Department of Health
An Roinn Sláinte
Männystrie O Poustie
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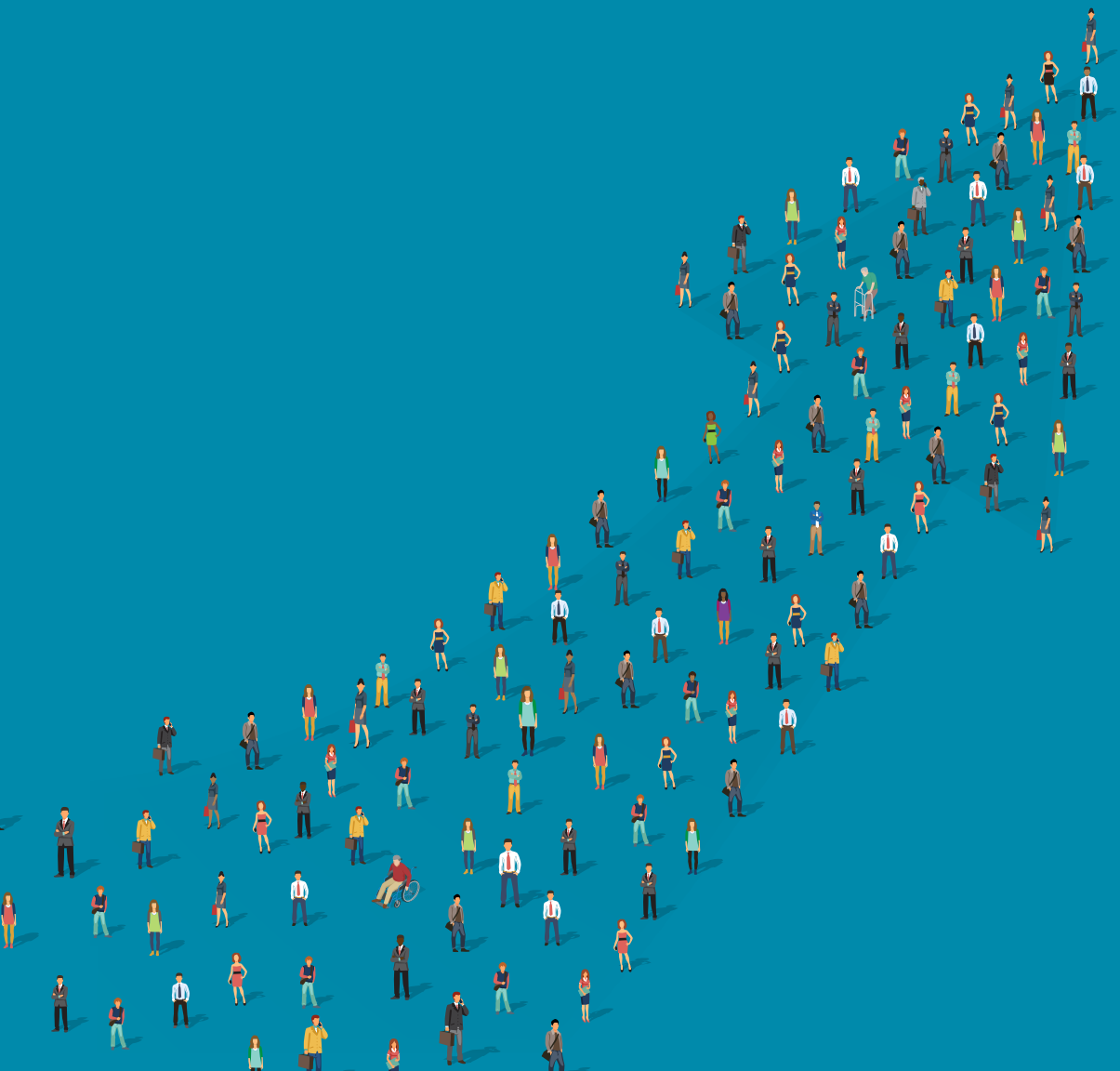
Co-production Guide

Connecting and Realising Value Through People



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Section 1:

What do we want to achieve?

1.1 Our Task

The **Delivering Together** Transformation Implementation Group (TIG) asked for the development of a practical guide to support the application of co-production across our health and social care (HSC) system. This guide has been developed using the principles of co-production in partnership with people who have experience in using health and social care services, Carers, HSC staff, Managers, Personal Public Involvement (PPI) leads, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Patient Client Council (PCC). They were partnered by community and voluntary sector representatives, local government representatives and policy makers from the Department of Health (DoH). Together they have brought their extensive knowledge and experience of co-producing to inform this guide. It is this system wide partnership approach that has given the guide its genuine authoritative footing in providing direction on how co-production can be an enabler of transformational change.

Transformational change in this guide means harnessing the collective efforts of policy makers, people who use services, carers, staff, staff representatives and local communities who all ***work together in partnership to improve health and wellbeing outcomes*** for the people of Northern Ireland. It places **people** at the centre of decision making and aims to connect people together in representative networks so that they can meaningfully influence, shape and participate as real partners in the commissioning, planning, delivery and evaluation of services.

Recognising that co-production is a developmental and incremental process the guide acknowledges that it will take time to fully embed and reflect the principles of co-production in HSC systems. The guide however sets out an ambitious mandate and outlines the key steps required for the adoption and implementation of co-production across all HSC organisations. It represents an opportunity to co-ordinate and integrate all the work undertaken through PPI, patient experience, service user feedback, peer networks, expert patients, peer advocacy, public consultation and community development, into an integrated approach.

The guide requires all HSC organisations to review the extent of partnership working across its services and to develop an integrated plan in order to strengthen co-production between people who use services, staff, their representatives, local communities and multi-agency partners.

1.2 Co-Production Parameters

Uniquely the DoH and its 'Arm's Length Bodies' are the only public bodies in Northern Ireland which have a statutory duty to involve and consult its stakeholders, therefore the guide augments and builds on the requirements set out in current PPI policy[1].

Our goal is to support transformational change through a co-productive approach and promote the opportunity for all sections of the Northern Ireland community to partner with health and social care staff in improving health and social care outcomes. This will be done within existing statutory requirements. The extent to which decisions will be co-produced will be dependent on Executive and Ministerial priorities, adherence to legal and regulatory requirements, professional standards, and HSC organisational financial accountabilities.

It is also important to note that patient and public safety is paramount and there are a range of circumstances where Health and Social Care services within its statutory and legal duties may not co-produce decisions in order to safeguard people and families who are physically, psychologically and socially vulnerable. In this context it is incumbent in line with legislation, statutory, policy and professional requirements that HSC services and professionals are open and transparent about why this is so, and provide information on how people(s) best interest will be reflected and protected throughout decision making processes which impact their lives.

1.3 Our Purpose

To meet the challenges of a 21st century population, we need to be ambitious in how we plan to transform our services to meet the needs of our population, in a safe and sustainable way, so they can ***enjoy long, healthy, active lives*** and to enable those with long term and life limiting conditions to live as well as possible.

Delivering Together 2026 Section Four 'the Approach' identifies partnership working as one of the five enablers in the delivery of HSC transformation. Figure 1 sets out the core requirements and the guide has been developed in recognition that' *"Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all"*

1 https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi
2 Delivering together The Approach Section Four https://www.health-ni.gov.uk/sites/default/files/publications/health/health-andwellbeing-2026-delivering-together.pdf

Figure 1

Co-production will empower patients, service users and staff to:

• **design the system** as a whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;

• work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;

• be partners in **the care they receive** with a focus on increased self management and choice, especially for those with long-term conditions.

Delivering together commits health and social care to:

- Adopt the co-production and co-design model for development of new and reconfiguration services.
- Maximise the lived experience (patient & carer) voice across the system.
- Engage staff particularly staff who are closest to those who use our services in co-design and in the co-delivery of services.
- Build and strengthen partnerships working with other providers of care, including those in the community and voluntary sector and in other government sectors in support of Programme for Government (PfG) priorities.

1.4 Let's Talk About Language

Some of the language and concepts of coproduction are often misunderstood and interchangeably used. It is therefore necessary to set out a number of key definitions of terms used through this guide in order to support understanding.

Definitions used in this document have been developed to reflect and expand on The Executive Office of the Northern Ireland Civil Service (NICS) Policy Champion's Network Guides, *'A Practical Guide to Policy Making in Northern Ireland'* published in 2016 and *'The Good Practice Guidelines for Effective Stakeholder Engagement (2nd edition)'*.

The language and definitions also align with the strategic direction of ***Delivering Together***.

When we talk about co-production, we are referring to a concept that requires the complete application of the six principles and the key implementation steps outlined in Section 3 in addition to the core concepts of co-design, co-delivery and co-creation. A number of terms used throughout the guide to describe the full range of actions associated with ***co-production*** have been defined in order to assist understanding.

Definitions

People

The term **'People'** used throughout this guide refers to citizens across all lifespan groups who use services, their families, carers policy makers, HSC staff, Trade Union Side, local communities, communities of interest, communities of practice, multi-agency and community and voluntary sector partners.

Co-production

A highly **person centred approach** which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. It is deeply rooted in connecting and empowering people and is predicated on valuing and utilising the contribution of all involved. It seeks to combine people's strengths, knowledge, expertise and resources in order to collaboratively improve personal, family and community health and wellbeing outcomes. Co-production is not just a word, it is not just a concept, it is a genuine partnership approach which brings people together to find **shared solutions**, In practice co-production involves partnering with people from the start to the end of any change that affects them. It works best when people **are *empowered*** to influence decision making and care delivery processes.

Co-design

A **partnership approach** which seeks to establish a *representative co-design team* of people, who come together to **design care pathways, develop new and revise existing services models**. The work of co-design teams is governed by person centred values, a shared ambition and commitment to generate solutions in line with the quadruple aim outlined in Delivering Together 2026.

Co-delivery

A partnership approach which aims to **empower multidisciplinary** teams to deliver **integrated care** solutions for their population. It also involves developing and integrating expert patient, peer and community led services into the delivery of health and social care.

Citizen Powered Health and Wellbeing

This is a population health approach which seeks to create the conditions in which people can be empowered, to take a more active role in their own health and social wellbeing. It crucially involves addressing the wider determinants of health and social wellbeing and requires a shared understanding of need. Based on population need stratification, it requires targeted resources in support of prevention, early intervention, recovery and personalised support for those with long term and life limiting conditions.

Lived and Learned Experience

Throughout the guide the terms 'lived experience' and 'learned experience' are used. **Lived Experience** is used to describe the direct experiences, perspectives and views of patients, clients, service users, peer advocates, and carers of their own health and social care needs and that of the services they received. **Learned experience** includes all those staff who are directly involved in leading, managing and providing health and social care.

Being Representative

One of the key objectives of co-production is to avoid unrepresentative perspectives and opinions and to create from the outset equal opportunities for people to influence and shape the design and delivery of health and social care. This means ensuring a representative balance of the people who use services, carers, staff, trade union staff and as appropriate other partners in co-design and co-delivery teams. It is also important in line with Section 75 responsibilities that particular attention is paid to including under representative/hard to reach groups.

Shared Decision Making to Enable Partnership Working

Decision making in HSC is governed by a wide range of legal, professional and policy mandates. In the case of HSC organisations the specific responsibilities of their Chairs, Boards and Chief Executives as well as of the sponsoring Department are set out in the management statements between the Department of Health and each of these HSC organisations. Set within PPI legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes. This requires a commitment to create opportunities for shared decision making to enable partnership working which involves sharing information and developing collective evidenced based solutions. The principle of shared decision making is deeply rooted in prompting equality of opportunity for people who use services and those who provide them to **influence decisions about health and wellbeing**. As co-production develops shared decision making should become the accepted approach in the design of services. Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to **empower partners** to take **shared ownership** for the delivery of health and social care outcomes. This does not remove or dilute statutory accountability, however leaders act as catalysts in facilitating transformation by empowering people to work together to generate improvements in care outcomes.

Section 2:

Why Co-production is Important

2.1 The Co-production Ambition for 2026

As outlined in the draft PfG, our ambition is to enable people to ***enjoy long, healthy, active lives*** and one of the critical building blocks in achieving this aim is to move towards the creation of a 'Citizen Powered Health and Social Care System'. This requires the mobilisation of people into representative networks. **We want a system that partners and organises health and wellbeing with people, for people, and by people.** Therefore the only way to understand what matters to people is to work as partners with them. This requires a commitment to create (through genuine partnership) working opportunities for people to influence the decisions and shape the direction of health and social care.

A citizen powered health and social care system helps to support the building of people's social capital and recognises that the infinite talents and resources of people who use public services are often overlooked and sometimes diminished by the predominance of professional structures. There is a tendency to see **what's wrong, not what's strong,** alongside the unconscious willingness of people to slip into a passive role as recipients of services. **Therefore building social capital methods into the design and delivery of care is a critical aspect of co-production**.

It involves strengthening the commitment and connections between people and their respective social and community networks. Doing this not only addresses the immediate needs of people, but also enables collective action in tackling the wider determinants of health and wellbeing at both strategic and local levels. Inevitably this requires a commitment to embed community development and social enterprising approaches as we implement co-production. This is essential in generating new and innovative solutions with people.

As a system we will:

- **Value** and embed co-design and co-delivery as a core practice in improving health and wellbeing;
- **Value** the contribution and experience of people who use services by creating the conditions for them to ***enjoy long, healthy, active lives*** through the provision of personalised, evidenced based care and support.
- **Value** the outcomes that matter to people, families and their communities.
- **Value** evidence, quality improvement and innovation in achieving sustainable person, family and community centered outcomes.
- **Value** our staff and the wider workforce in the co-design and co-delivery of care systems.

Co-production enables us to genuinely create a system which enables people to play an active role and become invested in improving personal and collective health and wellbeing outcomes. To achieve success, a whole system approach is required. In the next ten years we will work to have a system which will have:

1. **Connected people together as part of the care system.** People working through representative groups and networks and it is usual practice for people to co-design and co-deliver innovative health and social care solutions. Participation has balanced representation and co-design teams routinely consist of people who use services, staff who provide care and as appropriate other partners. Health and social care leaders at all levels are champions of co-production and have created the conditions for partnership working.

2. **Embedded a population health and wellbeing approach**. Population health data, and predictive technologies will be used to anticipate need. This approach enables the development of a shared understanding of need and how actions can change health and social care outcomes for individuals and communities.

3. **Built social capital** as evidenced by more people designing their own health and social care wellbeing solutions. Personalised budgeting, community development peer, expert patient, and social enterprising approaches have demonstrated how improvements can be delivered in health and social care.

4. **Empowered and enabled integrated multi-disciplinary team working.** Teams are self-managing and take responsibility for quality improvement and care outcomes for their respective area of practice and localities.

5. **Utilised enabling technologies.** People are enabled to personalise their health and wellbeing goals, track and analyse their own health data. Enabling technologies support the personalisation of knowledge, self-management and the interactions between people and their health and social care team.

6. **Enabled people to provide real time feedback** on their experiences of health and social care. People's feedback (staff, service users and carers) is utilised to identify areas of excellence and also for service improvement by putting things right when their experiences have not met agreed standards.

7. **Quality assurance systems** fully reflect the principles and practice of co-production. People become partners in the quality assurance process across health and social care services.

2.2 The Benefits of Co-Production

Much has been written locally, nationally and internationally about the benefits of co-production for society, communities and for individual people. As detailed in **figure 2** adopting a co-productive approach is at the heart of improving people's experience of care. Co-production, done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

Figure 2

The Heart of Experience

Co-production demonstrably improves people's experience of care. This is achieved through relationship building, valuing people's contribution, partnering with people in making decisions about their lives, and creating the conditions for co-design/co-delivery of health and social care services.

Think Outcomes

Co-production creates the conditions for people to be empowered to take active responsibility for their health and wellbeing. It gives equal weight to the biological, psychological and social models in the design and delivery of care. Co-production recognises that outcomes are significantly improved when people are enabled to contribute to and work in partnership in order to ***enjoy long, healthy, active lives***.

Optomising Resources

Co-production is a strengths based approach which aims to harness the expertise of people and creates opportunities for partners to pool their resources, their talents and expertise. Services can become more efficient, innovative and cost effective.

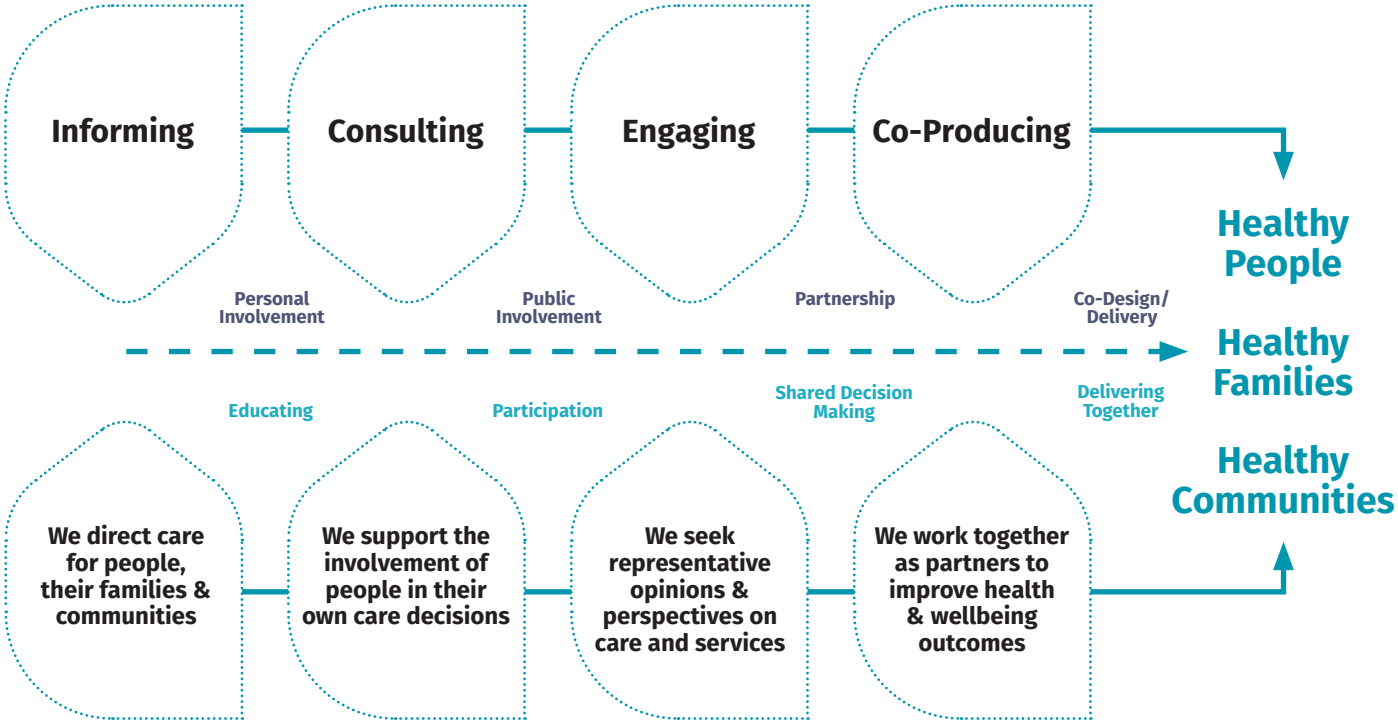
Staff Experience

Co-production is only possible when the staff who provide services are proactively involved as partners in the development and design of health and social care solutions. The evidence shows that when staff are empowered by their organisations and take responsibility the outcomes of care improve.

2.3 The Co-Production Pathway

Co-production has become an increasingly popular methodology in policy making, public health, services delivery organizations and in community sectors. It is important to **recognise** that the evolution of engagement and involvement to co-production in health and social care holds the promise of improving outcomes, it is not always clear what counts as or what is meant by "co-production", what it entails in practice, or what is actually being co-produced. This is because involvement, engagement and co-production approaches are all part of a continuum as outlined in the co-production pathway figure 3. This ranges from involvement, to co-design and co-delivery. The other reason why there is so much variation in approaches is often influenced by the context, culture and beliefs about when co-production is appropriate.

Figure 3



Whilst co-production may challenge conventional forms of engagement and involvement; common to all these approaches is a **desire to improve the interaction between people who use services and staff who provide care**. The real value of co-production is its ability to **create the space** to bring together different and representative perspectives in order to co-design innovative solutions which improve outcomes for people, their families and communities.

Locally, nationally and internationally 'co-production' is seen in current policy agendas both as the next logical step to personal and public involvement by offering a new way of incorporating people's expertise in more substantive and meaningful ways into the design and delivery of health and social care services.

One of its distinctive features involves bringing people into the decision-making process by working across organisational boundaries. This helps to reduce knowledge gaps and addresses power imbalances between different participants. Blurring boundaries erases artificial distinctions between 'recipients' and 'providers' of services. The process of co-production must take into account the participant's understanding of involvement and co-production; the differences between involvement and co-production; and how the power disperses between partners can be equalized through the process of co-design and co-delivery.

The power of co-production is best understood through the shared narrative that evolves when people find ways of working together to generate better outcomes and recognises the ***'sum is greater than all of its parts'.***

Figure 4

What co-production is and is not

✓ Co-production IS:	✗ Co-production is NOT:
Partners respecting each other and valuing each others perspective and contribution	Just giving people a chance to speak but not using the information.
Working together from the very start to identify and achieve an end result that is collaboratively agreed on.	Confrontation and 'winning and losing'.
Listening to each other and understanding where everyone is coming from and the particular challenges they face.	A quick fix.
At times deferring to the other on grounds of practicality, economics, ethics, equality of civic rights, requirements under section 75.	Consultation i.e. having a plan and then going out to tell people about it OR even having a plan, asking people's thoughts and about it and incorporating these thoughts into a revised plan.
Valuing, learning from and building on the different skills, assets, experience and expertise that different people bring to the process.	One partner simply trying to persuade another to come around to their way of thinking.
Working in ways that best meet the needs of all partners.	Listing problems and expecting someone else to solve them.
Sharing ownership for developing solutions that are evidence based, work and are deliverable.	A new way to get your personal agenda on the table at the expense of someone else's.
Breaking down barriers between professionals/ providers and people using public services.	A new forum for public service staff to tell people what is going to happen, or for people to lobby the public sector.
Committing jointly to support and develop the capacity and understanding of all people involved in the process.	
Trust, support and information sharing.	
Taking shared ownership when solutions don't work first time and taking a joint problem solving approach to move forward.	
Talking with and not to.	

Section 3:

Guide on ‘How To’ Co-produce

3.1 Who can use this Co-Production Guide?

As outlined in figure 5 the Guide has been developed for all those involved in the design and delivery of health and social care specifically with:

1. people who use services their families and/or Carers,
2. local communities, community groups, communities of practice and community of interest.
3. Policy Makers, system Leaders, staff who deliver care and TUS.

Figure 5

It aims to provide guidance on the core principles and practice which underpin co-production and should be of specific use to:

The co-production principles outlined in this guide have been tailored in section 3 to support the embedding of co-production into policy making, strategic planning and care delivery. The Guide is specifically intended to complement existing PPI policy and other key areas of transformation identified in ***Delivering Together***, which includes but is not limited to:

- HSC Leadership Framework;
- Improvement Institute;
- HSC Community Development Framework;
- e-Health Strategy.

- HSC Organisations
- HSC Board Members and Executives
- PPI staff and forums

- Carers
- Primary Care Services
- Local communities
- Communities of Interest
- Community and Voluntary Organisations

- Patient Client Council
- Policy makers and transformation work-stream leads
- People with lived expereince and peer networks

- Staff at the point of care delivery
- TUS
- Operational Managers, Team and Clinical Leads

3.2 The six principles of co-production

The following six principles will enable the implementation of co-production across all HSC organisations. Building on existing PPI infrastructure and using practical steps outlined in this guide each HSC organisation will embed co-production in its strategic, and operational planning.

Valuing People

Co–production is a person centred process which is dependent on building reciprocal relationships between people. It is based on developing mutual respect, openness and accepting collective ownership for outcomes. It recognises that people possess a wealth of different knowledge and expertise about needs, what matters, and what has to change in order to deliver better outcomes. This means we will:

- acknowledge that everyone on the co-production team is an asset with individual skills, strengths and experiences to contribute;
- find ways to use and develop these assets; value everyone's contribution; and build on citizen's ability to participate; and
- work together to develop confidence and strengthen capacity, making sure the voices of everyone co-producing on a project is heard and understood.

Building Representative People Networks

A core principle of co-production is to move towards balanced meaningful participation, engagement and shared ownership. It is about developing effective collaborative partnerships in order to co-design and co-deliver services. It is dependent on developing representative and sustainable networks, with people from all sectors including those who have been marginalised and are hard to reach. The ***principle of representative*** means that co-design and co-delivery groups should reflect a balance of people who use services, staff who provide services and as appropriate other external partners. This requires detailed stakeholder mapping using the **'ARE IN'** principles:

- **A**uthority: People with the ability to act to influence change and enable it to happen when a solution has been developed by the group.
- **R**esources: People who know what we have capacity to do/not do (e.g. finance/HR/access/influence).
- **E**xpertise: In the topic (social, economic, technical, professional etc.)
- **I**nformation: That others need (data etc)
- **N**eed: Service users, carers, staff and others who will be affected by the outcome

Mapping stakeholders in this way will help strengthen existing networks; enable the development of new networks; and to bridge networks where gaps exist. It also creates a real opportunity to maximise social capital through the development of peer led/community networks.

Building People's Capacity

Co-production is dependent on creating the circumstances for shared decision making and power from boardroom to point of care services. This requires investment in:

- building people's knowledge;
- training people in PPI, co-production, quality improvement, population health and community development approaches; and
- harnessing the efforts and work of: local PPI forums; co-production teams; peer networks; Integrated Care Partnerships (ICPs); thematic/communities of interest; quality improvement teams; and other community networks into a logical representative approach.

Reciprocal Recognition

HSC organisations will need to dedicate resource to support co-production, invest in building the capacity within their organisation, mentor/coach/ support people with lived experience and release their staff to become involved in the co-design and in the co-delivery of services. Co-production requires the contribution of all participants to be valued and a commitment to learn together, and resolve different perspectives with respect. As appropriate co-design and co-delivery contributions may include non-monetary and/or monetary rewards.

Cross Boundary Working

Co-production also creates the conditions for a multi-agency approach to the improvement of outcomes for local communities. This is about mobilising all the assets of the community, voluntary sector, and all relevant government organisations. This creates opportunities to pool resources and assets in working towards shared goals and better health and social care outcomes.

Enabling and Facilitating

Co-production requires staff, leaders and managers to become facilitators and enablers of change. Effective facilitation is established by empowering all involved to have solution focused approaches and promotes joint responsibility for achieving positive outcomes. This means we also focus on outcomes and review by considering '*how much did we do, how well did we do it and is anyone better off?*' The system facilitates change and empowers people to have the confidence and opportunity to live their lives in the way they want to and to take control of their own future health and wellbeing.

3.3 Practical Guide for Policy Makers

This section is to help policy makers think about their role in enabling co-production in their organisations. Policy makers have a crucial role to play in creating the conditions for shared decision making to become a reality. This requires cultural change, commitment and collective leadership in order to engage people from the start in policy making processes and in the co-production of strategy.

'People with lived experience have said 'if you want us to step up, you have to learn to step down a bit'

Using the six principles:

Valuing People

People value the opportunity to be involved in shaping the key policies that affect their lives. For this to be meaningful policy makers should work to maximise the opportunities across the system for early involvement and engagement of people in the formulation of HSC policy. Make time for partnership working at all levels and facilitating the necessary background work order in to ensure people's voices and contribution are representative, valued, understood and reflected in the policy making process.

Building Representative Network

Policy makers will enable the active development of representative networks to support the drafting, design and evaluation of policy and strategy. This will include drawing representatives from these networks including unrepresented groups into the policy and strategy formulation process. Policy makers will proactively develop relationships within, across and outside their own department, in order to generate evidence based solutions.

Building People's Capacity

Through sharing knowledge and attending training programmes, policy makers will strengthen people's capacity to participate in the co-design of policy, strategy, and service improvement. There must be opportunities for reflecting and integrating people's experience and evidence into the development of new ways of working. This includes all partners understanding legal and statutory decision making processes as part of the progression towards shared decision making.

Reciprocal Recognition

Recognising and rewarding people's contribution particularly the lived experience and communities' contribution is a fundamental principle of co-production. In line with the reciprocity guidance, secure ring-fenced funding and/or other opportunities for reward to support the time people give to being involved in co-production work.

Cross Boundary Working

The draft PfG requires the wider public sector to work together to deliver better population outcomes. Policy makers should consider opportunities to collaborate and co-design policy widely to address need and ways to pool resources to deliver on agreed programmes of intervention.

Enabling and Facilitating

Policy makers have a critical leadership and enabler role in creating the condition for whole system collaboration (co-design). Policy makers can act as facilitators in the shaping of policy and in enabling collective agreement on the strategic shape and direction of services. Occasionally it may be important to source an independent person to facilitate the process of co-design.

Key Outcome

Community is more actively engaged in health and social care services design and delivery.

3.4 Practical Guide for Board Members and Executives

This section outlines the roles and responsibilities for HSC Boards and Executives (Non Executives, Chief Executives and Directors) leading the development of people powered health and wellbeing approaches through co-production, both within and across their respective organisations. For co-production to be successful it requires Boards, senior executive leaders to lead and have co-production embedded in the organisation's core business and its culture.

Valuing People

In creating the strategic and organisational conditions to enhance the role and contribution of people in the planning, development, delivery and evaluation of all the organisations activities and services. This involves leading from the front and valuing people's contribution by progressively sharing decision making and promoting co-design and co-delivery.

Building Representative Network

Through supporting the development of representative networks across all programmes of care. This includes investing time and resources in building relationships with local communities and groups of people who use services. It also involves investing in peer support, expert patient services and progressively creating self-managing teams who are empowered to co-produce with those who use services.

Building People's Capacity

Building the capabilities and capacity of the workforce to co-produce at all levels. Consider re-energising the role of the Board to overseeing the development of PPI/co-production in the organisation. This involves investing in co-production training across all parts of the organisation. It also involves open and transparent sharing of information in order to facilitate effective co-design and co-delivery with all relevant partners.

Reciprocal Recognition

Ring-fencing funding to enable the development of co-production across the organisation. This includes establishing systems that reward and recognise the contributions people make. It also involves learning from the experience of people who use services and staff who provide care by formally recognising how their contribution has changed the delivery of services.

Cross Boundary Working

As part of transitioning HSC systems of care, Boards and Executives will need to strengthen the organisation's community development role in addressing population health needs. Reach out and invest in multi-agency and community sector partnerships in order to deliver of better outcomes.

Enabling and Facilitating

Facilitating a change in organisational culture which embeds co-production at the heart of the organisation's strategic planning processes. This involves leaders providing oversight and enabling all those involved in service planning, development and improvement to reflect the principles of co-production in their practice.

Key Outcome

People are active participants in co-design and co-delivery of services. There are measureable and objective improvements in people and staff experience, care outcomes and there is evidence of increased productivity across all services.

3.5 Practical Guide for People with Lived Experience & Peer Networks

This section outlines the roles and responsibilities of people with lived experience in participating in service development and in leading co-production. Lived experience includes: direct experience of a health and social care need, carers, advocates and all peer support networks. Fundamentally co-production is a ***deeply person centred approach*** and is based on ***'No decision about me without me'***. It recognises the knowledge of people with lived experience **is of equal value** to staff experience and knowledge. Individuals and peer led/support groups therefore have a fundamental partnership role in formulating their own needs, developing their own personalised support plan, shaping and influencing policies, strategies, and in the co-design and co-delivery of services.

Valuing People

Recognise the value placed on their personal experience and knowledge and will value the worked experience of staff and in partnership with them and other partners work to break down barriers, create mutual understanding of needs, develop shared goals and improve outcomes for all.

Building Representative Network

Have a lead role in developing and building representative peer networks, and in working with other partners who participate in delivering, advocating or enabling better health and social care outcomes. This also involves working in partnership with others and representing lived experience on regional and local co-design/co-delivery working groups.

Building People's Capacity

Avails of training and development opportunities alongside staff in co-production on how HSC systems works. Will also co-deliver training and development for staff, and other partners in seeking to create understanding of the personal, psychological, and social economic needs. People with lived experience will have a leadership role in supporting the development of peer led and expert patient models and services.

Reciprocal Recognition

As a basic principle recognise that everyone has expertise, skills and strengths. Share ownership and accept responsibility with others for shared decisions. This will include advocating for positive change in service delivery models with peers across HSC systems. As outlined in the recognition section of this guide the contribution of people with lived experience will also be recognised, valued, and, where appropriate, remunerated.

Cross Boundary Working

Work with others and across organisational boundaries and through their representative networks influence other government departments, local government and all communities in working together to deliver better outcomes.

Enabling and Facilitating

Be leaders and facilitators of change and an advocate for co-production, supporting and enabling HSC staff and peers to work together to solve problems. Develop with others new and creative solutions which deliver evidence based outcomes.

Key Outcome

The experience of the health and social care system is more person centred, your contribution has enabled change and as a result health and wellbeing outcomes have improved.

3.6 Practical Guide for Operational Managers, Team and Clinical Leads

This section outlines the role and responsibilities of Operational Managers, Team and Clinical Leads in developing and leading co-production within and across their respective organisations. Operational Managers, Team and Clinical Leads have a key role in translating co-production into operational practice and showing leadership by facilitating their staff and people with lived experience to work in partnership to deliver improvements in personalised care and to design solutions which enables better outcomes for people who use their services.

Valuing People

Will champion co-production and demonstrate their organisations commitment by building lived and learned experience into the design of care pathways, service development and in the auditing and evaluation of services. Organisations will need to be accessible and visible in supporting, mentoring and in acknowledging the value of people's contribution.

Building Representative Network

Support the strengthening and development of partnerships working between staff, people with lived experience and their respective communities. Scope partners, map assets and enable the development of peer/lived experience networks. Create the conditions to support networks in the decision making process.

Building People's Capacity

Create time for staff to participate in co-design/co-delivery programmes. Develop training needs analysis, facilitate training in PPI and co-production methodologies. Embed co-production principles in team meetings, supervision, revalidation and continuing professional development processes. Create opportunities for people with lived experience to become involved in the development of care pathways and services. Ensure all participants are given the information they need to meaningfully contribute.

Reciprocal Recognition

Value and learn from the contribution of others, recognise and reward people in line with the principles in this guide. Link all co-design and delivery work to enable better outcomes.

Cross Boundary Working

Lead and build the necessary cross-government or multi-sector partnerships in generating solutions for improving people and communities outcomes. Proactively build connections and contacts beyond 'usual' boundaries, invest in and pool resources with others in outcome focused solutions.

Enabling and Facilitating

Develop/strengthen facilitation skills, and through effective compassionate leadership enable people with lived experience, point of care staff, and communities to solve problems together.

Key Outcome

Teams feel empowered; staff and people with lived experience feel valued; and health and wellbeing outcomes for people with lived experience have positively improved.

3.7 Practical Guide for Communities

This section helps communities as they embark on a transformational co-production process. Communities can be geographical or communities of interest. Geographical communities may reflect a location like a housing estate or a town. Communities of interest may be groups of people who come together from a shared experience or circumstance i.e. Tenants group or Men's shed. Co-production provides the opportunity for health and social care, other public services and the community and voluntary sector involved in health and social care provision to work with communities to design and produce services that are relevant to them. This transformational co-production process enables a different and deeper level of interaction and engagement of all those involved, from HSC organisations to other parts of the public sector through to local communities.

Valuing People

Proactively engage and build on the experience and knowledge of the people who use services and the experience of people and organisations that make up the local community.

Building Representative Network

Find and develop the peer supports that are available at community level. This may mean working in partnership with a number of new people or organisations, finding areas of common interest, or identifying gaps that others in your community can support or help in.

Build People's Capacity

Engage in activities and experiences which strengthen the levels of trust within communities and those community based organisations which are working to improve and sustain health and wellbeing. This includes HSC as well as other organisations i.e. councils, police etc. Refer to and use the knowledge known to the community to help determine what is relevant to their situation and circumstances.

Reciprocal Recognition

Value people's contribution in whatever form it takes. Be willing to use new ways to recognise people for their involvement through the use of schemes like time credits and time banking. Move towards working in a way which is reciprocal and uses the experience and knowledge communities have, and which introduces new communities to the process where they see positive benefits.

Cross Boundary Working

Traditional roles are re-examined and those best placed to address an issue with skills, knowledge, expertise and where necessary reallocation of finance are supported to do so. This is best done through established trusting relationships. These are built over time and will not happen overnight.

Enabling and Facilitating

As a community we are willing to learn and change alongside those within the HSC organisations and other public bodies. Move towards working more collaboratively investing our time into building relationships and shared solutions to overcome complex problems.

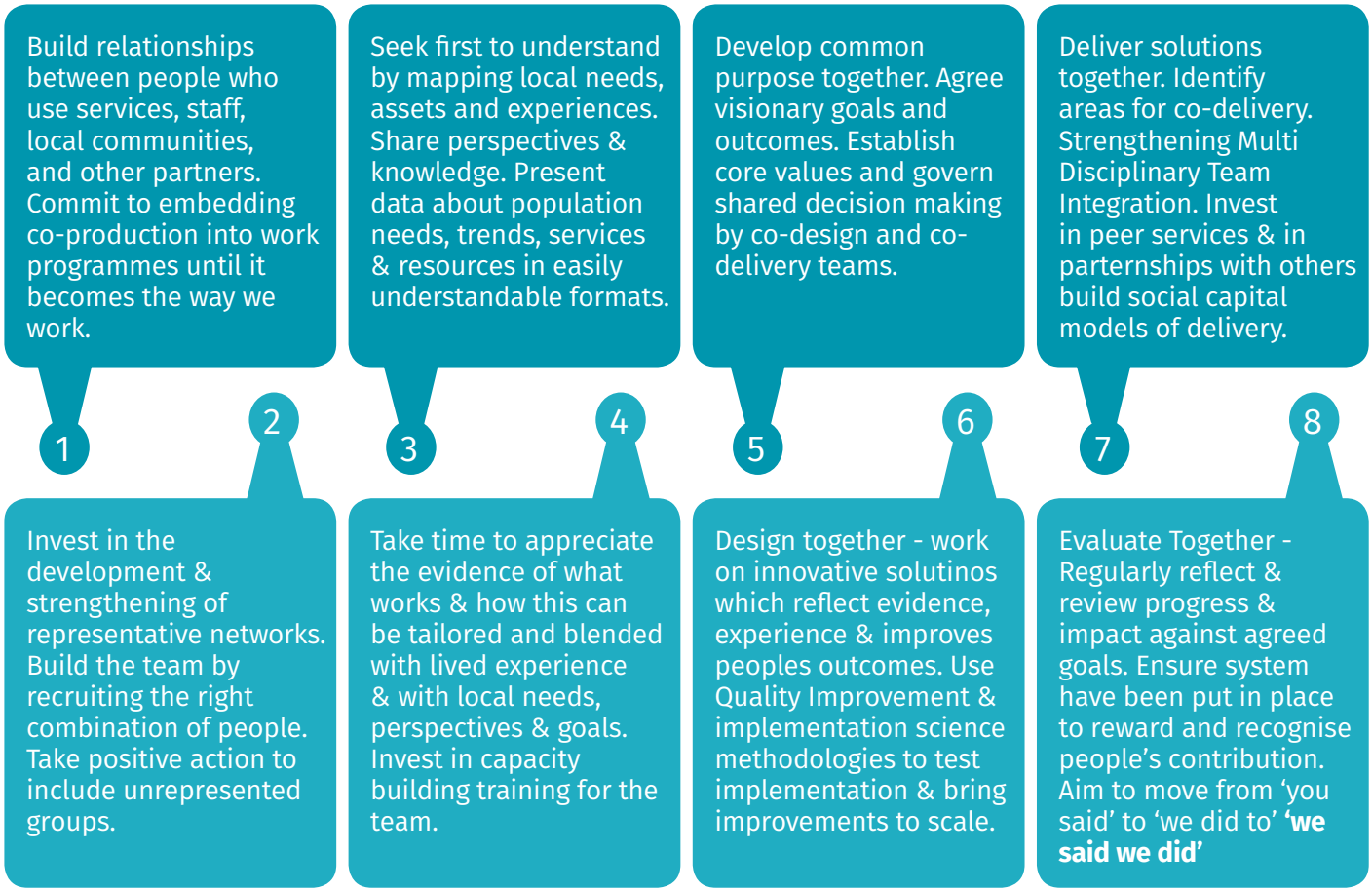
Key Outcome

Community is more actively engaged in supporting health and social care services design and delivery.

3.8 Key Implementation Steps to Effective Co-Production

To translate these prinicples outlined in section 3, figure 6 below, outlines eight key implementation steps which will enable the effective use of co-production within and across each health and social care organisation.

Figure 6



3.9 Collective Leadership

Co-production requires collective leadership at all levels. It reflects the need for distributed leadership and distributed ownership of policy, strategy and delivery within and across systems. It means system leaders:

- are accessible and visible to people who use services and the staff who provide them;
- adopt a facilitation role 'clearing the way' to enable shared decision making and real partnership working to occur, until it becomes the 'way we do things'; and
- exemplify the values and principles of co-production by ensuring they maximise the opportunities of partnership working in order to improve outcomes for all.

3.10 Reciprocal Recognition

At the heart of co-production is a commitment to value, reward and recognise the contribution of all partners, particularly people with lived experience. All the core literature on co-production recognises the principle of **reciprocity** which is defined as ensuring that people receive something back for putting something in, and builds on the premise of recognising and valuing people's contribution.

Examples of Reciprocity include mutual respect, equality of opportunity, joint learning, recognition, flexible rewards, and remunerating people for their role and contribution. This can also include benefits in kind, such as 'out of pocket' expenses, and meeting training and development costs. Depending on role or task being undertaken, rewards should be flexible and provide choice. The importance of choice cannot be overstated.

Recognise that there may be personal reasons why people do not want or are unable to accept payment for commissioned work and therefore rewards for people's time should be flexibly applied.

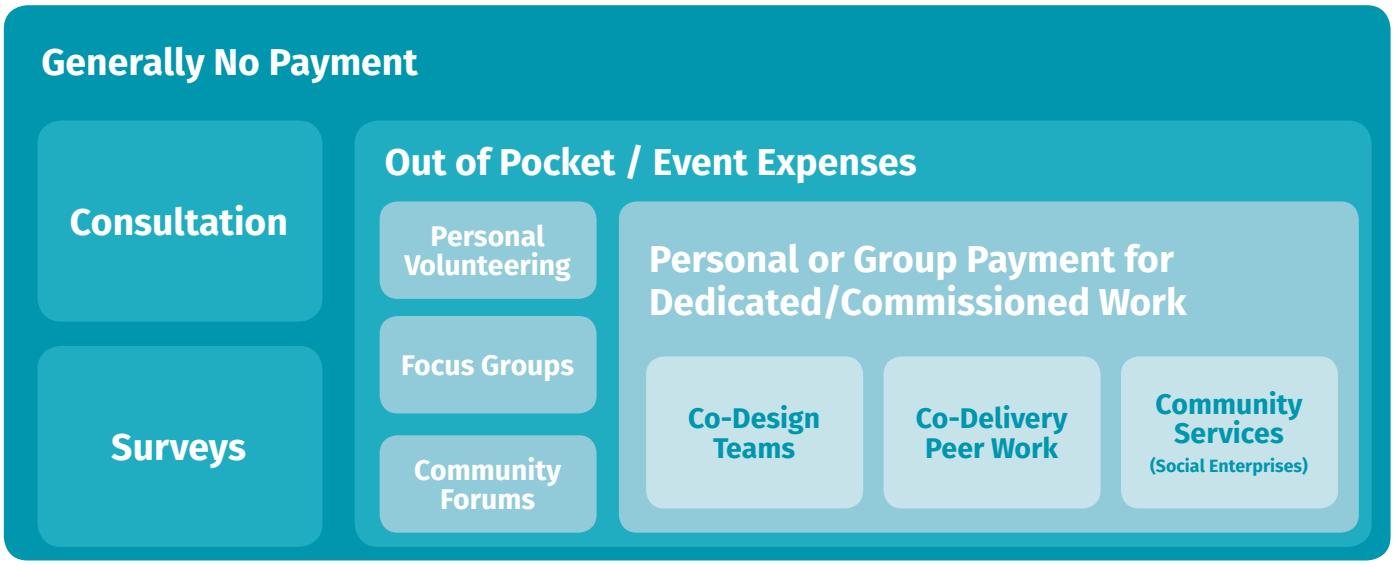
HSC organisations should plan and budget for co-production activities on an annual basis.

In the spirit of co-production, monetary and non-monetary rewards should be appropriate to the function and role required. In the same way that professional services are increasingly required to demonstrate outcomes, all peer led activities should be effectively planned and linked to outcomes.

All sessional peer led activities will be supported by a role specification which will outline the level of responsibility, skill, expertise, and experience required. It is important to note we must not substitute the important value that is associated with volunteering and good will, but aim to achieve a balance between the value of maximising personal involvement, enabling peer networking, and repaying the contribution of people with lived experience involved in co-production.

The table below is intended as a guide to reflect the principles of co-production set out in section 3. Payments should be in line with the existing HSC/NICS expenses, role specification, services commissioning, and recruitment processes.

Figure 7 (illustrative only)



3.11 **Conclusion**

Co-production is fundamentally an investment in relationships, which when successful leads to improved outcomes for our population. It is a crucial foundation for enabling people and communities to influence their own health and wellbeing by contributing to the co-design, co-delivery and improvement of HSC services. Recognising and harnessing the mutual strengths, capabilities and potential of people, staff and communities provides a real opportunity to achieve positive change.

Success will require a sustained commitment from leadership at all level, a willingness to inspire innovation and share:

- decision making;
- knowledge; and
- resources

to achieve transformational change. Co-production is about ***'realising value through people'***. It can move us from a culture of 'you said, we did' to 'we said, we did it together'.

3.12 **With special thanks to the Co-production Working Group**

This Guide has been co-produced by a group of people with a vast range of knowledge and experience in using co-production approaches and PPI standards within health and social care services. They worked professionally, tirelessly and enthusiastically as a team to reflect their learning and experiences in how coproduction can be used to improve people's health and social care outcomes.

In the months that we journeyed together working on this project, we have built strong relationships and trust with each other. We communicated well together working through issues to focus on the practical solutions to using co-production as a method of involvement for transformational change.

Their contributions have been exceptional – THANK YOU ALL

Section 4:

Essential Reading

4.1 Department of Health - Policy and Strategic Frameworks

- ☆ **Health and Well Being 2026 - Delivering Together**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

- ☆ **Systems not Structures**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

- ☆ **Personal and Public Involvement Legislation**

  https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi

- ☆ **Department of Health – Personal and Public Involvement Consultation Scheme**

  https://www.healthni.gov.uk/sites/default/files/publications/dhssps/DHSSPS%20Personal%20Public%20Involvement%20Consultation%20Scheme.pdf

4.2 Supporting Literature

- ☆ **SCIE – Guide to co-production in social care**

  https://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/

- ☆ **British Medical Journal – from tokenism to empowerment**

  http://qualitysafety.bmj.com/content/qhc/early/2016/03/18/bmjqs-2015-004839.full.pdf

- ☆ **Health Foundation Improving Outcomes by Helping People Take**

  Control – The Theory and Practices of Co-Creating Health.

  Improving Outcomes by Helping People Take Control The theory and practice of Co-creating Health. - ppt download.

- ☆ **Welsh Government Co-producing services – Co-creating Health.** http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%288%29%20Co-production.pdf

- ☆ ***Scottish NHS Co-Production – Health and Wellbeing*** http://www.govint.org/fileadmin/user_upload/publications/Co-Production_of_Health_and_Wellbeing_in_Scotland.pdf

- ☆ ***Scottish Joint Improvement Team – Co-Production OPM Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care*** http://www.healthissuescentre.org.au/images/uploads/resources/Coproduction-health-wellbeing-outcomes.pdf

- ☆ **Scottish Recovery Network People Powered Health and Wellbeing – Shifting the Balance - How people with lived experience and people who work in services can have good conversations and build connections to co-produce wellbeing** http://www.coproductionscotland.org.uk/files/8014/2788/6655/4._People_Powered_Health_and_Wellbeing.pdf

4.3 Organisations and Networks with Expertise in Co-Produciton

- ☆ **Co-production Wales: Co-production Network for Wales**
  https://coproductionnetworkwales.wordpress.com/
- ☆ **Co-production Scotland – Scottish Co-production Network**
  http://www.coproductionscotland.org.uk/
- ☆ **Co-Production Northern Ireland – Community Development Health Network**
  https://www.cdhn.org/co-production
- ☆ **Kings Fund**
  https://www.kingsfund.org.uk/
- ☆ **Nesta**
  https://www.nesta.org.uk/
- ☆ **New Economics Foundation**
  http://neweconomics.org/
- ☆ **SCIE**
  https://www.scie.org.uk/co-production/

Annex A:

Examples

CO-DESIGN WITH COMMUNITIES

Daisy Hill Hospital (DHH) Pathfinder Project

CONTEXT

A need to develop plans for urgent and emergency care services in the Newry and Mourne area was identified against a background of significant public concern about challenges facing the Emergency Department (ED).

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Trust Directors***
Resources:	***Trust assigned Project Manager, PHA medical consultants, Trust Directors, Trust Head of Communications***
Expertise:	***Clinician and Managerial staff, GPs, Service and Professional Managers, PHA Medical & Nursing staff, NIAS, Commissioners (HSCB and SLCG representatives)***
Information:	***PHA, SHSCT, HSCB***
Need:	***Representatives from the local community, TU representative (UNISON)***

A Daisy Hill Hospital Pathfinder group (DHHPG) was formed to take forward the required development plans. The Trust Board approved adopting a co-production approach for this project. Membership of the group was wide ranging as noted above and of significance included 5 people from the local community. The latter members were selected via an open recruitment process which was facilitated by the Confederation of Community Groups, Newry and District. Essential criteria for selection included access to a local community 'network' that could be utilised to consider and provide feedback on proposals as the project progressed. The professional and managerial staff also had access to networks from their respective fields. The professional staff, while unsure as to how it would progress, embraced this new way of working with the local community. To meet the needs of the local community group members, the Project Lead met with them as required in advance of DHHPG meetings to talk through any issues, unfamiliar concepts, training needs and ideas. Tailored briefings were also provided for these members to enable everyone to be at the same starting point with regards to information and understanding – this ensured power was balanced in meetings.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

A stakeholder mapping exercise was completed to identify what was available in the local area. To facilitate as many people as possible meeting with the Project Lead individually or in a small group, engagement meetings were arranged in several community settings and promoted using a variety of methods including an internet Invite Video. These meetings provided an opportunity

for people to raise concerns directly with the Project Lead and share information about local networks. All considered the meetings as positive and that many stated that they felt their views had been heard and valued. An early step was the production of additional supporting information collated through a comprehensive Health Needs Assessment (HNA). This included a range of relevant local and regional statistical data and information gained through clinical audits and a literature review. This was developed by and shared with all members of the DHHPG for consideration.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

Recognising the need for wider staff engagement, an interactive workshop attended by 100 staff and GPs was undertaken to identify their issues, concerns and potential solutions. Collectively the DHHPG considered the output from the workshop alongside information from the Health Needs Assessment, the clinical audits and the literature review to identify priorities. One was the development of a Direct Assessment Unit (DAU) at DHH as an alternative pathway to ED for stable patients. The DHHPG recognised the value of learning from others and arranged a visit to Antrim Area Hospital (NHSCT) where a DAU had been operating for several years. A delegation representing a cross section of all stakeholders from the DHHPG met with medical and nursing staff and explored a number of areas including flow between the primary, acute and community services. The visit helped to create a vision of how a DAU might operate in DHH and highlighted the significant benefits to patients.

The SHSCT was proactive in recognising the need to communicate the continued progress of the Project's work and designated a communications officer to work alongside the team. A communication strategy was developed with a monthly on-line E-Zine that all members of the DHHPG were responsible for sharing in a suitable format within their respective networks and bringing feedback back to the group to aid the wider development process.

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

The information from the Health Needs Assessment paper confirmed for members the need for an ED on a 24/7 basis and the group's focus then shifted to how best they could achieve this. To progress this vision the group agreed priority workstreams and established specialist subgroups to consider:

- ED Workforce;
- Improving Patient Flow, including Rapid Assessment/Short Stay Service; and
- Strengthening Services for the Sickest Patients.

Each subgroup contained members from the community; a range of clinical and non-clinical staff from primary, acute and community settings; and staff side representatives. They worked together, using their collective knowledge, data and networks to develop the proposed new service model, alongside the DHHPG. A final report was published in December 2017 ***http://www.southerntrust.hscni.net/pdf/DHHPG%20Final%20Report.pdf***

Step 5 – Co-delivery

This example primarily focusses on co-design but with a view to developing co-delivery as part of implementation of the model.

Step 6 – Co-evaluate

At the time of writing the co-design phase of this project has just been completed. Regarding implementation and evaluation of the proposed model, the final report commits to continuing the wider partnership approach to successfully co-deliver and co-evaluate this project. The situation regarding Daisy Hill hospital was a contentious, high profile, emotive issue. The co-production approach enabled all parties to effectively outline their positions, consider these in the context of clear evidence and information and then develop solutions in partnership.

Michael McKeown, President of Newry Chamber of Commerce, captured the impact of the process. "I have been privileged to sit on the DHHPG as a community representative. Remarkable change is taking place. Now is the time to... remove the negative. Replace the word 'save' with the word 'support'. Support Daisy Hill."

CO-DELIVERY IN MENTAL HEALTH

'You in Mind' Mental Health Care Pathway and Recovery Colleges

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority: PHA HSCB Trust Directors

Resources: PHA Nursing Facilitated Regional group, Trust MH service improvement officers, Trust service user and carer networks.MH Operational managers, AD Mental health.

Expertise: External ImRoc facilitators, PHA, Trust clinical staff, service user and carer/ families,Service improvement managers.

Information: All Trusts, PHA,HSCB

Need: TU Representation

When the group was formed, members outlined their initial anxieties in order to build trust – people with lived experience expressed concern about dominant professional perspectives, whilst the professional anxiety was that coproduction might undermine professional expertise. Overcoming these anxieties required all to have an agreed understanding of our values and our vision of recovery orientated practice and its practical application. This involved true partnership working and mutual respect for each other's point of view to develop relationships.

Each of the 5 areas agreed to either use existing or if required to create a new network outside of the group that could be used to engage with and inform the process as it evolved – in line with PPI statutory requirements.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity and Reciprocal Recognition

Taking a strengths based approach, the various partners outlined the value of the different knowledge bases and networks available to them during the process and this enabled them to identify training gaps. They used the results of a regional survey of the experiences of people using or caring for someone who uses mental health services – which clearly outlined the need for 'good communication', 'shared care', 'timely information' and the importance of respectful and dignified care.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

The consensus view on our vision was to work in a co-productive way in order to transform people's lives and make it part of the way we work on a daily basis. By doing this we wanted to create a culture where the values of hope, control and opportunity became the norm. Working in equal partnership to put co-production at the heart of mental health care by co-producing a NI Mental Health Services Framework that incorporated the 'You in Mind' mental health care pathway and the development of Recovery Colleges.

Step 4 – Co-design the Solution

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

Giving equal weight to people's lived experience with professional expertise was fundamental to promoting co-production. This influenced practice, reform of services and was instrumental in the revision of the Northern Ireland Mental Health Services Framework. The establishment of an expert by experience writing group ensured the pathway remained grounded and real for everyone involved. The group helped translate a complex range of evidence and co-production concepts into an easily understood practical guide.

The vehicle used to facilitate the establishment of Recovery Colleges was through the *'Implementing Recovery through Organisational Change Programme'* (IMROC). The Recovery Colleges have been designed using a 'hub and spoke' model and programmes are delivered within local communities through a wide range of community and voluntary sector venues and public buildings. A wide range of co-produced courses have since been developed in partnership with people with lived experience and with the active involvement of voluntary and community sector professionals.

Step 5 – Co-delivery

Principles demonstrated - Valuing People, Building People Networks, Building People's Capacity, Reciprocal Recognition, Cross Boundary Working and Enabling and Facilitating

The establishment of Recovery Colleges created a robust network of people with lived experience who are now actively involved in the design and delivery of a wide range of co-education programmes across Northern Ireland.

The 'You in Mind' care pathway and the Recovery Colleges have helped to mainstream and embed co-production, whilst also initiating a culture shift across mental health care. The co-delivery of this work has led to the establishment of peer support worker posts, five Recovery College Hubs and the appointment of Recovery College peer educators.

Step 6 – Co-evaluate

Principles demonstrated - Valuing People, Building People's Capacity, Cross Boundary Working and Enabling and Facilitating

The approach to evaluating the difference Recovery Colleges have made to people's lives is being carried out using an outcomes based accountability approach.

We consider how much we do regarding numbers of attendees and co-produced courses; how well we do it - using the 8 criteria identified by IMROC for developing a Recovery College; and finally if anyone is better off?

We consider feedback on:

- improved knowledge;
- self-reporting on improved confidence and wellbeing;
- improved connections with others in the community; and
- wanting and having opportunities to give back.

CO-DESIGN WITH COMMUNITIES
Primary Care Multi-Disciplinary Teams

CONTEXT

Delivering Together: Health and Wellbeing 2026 identifies enhancing support in primary care as a key priority. It sets out a vision for a primary care service focussed equally on mental, physical and social wellbeing which is able to intervene early to support self-management and independence. In order to deliver this, a broader primary care team is needed with a genuinely multi-disciplinary team wrapped around GP Practices.

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Department of Health, HSCB and PHA reps***
Resources:	***Department of Health, Trust, HSCB, PHA and GPs reps***
Expertise:	***DoF and HSCB analysts, health and care professionals***
Information:	***Department of Health, HSCB and PHA reps***
Need:	***Patient representatives, Trust, GP, HSCB and PHA reps***

A working group was formed to develop an approach to rolling out the new primary care model set out in Delivering Together. Given the very wide scope of primary care it was not possible to include all interested groups and parties round the table – instead a smaller group including a user representative, Trust and GP representatives was formed with membership from different regional agencies and from different professional backgrounds and expertise. Members of the group were expected to communicate back to their own professional networks, regional groups and organisations. The group discussed approaches to user engagement and agreed to expand the number of user representatives on the working group and create a separate service user and carer reference group to feed in a wider range of views.

Members of the service user and carer reference group were recruited from existing networks and have been meeting monthly. The group is chaired by a service user and they have been considering the principles that should underpin primary care MDT working from a user perspective.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People Networks, Reciprocal Recognition and Cross Boundary Working

A stakeholder mapping exercise was completed and a stakeholder engagement plan developed which is reviewed monthly by the working group.

An evidence base was developed through reviewing quantitative data about existing demand and service performance, commissioning a survey giving us new insight into the case mix presenting to GPs and through work to review best practice locally, across the UK and internationally. This information was reviewed and discussed collectively with all partners on the team to inform the next steps. Different members of the group have also led presentations on key elements – such as the role of social workers, or the proposed neighbourhood nursing model, or paediatric care. In addition, the working group has had presentations from others in the systems on topics which are relevant – such as primary care infrastructure or mental health.

To further enhance what we knew about the current models in place, a local best practice workshop was held. The approach to co-production was discussed and each of the 5 Trusts presented on their current multi-disciplinary approaches to working in primary care. Discussions on the key learning points, questions and issues were held in small, mixed groups of those in attendance – this included Trust staff; GPs; patient and service user representatives; and community and voluntary sector representatives.

Alongside this, a significant number of meetings were held with groupings of community and voluntary sector organisations and key professional groups to explain our approach to the work and seek their early input.

Members of the servicer user and carer reference group all completed a short profile which allowed us to assess the spread of skills, experiences and interests which were represented in that group and consider whether there were any gaps that needed to be addressed or additional training. Having drawn membership from existing groups such as ICPs, representatives had already received training in core skills. Members of the group have been provided with time to engage informally over lunch in order to help build relationships within the group.

We drew on existing regional guidance to ensure service users and carers and professionals attending workshops (such as GPs) were able to claim back travel and other costs in line with regional guidance.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People Networks, Cross Boundary Working, and Enabling and Facilitating.

In the next stage we wanted to develop our proposals. To do this we needed to involve a wider range of perspectives into our discussions. We scheduled a series of regional facilitated workshops to do this. These are seeking to:

(i) Share what we know so far

(ii) Take views on what the future should look like

(iii) Gather suggestions for the principles that should underpin the approach to primary MDT working; and

(iv) Seeks views on the best approach to rolling out an MDT approach.

So far 3 workshops have been completed with a further 2 planned. The workshops have been held in daytime and in evenings to help ensure accessibility and have been at venues across Northern Ireland. Invitees included frontline Trust staff (doctors, nurses, social workers, AHPs and managers), ICP chairs and members, council representatives working on community planning, representatives from Trust PPI groups and from our own service and user reference group who were users of primary care services, GPs and practice or federation staff, Ambulance Service representatives, community and voluntary sector representatives, independent sector representatives, community pharmacy representatives and commissioners (LCG chairs).

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

To date the workshops have gathered views on the approach to roll-out and what elements should part of the initial model we seek to implement. Once the workshops have been completed, the working group will use this input in conjunction with the evidence collated in step 2 to make a recommendation to TIG about:

- a set of principles to underpin the work; and
- about how we should seek to roll the model out.

The exact design of the model will require further active engagement from a wide range of local partners in the areas that seek to test the model in.

Step 5 – Co-delivery

We intend to form a strong partnership with GPs, Trusts, community and voluntary sector, those with lived experience of using primary care services and staff involved in the delivery of the new model in each local area to ensure that practice on the ground can be adjusted, barriers removed and learning shared. Throughout the roll-out period it is intended that the service user and carer reference group will continue to play an active role in shaping the model we use as the 'network' for the service user reps on the Project Team.

Step 6 – Co-evaluate

DoF analysts are currently discussing the approach to evaluation with our service user and carer reference group, who are keen to shape the approach and help develop the questions we use. Proposals will then be brought back to the working group for consideration as part of our overall approach to measuring success.

We intend to co-create a continuous feedback loop that will allow us to learn from initial roll out, re-design the model with input from partners and users and support further roll-out and evaluation of the service.

Annex B

GLOSSARY OF ACROYNMS IN USE ACROSS HEALTH AND SOCIAL CARE

AHP	Allied Health Professional
ALB	Arms Length Bodies
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CAMHS	Child and Adolescent Mental Health Services
CEC	Clinical Education Centre
CHD	Coronary Heart Disease
CMP	Condition Management Programme
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COPD	Chronic obstructive pulmonary disease
CPD	Commissioning Plan Direction
CPO	Chief Pharmaceutical Officer
CSP	Chartered Society of Physiotherapy
DOH	Department of Health
DE	Department of Education
ED	Emergency Department
ELCOS	End of Life Care Operation System
FPS	Family Practitioner Service
FSH	Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
GPSI	General Practitioner with Specialist Interest
HIA	Health Impact Assessment
HLC Alliance	Health Living Centre Alliance
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSE	Health and Safety Executive
ICP	Integrated Care Partnership
IP	Inpatient
IPH	Institute of Public Health in Ireland
LCG	Local Commissioning Group
LD	Learning Disability
LGB&T	Lesbian, Gay, Bisexual and Transgender
LEP	Local Engagement Partnership

LTC	Long Term Condition – Chronic ailment from which there is no cure but will require long term treatment or monitoring
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIAS	NI Ambulance Service
NIASW	NI Association of Social Workers
NIBTS	Northern Ireland Blood Transfusion Service
NICE	National Institute for Health and Clinical Excellence
NICVA	Northern Ireland Council for Voluntary Action
NIFRS	NI Fire and Rescue Service
NIMDTA	NI Medical and Dental Training Agency
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NIPSA	Northern Ireland Public Service Alliance
NISAT	Northern Ireland Single Assessment Tool - for use when planning home care for older people
NISCC	NI Social Care Council
NMTG	Nursing and Midwifery Task Group
OSS	Office of Social Services
PCC	Patient and Client Council
PD	Physical Disability
PfG	Programme for Government
PHA	Public Health Agency
PPI	Personal and Public Involvement
QOF	Quality and Outcomes Framework
RQIA	Regulation and Quality Improvement Authority
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SCIE	Social Care Institute for Excellence
SEHSCT	South Eastern Health and Social Care Trust
SET	South Eastern Trust
SHSCT	Southern Health and Social Care Trust
TDP	Trust Delivery Plan
Trust	Provider of Health and Social Care Services to a particular population
TYC	Transforming Your Care
UU	Ulster University
WHSCT	Western Health and Social Care Trust