am	Absorb Ask questions Give feedback	<b>Where are we in the process?</b> Introduce self Explain strategy process Explain feedback document Demonstrate use of feedback Remind group of behaviours and scope	<b>Tony Williams</b> Laptop + projector + screen Projected copy of process diagram 60 Copies of process guide 5 Copies of feedback document 1 Copy of feedback on process so far	Learner questions and feedback

			Posters depicting agreed behaviours Diagram showing scope	
11:20am - 12:00 Midday	Give feedback Contribute to discussion	<b>Understanding how things are #1</b> <ul style="list-style-type: none"> <li>• Presentation / discussion on JSNA and significant National drivers - LT / HR</li> <li>• Presentation / discussion on commissioned services - SF</li> <li>• Interactive exercise - perceptions of diagnoses and spending - SF</li> </ul>	<b>Liz Trayhorn / Helen Raison / Sylvie Ford (presenting)</b> <b>Tony Williams (recording)</b> Laptop + projector + screen Blank pie charts Flipchart easel Flipchart Pad Pens	Feedback from group  Completion of interactive exercise
12:00 midday - 12:30pm	Contribute themes Choose themes	<b>Shaping the debate</b> Explain process Discuss confidentiality Invite audience to contribute new themes Affix new themes to wall Ask audience to vote for themes	<b>Stephen Hardisty</b> 13 Theme titles on A4 sheets Blank A4 sheets Blu-Tac Voting buttons	Completed theme sheets Votes
12:30pm - 1:30pm	Eat and drink	<b>Lunch</b> Assess Shaping the Debate exercise and prep tables for afternoon sessions	<b>Tony Williams / Stephen Hardisty</b>	
1:30pm - 2:30pm	Tell stories	<b>Hearing stories exercise #1</b> Explain process Ask audience to move to tables based on themes Hear stories and facilitate content	<b>Tony Williams + all facilitators</b> Flip chart paper Indelible marker pens	Completed storyboards
2:30pm - 3:30pm	Tell stories	<b>Hearing stories exercise #2</b> Ask audience to move to different tables based on themes	<b>Tony Williams + all facilitators</b> Flip chart paper Indelible marker pens	Completed storyboards


		Hear stories and facilitate content		
3:30pm - 4:00pm	Absorb Ask questions	<b>What happens next?</b> Explain next stage in process Ask for questions Record feedback	<b>Tony Williams</b> Large copy of process diagram Flip chart easel and flipchart pad Pens	

## Event 4 - Deciding How the Future Should Be

The fourth workshop was again at the Kingsmeadow Conference Centre. Like the third workshop it employed discussion groups working in parallel to address a wide variety of subjects.

Prior to the fourth workshop analysis had been done of the feedback recorded in the feedback log (by now of 80+ pages volume), The analysis suggested an emergent shape in the feedback received, and this had been debated and agreed in the Steering Group. The themes were suggested to be:-

Shape which has emerged from the feedback log

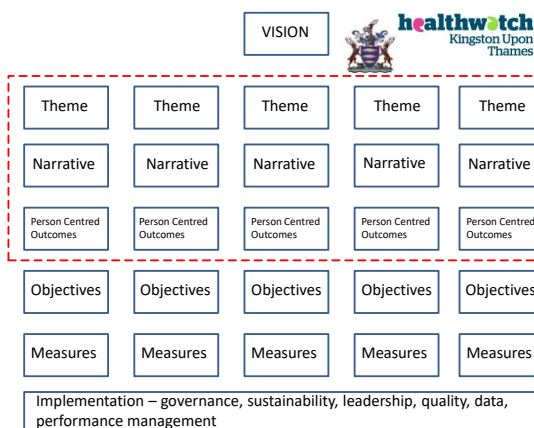


- Good Mental Health for All**
  - Prevention, mental health awareness and tackling stigma
- Early Intervention**
  - Information, self-care, carers, GPs and signposting
- The Wider World**
  - Recovery, peer support, voluntary and community sector and user involvement
- Access to Services and Support**
  - Access to mental health support, especially to psychological therapies and inequalities
- Integrated Care**
  - Joined up mental health care including holistic care

As five themes had been identified the community was seated at five large circular tables, 12 per table. Each table, as with workshop #3, was equipped with a facilitator and a scribe.

We asked the community to flesh out each theme with a narrative - a paragraph describing their feelings about these subjects; and to define “person centred outcomes” for each.

Today's Scope



Outcomes (what great looks like)

*noun*

the way a thing turns out; a consequence.

"it is the outcome for me that counts"

*synonyms:* [result](#), [end result](#), [consequence](#), net result, [upshot](#), [effect](#), [after-effect](#), [aftermath](#), [conclusion](#), end product

We gave definitions and examples of the kind of material we were looking for.

## EXAMPLES OF PERSONAL OUTCOMES



- The staff I meet are trained to understand my issues and my mental health condition and are able to help me as a whole person
- When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time.
- I received a seamless service from the three organisations that supported me through my illness
- I feel better (e.g. am less anxious, depressed) following the care I have received
- If I raise complaints, they are taken seriously, and I am told what has happened in response
- I was able to get support within a reasonable and guaranteed timeframe
- I have or know how to get support to help me access benefits, housing and other services I might need
- I am not stigmatised by services and professionals as a result of my health symptoms or my ethnic or cultural background
- I am provided with peer support from people who understand my culture and identity

... Make them personal outcomes **if you can**

Other kinds of outcomes were OK too.

## EXAMPLES OF OTHER OUTCOMES



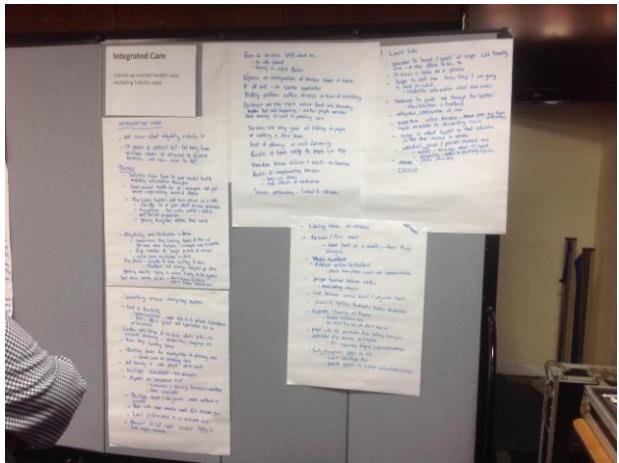
### Other ways of recording 'What great looks like'

It is sometimes difficult to explain what you would like to see as a personal outcome. If so please record it in any other way you can

- A one-stop shop
- Someone to help me decide what to do
- Everyone is referred to the right place. No referrals are rejected
- Shift to a more comprehensive suite of services in the community and primary care (tier 1 and 2 services) that can meet our needs.
- Commission a service for X
- Improve the quality of care at Y

People set to work ...

At the close of the day the next steps were outlined.



**Figure 2. OUTCOMES for KINGSTON MENTAL HEALTH STRATEGY**

These are the outcomes the community decided on.

**Overarching**  
 I have someone to talk to I am not socially isolated Staff have received all the training they need to support me Services are working together to support me

**Carers**  
 I feel listened to, respected and had my say I feel confident we can work towards quality support when I am not around I am involved in discussions about care if consent is given I was offered a Carer's assessment and support regardless of Care Act eligibility A crisis plan is always shared with me if consent is given I am able to contribute to the process of early contact with healthcare and diagnosis I have sufficient support to access information

Table 3 rebelled and decided their theme should be called Community Connection

**Mental Wellbeing**

- I feel safe and am not scared
- I have a purpose and contribute to society
- I feel happy
- I am happy to help others
- I am not lonely
- I feel comfortable talking about my mental health
- I can take part in social activities that I enjoy
- I have learnt some skills to help me cope when things go wrong
- I am able to access support to learn and develop as a parent
- As a young person I know a trusted adult e.g. in my school who I can talk to when I can't talk to my own parents
- I feel well

**Early Intervention**

- I am aware when I need help and know where to find it
- I can easily access reliable, useful information and advice when I need it
- I can be guided through the system if I need help
- My GP knows all the options for care and I get the best option for my needs first time, in a timely manner
- I felt heard and understood when I needed help
- Services I encounter are proactive in helping me
- My GP gives me enough time to talk about my mental health issues
- I don't have to tell the receptionist my mental health problems
- I am provided with realistic, useful and timely information about my condition, side effects and waiting times

**Community Connection**

- I am living somewhere I feel comfortable, supported and safe
- I feel a valued part of the community
- I feel supported by the community
- I can use my experience to help others
- I have equal opportunities and do not suffer discrimination
- I do not need to justify and explain myself to others
- I belong to a network of support - professionals, service users, buddy schemes and family
- I have the support I need to obtain/ retain employment
- My family understands and supports me
- I always have a place to go where I felt welcome and supported
- I have aftercare that meets my needs. Services are flexible (easy in/out)

**Access to Services**

- I can access the help I need when I need it
- I make shared decisions with care providers
- If I don't meet the criteria I am helped to access more appropriate services
- When I am in crisis I can communicate with someone who understands my crisis and can help
- Services are approachable, welcoming and friendly
- Services are provided in a way that I don't feel stigmatised
- I feel that services understand my particular needs (e.g. LGBT, BME etc.)
- I can access services in different ways, times and places to suit me
- Services work with me to remove barriers to support e.g. anxiety, disabilities, ASD

**Joined up Care and Support**

- I am confident I am getting the help I need
- I trust the people helping me
- I am only asked about my needs once and there is a proper handover between workers
- People do not try and fit me into a box
- I felt comfortable and connected with the people who support me
- I am actively involved in decisions about my care
- I have consistent ongoing support
- Services are focused on outcomes which are important to me
- Services work together to meet all of my mental and physical needs
- Services treat my family and I with respect
- Services are flexible around me
- I decide how I am communicated with

## MH Strategy Session Plan - Workshop Event #4

Facilitators: Tony Williams, Sophie Bird, Helen Raison, Sylvie Ford, Liz Trayhorn, Iain Richmond, Donal Hegarty      Location: Kingsmeadow      Date: 11<sup>th</sup> October 2016

Topic: Developing the Future State      Start Time: 11:00am      End Time : 16:00

Aim: Develop themes, narratives, objectives and actions for design of future delivery

Objectives/Outcomes  
 Develop themes  
 Develop expansion of themes into clarifying paragraphs (narratives)  
 Determine person centred outcomes

Timing	Learner Activities	Teacher Activities	Resources	Assessment
11:00am - 11:05am	Absorb Ask questions	<b>Welcome and housekeeping</b> Introduce self Explain layout at Kingsmeadow <ul style="list-style-type: none"> <li>• Toilets</li> <li>• Refreshments</li> <li>• Emergency procedures</li> </ul> Explain agenda	<b>Helen Raison</b> 60 Name badges 60 Copies of agenda	Learner questions and feedback
11:05am - 11:20am	Absorb Ask questions Give feedback	<b>Where are we in the process?</b> Introduce self Explain strategy process Explain feedback document Demonstrate use of feedback	<b>Tony Williams</b> Laptop + projector + screen Projected copy of process diagram 60 Copies of process guide	Learner questions and feedback

		Remind group of behaviours and scope	Copy of master feedback document 1 Copy of feedback on process so far Posters depicting agreed behaviours Diagram showing scope	
11:20 - midday	Contribute themes Choose themes	<b>Shaping the Future Together</b> Explain process for the afternoon Describe the themes Check audience comfort with the themes Describe a sample theme: <ul style="list-style-type: none"> <li>• Theme title</li> <li>• Narrative</li> <li>• Person centred outcomes</li> </ul> Identify 5 groups Apportion attendees to groups	<b>Tony Williams</b> Powerpoint slide - Example of a theme, a narrative, person centred outcomes	
12:00pm - 1:00pm	Eat and drink	<b>Lunch</b>		
1:00pm - 2:30pm	Contribute views	<b>Shaping the themes</b> On each table: <ol style="list-style-type: none"> <li>1. Agree a theme title</li> <li>2. Agree a narrative describing the theme</li> <li>3. Identify outcomes which would deliver the theme</li> </ol>	<b>All facilitators</b> Copies of feedback log cut by theme Flip chart paper Indelible marker pens Blu-tac	Completed flip chart pages
2:30pm - 3:30pm	Listen and fine tune products with feedback	<b>Playback</b> Facilitators play back the themes, narratives, objectives and actions	<b>All facilitators</b> Completed flip chart pages Indelible marker pens	Amended flip chart pages

			Blu-tac	
3:30pm - 4:00pm	Absorb Ask questions	<b>What happens next?</b> Explain next stage in process Ask for questions Record feedback	<b>Tony Williams</b> Large copy of process diagram	Completed flip chart page of feedback

## Completing the Picture

During the period August - November 2016 personnel from HealthWatch went to meet local organisations and individuals who could not attend the workshops to elicit their views. As always, feedback was incorporated into the feedback log.

An online feedback form was created using surveymonkey and contributions were invited by email and from a link on the HealthWatch website.

## Event 5 - Refining the Strategy

Event 5 (the last in the series) again took part at the Kingsmeadow Conference Centre. The objectives were

- To review draft strategy content (the primary objective)
- To discuss governance in Mental Health in Kingston
- To obtain feedback on the co-production process (to inform this document)

Again we had 5 tables with 12 seats at each. Again we used facilitators and scribes.

For the primary objective, the tables were labelled A - E, one each for the five themes of the strategy. Draft Content from the strategy had been reproduced for each table. The content contained the person centred outcomes from Event 4, and a description of the actions which would be taken to bring them into effect. Community members were asked to self-identify which theme they wanted to review. The strategy authors had produced a script for facilitators which posed the following questions:-

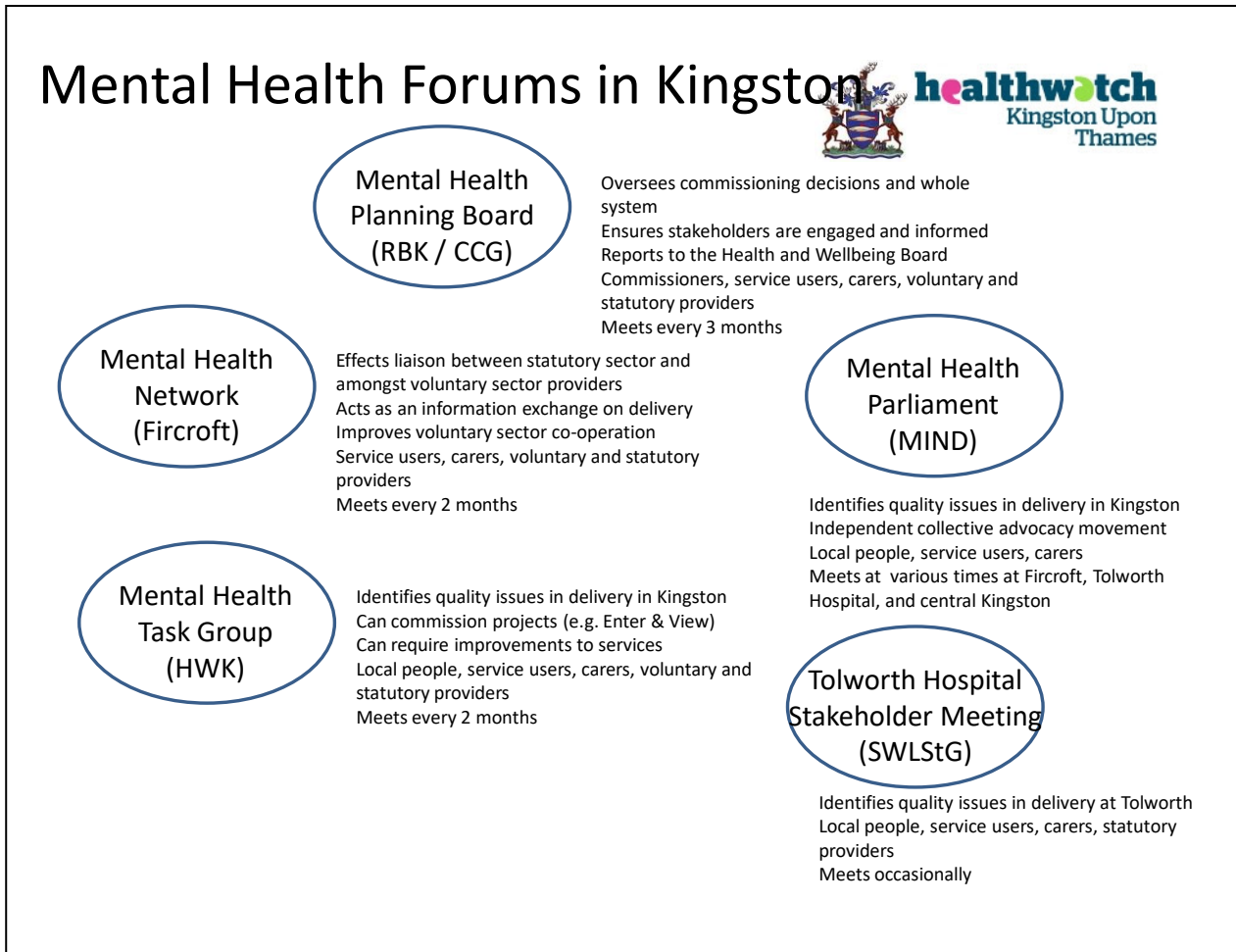


### Your task in the main afternoon session

1. Do the actions deliver the outcomes?
2. Are the actions (what we will do) complete?
3. Is there anything which needs emphasis or that we should tackle first?
4. Anything else?

The scribes captured feedback on flip chart paper.

When the primary objective had been reached, the community discussed governance in mental health in the borough. There are lots of forums which involve community:-



For the last session the tables were repurposed so that they were each concerned with one of the five co-production events. The community was asked to give feedback on what worked and didn't work at each, and for observations on the whole process.

At the close of the day the next steps were outlined.



## MH Strategy Session Plan- Workshop Event #4

Facilitators: Tony Williams, Sophie Bird, Helen Raison, Sylvie Ford, Liz Trayhorn, Iain Richmond, Donal Hegarty      Location: Kingsmeadow      Date: 13<sup>th</sup> December 2016

Topic: Developing the Future State      Start Time: 11:00am      End Time : 16:00

Aim: Refine the future state

Objectives/Outcomes  
 Review strategy content and obtain feedback  
 Design implementation governance  
 Reflect on the process so far and obtain feedback

Timing	Learner Activities	Teacher Activities	Resources	Assessment
11:00am - 11:05am	Absorb Ask questions	<b>Welcome and housekeeping</b> Introduce self Explain layout at Kingsmeadow <ul style="list-style-type: none"> <li>• Toilets</li> <li>• Refreshments</li> <li>• Emergency procedures</li> </ul> Explain agenda	<b>Helen Raison</b> 60 Name badges 60 Copies of agenda	Learner questions and feedback
11:05am - 11:20am	Absorb Ask questions Give feedback	<b>Where are we in the process?</b> Introduce self Explain strategy process Explain feedback document Demonstrate use of feedback Remind group of behaviours and scope Introduce video clip from Tonia	<b>Tony Williams</b> Laptop + projector + screen Projected copy of process diagram 60 Copies of process guide Copy of master feedback document	Learner questions and feedback

		Michaelides	1 Copy of feedback on process so far Posters depicting agreed behaviours Diagram showing scope Video clip from Tonia Michaelides	
11:20 - midday	Choose groups to in which to participate	<b>Shaping the afternoon sessions</b> Explain process for the afternoon Explain the products Remind about the 5 themes (+1?) Identify 5 (6?) groups Apportion attendees to groups	<b>Tony Williams</b> Powerpoint slides Copies of strategy content  <b>Helen Raison</b> .ppt slides on strategy shape	
12:00pm - 1:00pm	Eat and drink	<b>Lunch</b> Become familiar with strategy content		
1:00pm - 2:30pm	Contribute feedback, debate	<b>Reviewing the content</b> On each table: Facilitator conducts review Attendees give feedback; debate Get views on emphasis Scribe records feedback Identify any necessary actions, esp. Outside traditional service provision, e.g. peer networks	<b>All facilitators</b> Copies of feedback log cut by theme Copies of content cut by theme Pens  <b>Tony Williams</b> Monitor timings	Completed feedback forms / annotated strategy content
2:30pm - 2:40 pm	Look at content on other tables	<b>Break</b>	<b>Tony Williams</b> Put out materials for feedback	
2:40pm -	Listen and fine	<b>Implementation and Governance</b>	<b>Helen Raison / Tony Williams</b>	Completed flip chart

3:10pm	tune products with feedback	Describe governance for approval of strategy Discuss implementation Describe existing governance mechanisms Ask permission to cite attendees in strategy Seek feedback	Flip chart pages Indelible marker pens Blu-tac	pages
3:10pm - 3:40pm	Contribute views on process so far	<b>Feedback on Strategy Co-Production Process</b> Assign one workshop per table Ask attendees to move to tables Record feedback	<b>Tony Williams</b> Flip chart paper Indelible marker pens Blu-tac	Completed flip chart page
3:40pm - 4:00pm	Absorb Ask questions	<b>What happens next?</b> Explain next stage in process Ask for questions Record feedback	<b>Tony Williams</b> Large copy of process diagram	

## Feedback we received at Event 5

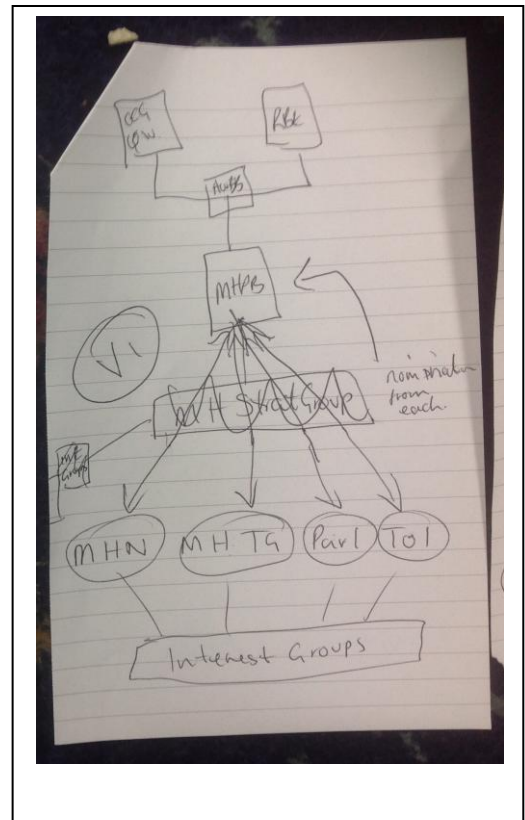
The feedback from Workshop 5 relating to events and process has been reproduced here specifically to indicate learning and to inform other co-production exercises. The feedback from the other workshops has gone into the strategy itself.

### *Discovering Assets*

- Audio was poor
- Not enough space in Quaker Meeting Room
- Achieve improved knowledge of assets in Kingston
- Did not however feedback to get validation
- Need to clarify how output has been used
- Mixed level of understanding but this has improved in workshop journey
- We should do workshop notes so that people understand outputs and linkages to strategy development
- Advance circulation of materials to be sent to allow people to prepare
- Action now is to circulate electronic copy of workshop 5 briefing paper

### *Governance*

- All groups relevant
- Need structure immediately to co-ordinate feedback to MHPB (with nominees attending MHPB)
- Need links to interest groups in area
- Transition to formation of a champions group who co-ordinate views into cohesive points for MHPB
- Groups need to demonstrate a clear value for people who attend and
  - A clear purpose
  - Clear link to governance i.e. people need to know where their views go
  - Good feedback to know their input has been valued
  - Missing: Children's and Young People's Group
- There are other groups e.g. CAMHS
- There are a lot of different meetings
- Tolworth - recently low attendance - not as effective anymore for services organized about Tolworth Hospital
- Fircroft has a small membership - could merge with HWK?



- Planning Board - has oversight of the strategy - Commissioners' perspective - has lay members
- Fircroft & HWK to merge meeting for governance over strategy
  - We will not lost this group of people
  - Steering Group
- MH Task Group works well
- What do they do and do they talk to each other?
- What forum would we need to police the strategy?
- Some forums should just be involving service users + carers so can review outcomes without problem
- Parliament - 3 same issues - Parliament will go to provider to try to resolve issue. Governance? Under umbrella of MIND. Accountability? Parliament will connect with HealthWatch if required - what is governance of board? It is independent advocacy role. No way of feeding issues to CCG or Mental Health Planning Board.
- Parliament issues not communicated to commissioners - need to feed in to

### *Deciding How the Future Should Be*

- This was pivotal / meaty workshop
- Getting everyone using "I" statements
- All other workshops laid foundations of this workshop
- Other workshops formed the dynamics
- GPs not engaged in workshops. If this continues should go in press
- GPs are important to be involved so need to meet them halfway
- Well facilitated as lots of difficult (personal) issues to discuss
- Negative point - some topics have attracted more people - reasons? Is there a gap because we want someone else to do the work for us?
- Access table - people are energetic and positive passionate about the future. All people involved in process need to be communicated to in future for strategy
- Newsletter update? Annual following workshop? More frequently?
- Send feedback views?
- What is timeline for progressing barriers? Solution to barriers in order to progress. Communicate.
- Bulletin / update - Regroup to look at review of outcomes and models of best practice.
- Make it SMART process

## Learning

The following are observations on the critical factors which we came to rely on to deliver the process. They include things that went right and things that went wrong. Usually we replaced one with the other. Not always though.

### *Make enough space to listen to all perspectives respectfully*

Everyone has a right to a view and for that view to be captured. Nothing breaks down trust quicker than preventing someone from being heard. Sometimes this has to be balanced with an agreement to move on because time is finite and other perspectives are waiting to be heard. To manage this, establish a group agreement on behaviours at the beginning of the process and make sure it is in the room at all subsequent events. Make reference to it at the start of every session. If something big comes up that cannot be addressed within the confines of the day, keep an “issue park” where those things can go. To keep faith with the group, you need to make sure you follow those things up before the next event. Some contributions might be hard to manage despite these agreements and it may be necessary to ensure someone has the relevant skills to manage it.

### *Churn happens*

It is naïve to think that the people who start the journey with you will be the same people there at the end. Some will but some won't. The process needs to contain mitigation for this reality. Some things you agree early on need to be rehearsed throughout as some of the people in the room won't have bought into them; behaviours, scope, the context for the session, the outcomes, for example. Make capacity for this and explain why you're doing it as you do it.

### *Make sure all feedback is recorded and seen to be recorded*

People will lose faith on any process in which their contributions are not visibly recorded and used. This means not only basic good facilitation technique - clarifying contributions before recording them on media which stays in the room - but people being able to see evidence in due course that these contributions have been used in later stages of the process.

### *Ground everyone in the process at the start of every session and follow it up at the end*

Before each session a mailshot carried a 2-page depiction of the process and the objectives for the day in prospect. A slot at the beginning of the day was necessary (as

not everyone reads emails and some read emails and forget) to rehearse with everyone where the journey came from, where it is now, and where it is going; and the expected outcomes for the day and how the process for the day is intended to work. This ensures that everyone is on board with what they are going to do for the day and how this will contribute in time to the end outcome. A brief slot at the end of every day should remind people where they will be going next so their expectations about subsequent involvement are managed. In the words of presenters everywhere, “tell ‘em you’re going to tell ‘em, tell ‘em and tell ‘em you told ‘em”.

### *All plans are useless but planning is essential*

Lesson plans (a steal from the teaching profession) were used to ensure that the outcomes for the day could be met by a series of coherent activities, and that the necessary resources for delivery could be identified and made available. That said, in a quote from Mike Tyson, “Everyone has a plan until they get a smack in the mouth”. Almost always something went wrong, either in the estimating of necessary time, or in the degree of engagement of the audience. This means enough capacity to manage the overall process has to be available in the room and unassigned, to recover from unexpected events.

### *An effective steering group is vital*

You need someone

- with a channel to the right stakeholders
- to own the process and the integrity of the process
- to manage the feedback log
- who can analyse lots of qualitative data and spot trends in it
- to chair who can keep meetings focused and is clear about actions
- who can pull lots of words together
- who can arrange events, catering, invitations, publicity of events etc

The organisations contributing to the Steering Group also need to commit time and budget to the process (including cost of venue hire and refreshments).

### *Time spent managing expectations is seldom wasted*

Checking not only whether outcomes met expectations, but also whether the process met expectations, not only refines the product but helps retain the trust of the group.

### *Removing hierarchy is easier said than done*

We paid a lot of attention to getting everyone to relate to each other as people, but habits die hard. At tea breaks and lunch, old mates tend to get together. Professionals tend to facilitate, and customers tend to voice opinions. At the very least, sometimes these things should be the other way around. Ideally they often should. And professionals can be customers and customers can be professionals, don't forget. This leads to -

### *The power of self-disclosure*

Shared experience bonds people together, possibly faster and more effectively than anything else, especially experience of adversity. If an atmosphere which promotes frankness and self disclosure can be created early on, fruitful contributions follow one after the other. Someone has to go first.

### *Know who's not there*

During the process it became apparent that a whole cadre of significant (professional) stakeholders were not engaged. Despite strenuous efforts this situation was not recovered. Ultimately, recovering this situation is a senior leadership issue. There were also "non professional" stakeholders who did not attend. The steering group needs to consider groups who might not be able / willing to attend workshops and develop alternative methods for engagement. They need to monitor who is and isn't attending workshops throughout the process and seek to correct problems if they arise.

### *Be the child of at least a medium sized God*

Few things are more pitiful than a change programme that no-one loves. Almost the first question at the launch event (from the community) was "Who owns this and will they be there till the end?". In the modern public sector this may be impossible to guarantee but it's critical to success nonetheless. So be lucky. Half-way through the process, South West London CCGs agreed to merge their back office functions, and roles changed. The SRO for the Mental Health Strategy stayed in the relevant post. It could have been otherwise.

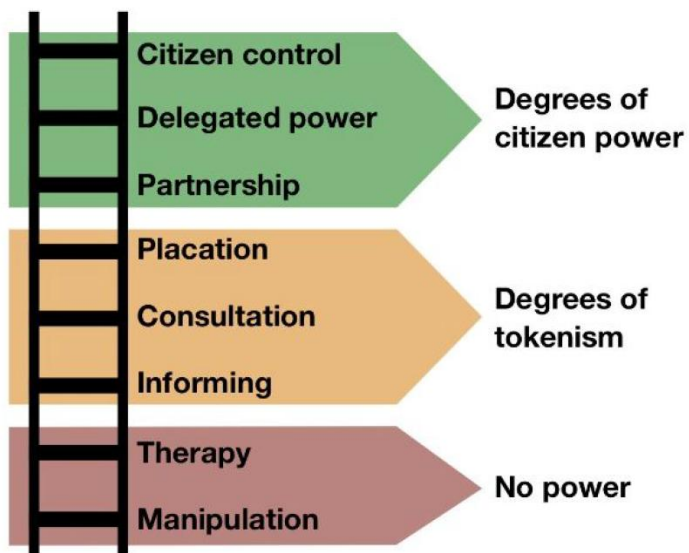
## Reflections on community empowerment

### Arnstein's Ladder

There are academic studies on power structures between government and community. Arnstein's ladder is a well known and respected study in this area. Content in this section is reproduced from the Citizen's Handbook<sup>6</sup>.

Sherry Arnstein, writing in 1969 about citizen involvement in planning processes in the United States, described a "ladder of citizen participation" that showed participation ranging from high to low. See Sherry R. Arnstein's "A Ladder of Citizen Participation," Journal of the American Planning Association, Vol. 35, No. 4, July 1969, pp. 216-224.

**Arnstein (1969) Ladder of citizen participation**



<http://www.citizenshandbook.org/arnsteinsladder.html>

The ladder is a guide to seeing who has power when important decisions are being made. It has survived for so long because people continue to confront processes that refuse to consider anything beyond the bottom rungs.

<sup>6</sup> <http://www.citizenshandbook.org/arnsteinsladder.html>

Here is how David Wilcox describes the 8 rungs of the ladder at [www.partnerships.org.uk/part/arn.htm](http://www.partnerships.org.uk/part/arn.htm) :

*1 Manipulation and 2 Therapy.* Both are non participative. The aim is to cure or educate the participants. The proposed plan is best and the job of participation is to achieve public support through public relations.

*3 Informing.* A most important first step to legitimate participation. But too frequently the emphasis is on a one way flow of information. No channel for feedback.

*4 Consultation.* Again a legitimate step attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window dressing ritual.

*5 Placation.* For example, co-option of hand-picked 'worthies' onto committees. It allows citizens to advise or plan ad infinitum but retains for power holders the right to judge the legitimacy or feasibility of the advice.

*6 Partnership.* Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.

*7 Delegation.* Citizens holding a clear majority of seats on committees with delegated powers to make decisions. Public now has the power to assure accountability of the programme to them.

*8 Citizen Control.* Have-nots handle the entire job of planning, policy making and managing a programme e.g. neighbourhood corporation with no intermediaries between it and the source of funds.

#### Assessment of this process against Arnstein's Ladder

This co-production process would appear to have achieved either level 5 - Placation - or 6 - Partnership. This is because:-

- The preliminary stages 1-4 have clearly been achieved; participants have been educated, information given about the context of the strategy and aims, and attitudes tested.

- Citizens (not necessarily “hand picked” - community members could self-select) have advised on planning (rung 5). Power holders have retained the right to judge legitimacy or feasibility in some areas (for example, clinical solutions must have an approved NICE evidence base for adoption).
- Planning and decision making (rung 6) is intended for the implementation phase (from April 2017) through joint committees.
- It is open to the CCG and RBK to adopt a governance model as part of the implementation phase which provides citizens with a clear majority of seats on committees with delegated powers to make decisions (which would be rung 7).

## Conclusion

Thrive Kingston was approved unanimously at the Health and Wellbeing Board at RBK on 28<sup>th</sup> March 2017. All consulted parties have broadly approved the outcomes achieved so far (which represent governance milestones and not actual business outcomes) and the process followed, to achieve a strategy which is a statement of intent at this stage, rather than delivery.

2017 marks the beginning of a process of co-creation of the priority outcomes from the strategy - the first real change, in prospect. There is agreement to continue the co-production process through the life of the strategy - 5 years. So at the time of writing, the question of adequacy of outcomes is still an open question. People have had a chance to say what they want. We have yet to see whether this is what will come about.

On the subject of community empowerment, a transparent dialogue needs to happen between local leadership at the CCG and RBK and the co-production group (and the wider community) about the feasibility and desirability of a shift in control to a more participative and empowered model of governance. This may be possible at or post the strategy launch, and at the Health and Wellbeing Board. It is arguable that as accountability for the strategy rests with the CCG and with RBK (leadership in community is invested in Local Authorities by the Local Government Act 2000), that higher levels of citizen power are not practically attainable. This is a matter of local democracy and leadership.