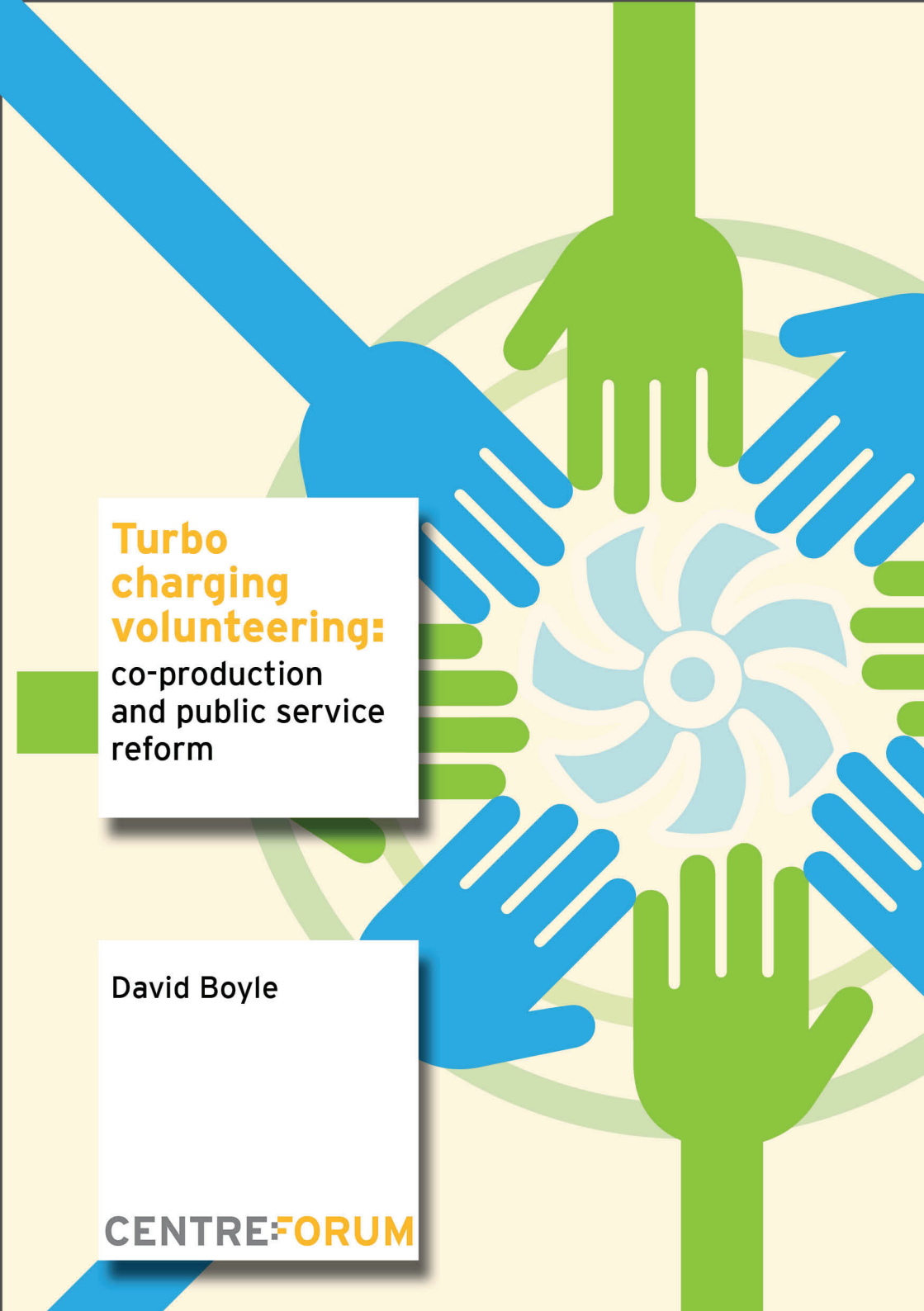

Turbo charging volunteering:

co-production and public service reform

David Boyle

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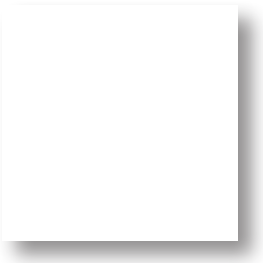

About the author

David Boyle is a co-director of the New Weather Institute and a fellow of the New Economics Foundation and has been at the heart of the effort to develop co-production and introduce time banks to Britain as a critical element of public service reform. He was co-author of three key reports for NESTA in 2009/10, 'The Challenge of Co-production, Public Services Inside Out and Right Here, Right Now' which set out co-production as a practical way forward for UK services. He was recently the government's independent reviewer on Barriers to Public Service Choice (2012-13). His book Broke: Who Killed the Middle Classes? was published by Fourth Estate in 2013. Visit his website www.david-boyle.co.uk

Acknowledgments

I would like to thank my pioneering colleagues in the social policy team at the New Economics Foundation, and the members of the Co-production Network that is co-ordinated there, for all their inspiration and guidance and experience on the ground, particularly Lucie Stephens, Julia Slay, Anna Coote and Sarah Lyall. Also to my colleagues at the Cabinet Office who provided such invaluable and imaginative support during the Barriers to Choice Review. I would also like to thank the staff at CentreForum for their advice and encouragement, Edgar Cahn for first introducing me to these ideas, and my wife Sarah for launching Rushey Green Time Bank all those years ago – and for much else.

Published May 2014 CentreForum

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Executive summary

Co-production is a term coined in the USA for the broadening and deepening of public services when they are delivered by the beneficiaries, alongside professionals. It may also be the type of service delivery model that the father of the welfare state, Sir William Beveridge, envisaged six decades ago. Yet the way public services have evolved in Britain has precluded it from being widely applied. Co-production denies that professionals are the only people required to do practical things. It also denies that everything necessary for support – whether in health, education or social care – can be paid for. Both of these were understood very well by Beveridge, but have been sidelined in the UK, and disastrously so.

The term 'co-production' is now in widespread use in public services. The NHS is formally committed to it. But all too often, the radical meaning of the idea, as set out by pioneers like Elinor Ostrom and Edgar Cahn in the USA, has not made it into the management and design of UK services. We have an opportunity however to think differently about the shape of services, how they can build social networks and reach out upstream of problems and prevent them occurring, or prevent them getting worse.

It is already possible to see examples of co-production working in the UK, from time banks in health and housing, citizen justice panels, co-operative nurseries, and perhaps also Local Area Co-ordinators in social care – all of which, in different ways, are re-shaping services so that they are delivered alongside the people who are benefiting from them, and their families and neighbours, and to reach out and rebuild social networks around the service centres.

This report looks at how this approach might be mainstreamed in the UK, including the following approaches:

Develop the supportive infrastructure. This proposes that local teams are employed to persuade local services to set up time banks, health champions or any of the other models, and then links them together and challenges them to tackle new, overlapping areas of activity.

Change the requirements for public sector contractors. This approach has the potential to prevent the narrowing of service outcomes. Service contracts need to specify where contractors will build social networks and, where appropriate, reduce need during the lifetime of the contract.

Reverse the priorities at assessment stage. Instead of reaching for care packages and complex solutions, there needs to be a range of options and organisations that make it possible for people to meet needs informally – achieved by assessments that look at what people can do, and want to do, rather than just what they can't do.

Merge budgets locally. These shifts can only be achieved if there are means whereby services can invest together in the preventive infrastructure that will help them all reduce demand in the long-term.

Organise a national network. There needs to be a national network that can balance the need for local loyalty and local budgets with national branding, national training support and qualifications. It may be that the model here is the National Trust.

The objective here is to reinvent volunteering through public services so that it becomes classless, absolutely ubiquitous, far easier, cross-departmental, and part of the fundamental purpose of those services. The purpose is to mainstream co-production in such a way that it shifts the way services are delivered, so that they can underpin the preventive services we so badly need.

1 Introduction

> "No change is made in this figure as from 1945 to 1965, it being assumed that there will actually be some development of the service, and as a consequence of this development a reduction in the number of cases requiring it."[1]

You may not recognise this paragraph immediately. It is a section of the Beveridge Report, published in 1942 – the only government report ever to have been a bestseller, and taken into battle by hundreds of thousands of servicemen, to whom it represented post-war hope. It set out the blueprint for the future, caring world.

This paragraph comes from the section where Sir William Beveridge, shortly to be elected as Liberal MP for Berwick, discusses his assumptions about affordability, and here lies the problem. Because it assumes, as you can see, that services would get cheaper over time, because need would be reduced.

That was the assumption on which the new welfare state rested and it was wrong – in fact it has been wrong everywhere, not just in Britain. Beveridge set out to slay what he called the Five Giants – Ignorance, Want, Squalor, Disease and Idleness. The problem is not that he failed to vanquish them; he killed them stone dead, but something he never expected happened. They came back to life again every generation and have to be slain all over again and, every time, it gets more expensive not less.

Through 60 years of peace and plenty, Beveridge's legacy has not managed significantly to narrow inequalities of income or health or to strengthen the kind of mutual support that he

1 W Beveridge (1942), 'The Report of the Inter-Departmental Committee on Social Insurance and Allied Services', London, HMSO.

outlined in Voluntary Action. Neither, in general, has the welfare state successfully tackled the underlying reasons why problems emerge in the first place.

What went wrong? This is such an important question that we hardly dare ask it, in case it is taken as a political excuse to wind up the Beveridge experiment altogether, and because the failure of the welfare state to create a sustainable improvement in social welfare threatens to overwhelm the public finances.

It is true that Beveridge was in some ways a victim of his own success – the welfare settlement led to longer lives, which sometimes (though not always) led to higher costs. It led to different diseases and to disabled children surviving into adulthood. These are partial explanations, but they don't really cover everything. Why has health spending risen so fast for all generations, not just the old?[2] Why is 70 per cent of NHS time dealing with chronic health problems?[3] Why has crime risen so much in the same period?[4] It isn't just that people are living longer.

But Beveridge himself was more aware of this conundrum than his reputation suggests. He was aware that the NHS, for example, was being rolled out by the Attlee government on lines very different to those he had suggested. He wrote an overlooked third report called 'Voluntary Action', which crystallised his thinking and his warnings about what might happen if the welfare state became too paternalist, and if people's instincts for self-help, and their ability to find solutions, were allowed to atrophy.[5]

He wrote that the state had an important role but equally important were what he called: "Room, opportunity and encouragement for voluntary action in seeking new ways of social advance…services of a kind which often money cannot buy".[6]

He was afraid that his reforms were encouraging people to focus passively on their needs. To emphasise his fears, he never used the term 'Welfare State', preferring the phrase 'Social Services

2 J Hawksworth, 2006, 'Long-term public spending trends', London: PricewaterhouseCoopers.
3 fullfact.org/factchecks/nhs_budget_chronic_care_long_term_conditions-2731
4 www.gov.uk/government/publications/historical-crime-data
5 W Beveridge, 1948, 'Voluntary Action: A Report on Methods of Social Advance', London: Allen & Unwin. Quoted in Participle (2008), Beveridge 4.0, London.

State', which he used to highlight the individual's duties or services. By 1948, Beveridge doubted whether his 1942 report was enough to build the cohesive, fairer nation he was trying to achieve.

This is not a simple argument. Membership of the self-help friendly societies peaked at around 10 million in 1945, but there is some reason to suggest that voluntary action in general did not decline in the years that followed.[7] But there is no doubt that it did decline in those areas where the welfare state had become involved – healthcare, education, maybe also social care.[8]

That narrative has become part of the critique of the Welfare State by the communitarian wing of the Conservative party. This is Phillip Blond: "The welfare state nationalised a previously mutual society and reformed it according to an individualised culture of universal entitlement."[9]

Conservative MP Jesse Norman used the example of the friendly societies to illustrate his claim that "the history of British government is littered with attempts at reform that have ignored existing institutions and so undermined them; and, correspondingly, with late rediscoveries of the wisdom of some forgotten tradition."[10]

We need to take the decline in voluntary action seriously, especially as rationed public services increasingly use 'need' as their currency of access. The only assets people have then are their own needs, which must be maximised if they are to access help. It is hardly surprising that needs seem to grow.

But there is another problem as well, as the needs increase: the over professionalisation which Beveridge warned against seems to have widened the basic divide in all public services – between an exhausted, remote professional class and their clients, who are expected to remain passive and easy to process.

This is not just disempowering, it can also be corrosive.

7 www.vahs.org.uk/wp-content/uploads/2011/04/Bernard-Harris-paper.pdf
8 There is also evidence the other way that, once the public sector began to withdraw from social care in the 1990s, there is more voluntary sector activity. See: J Kimbell, 2003, 'The voluntary sector: comparative perspectives in the UK'. London: Routledge, 36.
9 P Blond, 2010, 'Red Tory: How Left and Right have broken Britain', London: Faber & Faber, 282.
10 J Norman, 2010, 'The big society', George Allen & Unwin, London, 109.

"My idea of myself was someone who could be special for others, who could do something they needed," said the civil rights lawyer Edgar Cahn after a heart attack at the age of 44, describing why he invented time banks.

> "And here I was, a passive recipient of everyone else's help. I didn't like it. There was nothing I could do. Or was there? The question wouldn't go away. It never has. It became a very personal fight. I refused to be one more throw away person. And I knew that the fight was not just about me."[11]

But what brings the maximisation of needs, the corrosion of voluntary action, and the social passivity it encourages to a head is the combination of inflation in public services and dwindling budgets, as we approach what looks like the 'Beveridge Crunch'.

In 2011, a fearsome graph emerged from the London Borough of Barnet which has featured in hundreds of local government PowerPoint presentations ever since. It was known as the 'Graph of Doom', and it showed the rising costs of social care and children's services between them, overwhelming falling local government budgets shortly after 2020.[12]

There have been a number of critiques of the 'Graph of Doom', pointing out that a rise in taxation would put off the evil day, possibly forever. But rises in taxes on that scale seem unlikely – and there are similar graphs of doom you could draw about the NHS and other services. Estimates about how much needs to be carved out of NHS budgets in the next parliament range up to £30 billion.[13]

There has been remarkably little public debate about this sustainability problem, and whether public services can survive in their current form – or what form they might survive in – and there are short hand terms for the various candidates for solutions at the end of those same local government PowerPoint presentations: smart cities, personalisation, co-production – anyone who goes to local government conferences will be familiar with most of them.

11 E Cahn, 2001, 'No More Throwaway People: The co-production imperative', Essential Books, Washington,
12 www.gmcvo.org.uk/graph-doom-and-changing-role-local-government
13 www.bbc.co.uk/news/health-23258962

This report is about 'co-production' and it argues that it may be a partial solution to Beveridge's conundrum and therefore to the Graph of Doom.

The co-production critique follows Beveridge's third report. It suggests that the reason our current services are so badly equipped to respond to a changing society is that they have largely overlooked the underlying operating system they depend on: the social economy of family and neighbourhood.

We can no longer rely on continuing economic growth to provide enough finance for public services, and we find that our services have also become constrained by the New Public Management of centralised targets, deliverables, standards and customer relationship management software, which has narrowed the focus of many services and often undermined the relationships between professionals and patients, or between teachers and pupils.

Contrary to the hopes of many policymakers, artificial divisions between different categories of users, between professionals and clients, and between different service budgets, have all served to make the system more inflexible than before.[14]

If we are to make sure our public services are significantly more effective, we need a new idea to reshape them. This is the background to the emergence of co-production, and explains why its advocates are using it to free up the concrete structures and procedures of public services to make them more effective and cost-efficient. It also explains why some policymakers – including the Blue Labour and Red Tory variety – are looking back to the pre-Beveridge Welfare State for solutions, learning from mutual institutions and local self-help organisations which provided the backbone to welfare before the Second World War.

It also implies, perhaps, that the background which shaped Beveridge himself – the friendly societies and voluntary action around which he grew up – might provide part of a solution. The difficulty is that, although you can point to highly successful small examples of co-production in action in almost every service, very little has been written that sets out what taking these ideas to scale might mean. That is what this report tries to do.

14 D Boyle and M Harris, 2009, 'The challenge of co-production', NESTA, London.

It therefore proposes a major increase in voluntary activity, not through the voluntary sector, but in the area where it has shrunk so damagingly since 1945: public services.

2 What is co-production?

The clue which potentially modernised the idea of voluntary action, since its pre-Beveridge days, emerged in Chicago. It was there that Elinor Ostrom, the 2009 Nobel prize-winner for economics, was asked by the Chicago police to tackle a particularly confusing question for them: why was it that, when they took their police off the beat and into patrol cars – and gave them a whole range of hi-tech equipment that can help them cover a larger area more effectively – did the crime rate go up?[15]

This remains a problem and not one that is confined to the police. It lies at the heart of why public services become less effective on the ground as they become less personal and more centralised. Elinor Ostrom's team decided that the reason was because that all-important link with the public was broken. When the police were in their cars, the public seemed to feel that their intelligence, support, and help were no longer needed.

She called this joint endeavour that lies at the heart of all professional work 'co-production'.[16] It explained why doctors also need patients, why teachers need pupils, and politicians need the co-operation of the public, if they are going to succeed.

Chicago was also the city which Robert Sampson studied in the mid-1990s with his team from the Harvard School of Public Heath, trying to get to grips with the social factors behind violent crime. They split the city up into more than 900 different neighbourhoods and found, to their surprise, that none of the factors that are traditionally supposed to make a difference to crime – poverty for example – really seemed to be relevant.

15 E Ostrom and W H Baugh, 1973, 'Community Organization and the Provision of Police Services', Beverly Hills, Sage Publications.

16 R B Parks, et al, 1981, 'Consumers as co-producers of public services: Some economic and institutional considerations', Policy Studies Journal, Vol. 9, No 7, Summer, 1001-1011.

What did make a difference was what you might call a latent sense of co-production among people. It was whether they were prepared to intervene if they saw youngsters hanging about. Sampson called it 'collective efficacy'.[17] He described it as a "shared willingness of residents to intervene and social trust, a sense of engagement and ownership of public space".

As far as this report is concerned, there are three very important linked ideas here.

- First, that professionals need their clients as much as the other way round.
- Second, the implication that service users who are supposed to be such a deadweight on an exhausted public service system are also assets, miserably wasted by the current system. This is one of the key contributions of Edgar Cahn.[18] The proposition here is not that they are in the same category as public service professionals. It is that they are a potential resource for providing the kind of human skills and support which service systems find quite hard to provide, but which are enormously important for their effectiveness – befriending people, listening to them, coaching them perhaps, or just being there, being expert patients or ex-patients or ex-social work clients to advise on choices, or even to advise on 'choice'.
- The third implication is around the concept of a core economy, coined by the economist Neva Goodwin.[19] This is the notion that all local activity - parents bringing up children, looking after older people, or making neighbourhoods work - is not some magically inexhaustible resource outside the economic system. It is what makes the rest of the economy possible.

Those are the basic assumptions of the set of ideas called 'co-production', emerging on both sides of the Atlantic. It is a slippery phrase, taken on and rendered meaningless by senior managers in the NHS and a number of Whitehall departments, but it can broadly be defined as follows:

17 R J Sampson, et al, 1997, 'Neighbourhoods and violent crime: a multi-level study of Collective Efficacy', Science 277, 918.
18 Cahn (2001), op cit.
19 N Goodwin, et al, 2003, 'Microeconomics in context', New York, Houghton Mifflin.

> "Co-production means *delivering* public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of *change*."[20]

The two words that are arguably critical to making this transformative as public policy are italicised. It is about *delivering* services. It is about *doing,* and the purpose is a shift in the power relationships around services, philanthropy and charity.

There is no doubt that user management or consultation is co-production in a sense, and they are hugely important for other reasons – though consultation itself has become the object of cynicism on both sides these days. But co-production emphasises people using their *human* skills, not their advice or their instructions to managers. People don't become mini-bosses in co-production. They are recognised for their potential to broaden and deepen services because of what they *do*, not because of what they think. It is the *doing* that is important.

Politicians are not good at seeing this because most have devoted their lives to being around tables, taking decisions, and fail to see how it excludes people whose skills are less verbal. That is not to downplay the importance of consultation, just to suggest that other forms of involvement are important too.

It requires denying that professionals are the only ones that *do* things, something which Beveridge understood very well but which still has to be argued in the febrile debate about services.

Nor does co-production mean personalisation or personal budgets, important as they are too. The danger of personal budgets is that those who receive them can get flung into an atomised world, where everything has to have a price and where – as a recent story on the *Daily Mail* said – recipients might have to pay people to come to the pub with them.[21] Where personal budgets are relevant is when people can use them to produce

20 D Boyle and M Harris, 2009, op cit.
21 Daily Mail, 24 Apr 2008.

the kind of support networks that means they don't have to pay for friends. Personal budgets are necessary for that, but not sufficient.

This requires denying that everything necessary for support can be paid for, again something that Beveridge understood very well.

Finally, co-production is not 'trolley management'. The Australian post office says that, when people put their postcodes on correctly, they are co-producing postal services. Some supermarkets claim that people are co-producing when they stack their trolleys obediently and neatly, and get their £1 coin back. The term is used quite widely now in business circles and so a basic distinction has to be made.

But the whole purpose of co-production, as Ostrom and Cahn understood it, is to change the power relationships, to give people an equal stake in their services, to give them a means by which they can provide themselves with the kind of support they need – and to reach out upstream of problems and prevent them.

It will not work if it is just about saving money for managers. Without that objective of change – without that promise of transformation for both sides – then co-production is just nudging. It is just manipulation, and it will not have the staying power to work sustainably. Co-production has to be about change, personal change and a change in the power relationships involved in the delivery of services.

But all this is somewhat theoretical without being clear what might constitute co-production in practice. Co-production is sometimes described in terms of six examples, where services are designed to:[22]

- **Build on people's existing capabilities,** to seek out what they can do, not just define people by what they can't do, like some of the time banks in the NHS.[23]
- **Provide services which depend on reciprocal relationships** between professionals and clients, or services and communities, like the co-operative

22 J Slay et al, 2010, 'Public services inside out, NESTA, London.
23 See for example www.rgtb.org.uk

nurseries of Scandinavia and North America.[24]

- **Encourage mutual support networks among users**, especially to take over from professionals at the inevitable moment when professional help moves on – which it does even in the most generous public service set-ups.[25]
- **Blur the distinctions between professionals and users,** like the Chard Community Justice Panel.[26]
- **Be catalysts for broader services,** like some aspects of extended schools.[27]
- **Recognising users as assets to the service**, like the expert patients' schemes or the 17,500 trained volunteer health champions in Yorkshire.[28]

Services which use their clients, and their clients' friends and families, in this way are able to build a much broader range of activities. They also suggest an answer to the welfare conundrum, that delivering services to people who are supposed to accept them gratefully and passively, which undermines their ability to resist life's difficulties, also fundamentally undermines their ability to be the heroes of their own lives. There is also something about reciprocal services, on the other hand, where we ask people for something back, and give them the respect that goes with being equal partners in delivery, which can turn that situation around.

There are implications of this for public services. It implies they need to be much more integrated: not just extended schools which also do social services and health, but extended housing offices, extended police stations, extended surgeries which also do education – all of which are able to use the skills and time of the surrounding neighbourhood, their clients, families and neighbours, to reach out upstream of problems and stop them getting worse. It implies that social networks are critical to people's ability to thrive economically, socially and mentally, and that public services can have a role stitching them together again.

24 www.nurseryworld.co.uk/article/1157022/labour-says-co-operative-nurseries-key-affordable-childcare
25 Expert patients, for example.
26 www.southsomerset.gov.uk/community-safety/get-involved/community-justice-panel/
27 www.infed.org/schooling/extended_schooling.htm
28 www.altogetherbetter.org.uk/community-health-champions

One of the difficulties for those testing out these solutions in public services is that they often seem to conflict with the way services have been developing over the past generation. They rely on face to face influence when the trend has been virtual. They appeal to general skills when the trend has been increasingly specialist. They believe in ordinary skills, amateur in the best sense, when the trend has been increasingly over-professionalised.

Most important perhaps, as we have seen, co-production relies on the idea that the users of services, and their families and neighbours, are a vast untapped resource – when the trend has been to regard them as drains on an overstretched system.

Because of this, co-production represents a different pattern for the future of public services. It represents an attempt to tap into these resources and use them to reach out upstream of problems and prevent them from happening in the first place. It is an idea of public services which are, as their basic purpose, hubs to make possible a massive increase in voluntary activity, not through the voluntary sector but through the public sector.

It is a modernised version of the traditional liberal commitment to voluntarism – not because it can provide services on the cheap, because it is no prescription for that, but because human beings can solve human problems which sometimes nothing else can solve.

3 How does co-production work in practice?

If you have to get to an out-patients appointment at Lehigh Hospital, outside Philadelphia, then your chances of doing so without a car will often be nil. Buses are scarce creatures in this corner of Pennsylvania. There is a similar problem for patients who have been discharged, who don't have the luxury of a relative who can pick them up.

What do they do? The answer is that they often arrange for a lift through the local community exchange, and will be driven – not by ambulance drivers or other professionals – but by other patients, recovering ones or former ones. When you are feeling better, then you will be asked to do something similar for somebody else.

This is not the conventional way of doing things. There are some people who might refuse to countenance anything of the kind unless the drivers had undergone a few years training and full risk analysis. Other people might say – as they do say – that, if something's worth doing, then the government should do it. Yet there is something thrilling about the Lehigh way of doing things. The scheme saves money for the hospital, almost by definition, because people actually turn up for their treatment. But it also puts to work an absolutely huge human resource – people who are usually the recipients of public services, medicine or volunteering – and they turn out to be very good at it.

The Lehigh Community Exchange now has 450 members, run in the neighbourhood of Allentown by Kathy Perlow and her colleagues, and modelled originally on a similar project in Portland in Maine. It was funded, almost from the start, by the

hospital. The trouble was, they never really used it. Nor did most of the medical profession, at least until the arrival of a new doctor in the area who could see the possibilities.

Abby Letcher was from Michigan, where she had been studying the social determinants of health – and was increasingly frustrated by the way the medical profession was failing to take them into account. "We know people need community, they need social networks and friends. That's why I'm a doctor," she says. "We don't have medicines for these things and, because of that, I was beginning to feel really useless."[29]

The prospect of being part of a new practice based on 'relationship-centred care' lured her to Lehigh Valley, and – when she heard about the community exchange – she was determined to build that in too. The medical side of the exchange is now co-ordinated through a new health centre called Caring Place, where Abby works as a doctor, providing healthcare mainly for people in the area without health insurance, and looking for ways of building a healthier local community at the same time. Now people get referred to the exchange if they have depression, and might feel better for helping other people. From there they don't just drive other patients; they work alongside nurses dealing with palliative care, providing a friendly face or a shoulder to cry on or a bit of shopping.

Sometimes they do it better than the nurses because they can provide things that professionals are unable to do, especially when isolation is the main problem their patients are facing. "Caring individuals who are there because of you often do it better because they can provide a relationship," says Abby Letcher. "Of course there are paid professionals who care, but an informal support system will probably serve you better." This is how she explained it:

> "It is a fairly radical change, and it does challenge people's ethical and professional sense. But it has transformed the way we practice medicine. It has stopped us seeing our patients in terms of us and them, as if we were just service providers

29 The interview was carried out by me in 2009. See: Judith Lasker et al (2006), Building Community Ties and Individual Well Being: A case study of the Community Exchange organisation, Lehigh University, PA, available at is at www.lehigh.edu

> to people who are classed as 'needy'. We are no longer looking at them as bundles of need, but recognising that they can contribute, and when you see people light up when you ask them to do so, it changes your relationship with them. The culture has changed. The relationships are different, deeper and more therapeutic than they are in the usual doctor's office."

There are now co-production examples in justice (citizen's justice panels), in education (Learning to Lead), in head injuries (Headway East London), in nurseries (Scallywags parent run Nursery in Bethnal Green). There are experiments in almost every public service, welfare field and charity. The first of this kind in a GP surgery was the time bank which was launched as part of the Rushey Green Group Practice in Catford in 1999.[30] The intention was to help the doctors broaden out what they could offer. It would not just be visiting services or healthy walking or fresh vegetables, but also a network of mutual support to help people find that, suddenly, without quite realising it, they had a useful and necessary role – which can be transformative in itself.

The small-scale DIY service pioneered there was borrowed from a similar idea in Brooklyn, where the first time bank of its kind – Member-to-Member in Brooklyn – had pioneered a DIY team, made up of the elderly husbands of the members.[31] One lady in Catford lived in the dark because her curtains were too heavy to draw: the time bank allowed the surgery to fit lighter curtains. These were very simple things, like changing a light bulb, but they made a huge difference, and many of them were services along these lines which were entirely unavailable in either the public or private sectors.

There is also evidence that people believe what they are told by peers and volunteers more than council employees or professionals.[32] There are also broader advantages in giving people a more active voluntary role in public services.[33]

30 www.rgtb.org.uk
31 D Boyle et al, 2004, 'For the sake of a nail', New Economics Foundation, London.
32 See for example B C Sloane and C G Zimmer 1993, 'The power of peer health education', Journal of American College Health 41:241-245; and K Milburn (1995), 'A critical review of peer education with young people with special reference to sexual health', Health Education Research; 10:407-420.
33 Department of Health, 2006, 'National Evaluation of the pilot phase of the Expert Patient Programme', London.

These ideas have probably been researched most in healthcare, where the funding crisis is particularly pressing. The 'People-Powered Health' project from NESTA looked at how to apply the ideas behind co-production to long-term conditions – the most expensive, least successful aspect of NHS work.[34] NESTA's calculations, based on a range of studies, were that People-Powered Health along these lines could cut NHS costs by at least 7% and maybe up to a fifth. Even 7% comes to £4.4 billion.[35]

Evidence of other peer support programmes, in the UK and abroad, suggest that they give rise to savings in public costs of around £1 to £3 per pound invested, and more for the Health Champions programme which is closest to what is being proposed here, where there are savings in improved health and also in improvements in the lives and employment prospects of the champions themselves.[36] The purpose of the pilots is to embed navigation support in projects that are themselves cost effective

The results of modelling the benefits of time banks by a team at the London School of Economics suggested that, in general, the cost per time bank member averages less than £450 a year, but that the value of these economic consequences could exceed £1,300 per member.[37] This is how the team leader Martin Knapp explained it:

> "Despite numerous start-up expenses, peer programmes represent long-term cost effectiveness. This is largely because peer educators operate without any monetary gain 24 hours a day, seven days a week. Such a service would not be financially viable for most organizations, if conducted by professional staff... Evidence-based literature highlighting the efficacy of prison-based, peer-led programmes, research published to date suggests that such programmes are well tolerated,

34 www.nesta.org.uk/areas_of_work/public_services_lab/health_and_ageing/people_powered_health
35 NESTA, 2013, 'The business case for people-powered health', London.
36 N Hex and S Tatlock, 2011, 'Altogether better social return on investment case studies', York Health Economics Consortium.
37 M Knapp et al, 2010, 'Building community capacity: making an economic case', Personal Social Services Research Unit (PSSRU). See: www.pssru.ac.uk/pdf/dp2772.pdf.

> effective, and possibly more cost effective than professionally led programmes."[38]

Peer support services in mental health are also extremely cost-efficient. The cost per day for one acute mental health hospital in-patient has been calculated to be £259; by comparison, the Leeds Survivor-Led Crisis Service (see www.lslcs.org.uk) successfully supports people at £180 per day."[39]

Community courts have a successful track record. The pioneering Chard Community Justice Panel has a re-offending rate of 5%. The Washington Youth Court reduced reoffending from 25% to 9% among its target market.[40]

Informal solutions also come out well. Connected Care in Basildon has claimed impacts of over £1,000 per client, and a total of over £500,000 in savings across the town.[41] The most dramatic comparison here is the savings in the cost of social care achieved by Local Area Co-ordination in Western Australia, with informal cross-departmental advice and coaching (see below). Savings in the Local Area Co-ordination project in Middlesbrough have been estimated at between £1.80 and £3 per £1 invested.[42]

Perhaps the most compelling description of co-production in practice was in the evaluation of the Health Champions project in Yorkshire:

> "Becoming a community health champion has health benefits such as increased self-esteem and confidence and improved well-being. For some champions, this was the start of a journey to other opportunities such as education or paid employment. There were many examples of the influence of champions extending to the wider community of family, friends and neighbours, including helping to support people to take

38 Devilly et al, 2005, 'Prison-based peer-education schemes' in Aggression and Violent Behaviour Vol 10. 219-240.
39 Basset et al, 2010, 'Lived experience leading the way: peer dupport in mental health', Together UK. See: www.nsun.org.uk/modules/downloadable_files/assets/livedexperiencereport.pdf.
40 youthcourtofdc.org/
41 A Bauer et al, 2011, 'Economic evaluation of an "Experts by Experience" Model in Basildon District', LSE Health and Social Care, London.
42 Peter Fletcher Associates Ltd, 2011, ,Evaluation of Local Area Co-ordination in Middlesbrough, PFA Ltd.

> part in community life. Champions recognised the value of connecting people through social networks, group activities, and linking people into services and the impact that that had on health and well-being. Project staff and partners also recognised that champions were promoting social cohesiveness and helping to integrate people into their community."[43]

All of this demonstrates that there clearly is public sector volunteering happening at every level. Nearly every government department deals with volunteers, even the Ministry of Defence.

But here is the problem. If informal peer-support has proved itself so well, why does it remain a peculiarity, struggling for funding outside the mainstream? Is it possible to imagine a reform of public services that would use these ideas at scale and humanise them, and to provide the revolution in effectiveness that they so badly need?

43 J Woodall, 2012, 'Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber', Perspectives in Public Health, Aug 13.

4 Co-production as an answer to public service reform

There may be other knock-on effects of an enormous increase in volunteering in public services. In Julia Neuberger's book about older people, Not Dead Yet, she described with horror how her uncle was neglected in three of the four hospitals in which he lived his final weeks.[44] She explained that the one exception was also the hospital which was most cash-strapped:

> "When my uncle eventually died, in the hospital which really understood and respected his needs and treated him like a human being, there were volunteers everywhere. In contrast, there was barely a volunteer to be seen in the hospital which treated him like an object, although it was very well staffed. At a time when public services are becoming more technocratic, where the crucial relationships at the heart of their objective are increasingly discounted, volunteers can and do make all the difference."

She was writing shortly after the first Mid-Staffordshire revelations. What she suggests is that volunteers are the antidote to this. In wards where older patients might otherwise be mistreated or ignored, she says, "the mere presence of older volunteers are the eyes and ears that we need." Human beings provide that kind of alchemy, however target driven the institution is around them.

Julia Neuberger was talking about hospitals, not about social care and companionship, but the move towards getting volunteers into public services to work alongside professionals is not just about using resources better – it is also humanising. It is the

44 J Neuberger, 2008, 'Not dead yet, a manifesto for old age', HarperCollins, London.

antidote to de-humanising targets and to hidden brutalities in the system that we find out more about every time the Sunday papers drop through the letterbox. It is also the antidote to the kind of lazy, exhausted cruelty that the social care machinery inflicts on claimants all the time.

Having human beings working alongside professionals reminds them of what is important. It allows professionals to see situations that they might otherwise ignore out of habit, and see them through the eyes of an outsider, but they have to be *working* alongside not just observing. Observers seem not to have the same effect: they are regarded as controls, not as fellow human beings.

This begins to make clear the outlines of a new objective in public services which can bring the power and energy of mutual support to bear on every area. It means an enormous extension in volunteering, not through the voluntary sector – this is not about middle class semi-professionals ministering to the needy – but through the public sector, where the beneficiaries support each other, as a major element of a new, more mutual, design.

It would mean that every service outpost would include or involve some mechanism for allowing service users become equal partners in the delivery of services – and capable of rebuilding social networks. These networks would make up a new mutual infrastructure that supports people where they live and in informal or semi-informal ways. In would mean the basic work of the mutual support infrastructure would include providing:

- Navigation and other advice in health, social care and education.
- Some of the transport needs for people who are unable to exercise choice of public services anywhere except extremely locally (though this will of course require additional local support to cover petrol and insurance).
- Some long-term support for people coming out of professional care, whether it is for depression, family breakdown or a range of other problems.
- Support and advice from long-term patients with diabetes, depression, asthma and other conditions for

new patients with the same thing.

- Support for people just out of hospital, and a range of other DIY or befriending services which can broaden and deepen what public services can offer.
- A means by which it is possible to divert the most demanding patients or other users into mutual support which might be more beneficial.
- Support needs for patients with complex needs and their families navigating hospital systems.
- Grandparenting.
- Reading or other kinds of support in schools.

The navigation problem is particularly pressing. The Barriers to Choice Review revealed that there are somewhere between a third and a fifth of service users who are unable to benefit from formal choice mechanisms because professionals are sometimes too stretched to spend the time that people need.[45]

This is a particular problem for some disadvantaged groups, particularly if key information is only available on the internet, and for a range of reasons they are unable to access the internet directly; perhaps because they find it hard to process complex written text, perhaps because they are visually impaired blind, or perhaps because they have never mastered computers. This is especially a problem for people who find written descriptions, especially written descriptions online, difficult to access.[46]

It is partly sometimes because key information is too voluminous for people unused to processing it in that form. The review heard from people who said that they did not find much data useful when making a decision and preferred to rely on advice from

45 D Boyle, 2013, 'Barriers to choice review', Cabinet Office, London.

46 Research suggests that one in three people over 65 are unable to understand basic written instructions about taking an aspirin tablet (See: S Bostock and A Steptoe (2012), 'Association between low functional health literacy and mortality in older adults: longitudinal cohort study', BMJ, 15 Mar, 344). In social groups DE, only 64 per cent of men and 50 per cent of women have access to the internet, see: Ipsos Mori Social Research Institute (2011), 'No decision about me without me: Challenges for the NHS', presentation, June. Many older people in all classes do not use computers. For visually impaired people and some other disabled people, there is really no alternative to face to face conversation.

doctors.[47] There are similar stories about choosing schools. Often the information people really need (the friendliness of schools or consultants) is only available from non-professionals.

Most public services have tried to address this problem by experimenting with 'choice advisors' or 'choice navigators', but they were an extra professional cost and most have now disappeared, though there are some exceptions. There are some choice advisors still employed by local education authorities, some also whose task is to advise on subject choice rather than school choice. There are still some professional choice advisors in youth services. There are also a range of other advisors based at carer centres, or dementia support outreach advisors attached to various voluntary sector projects, but who are at risk of disappearing together with their contracts.

GPs play a continuing and vital role.[48] Often people will use specialist nurses like physiotherapists, who people see for more often and for longer periods, to advise them informally. But there are fewer specialist nurses in every sector, which causes problems for people who need complex or cross-departmental advice.

One area of public service where choice is extremely hard to roll out without advice and support is in social care, this advice or 'brokerage' for people who get direct payments is often done by social workers, but is sometimes provided by specialist brokers who are contracted as part of the personal budget in return for a set percentage. Without these advisors in the system, the problems include:

- Online information is not enough for some important sections of the community, and there is a need for face-to-face advice in all services.
- The multiplicity of sources of advice does not yet address the problem of the fragmented nature of public

47 One of the main reasons why people decide not to choose differently is that they say they had too little information to help them decide. Very few seem to use official sources of information. The 2009 study found that only 8 per cent used a booklet about choice to help them, and only 5 per cent used NHS Choices. L Jones and N Mayes, 2009, 'Systematic review of the impact of patient choice of provider in the English NHS, London School of Hygiene and Tropical Medicine, London

48 49 per cent of people offered a choice of hospital used their GPs to provide the information they need (see: Department of Health, 2008, 'National Patient Choice Survey'). As many as 67 per cent want information from their GPs to help them choose, (see: Coulter et al (2005)).

services, especially in the borders between health and social care.

- Professionals' resistance to formalising their relationship with clients with formulaic offers of choice. They are right to resist: it is often the informality and openness of that relationship which makes the kind of equal two-way conversation about options possible. Professionals need to be able to give advice – the 'what would *you* do?' question.
- Advice needs to be independent, and the review heard about concerns about how much it can be independent when it is provided about local authority services by local authority employees.

The Barriers to Choice Review looked at other institutions that might be able to help, and described a whole range of organisations which provide signposting using either professional 'navigators', or from local people who have some local knowledge and have been trained to listen effectively and help people make decisions, or from a combination of the two. Each of these methods have elements of navigation that they emphasise differently:

- Local Area Co-ordinators (professional navigators and coaches, encouraging mutual support, see above).
- Time banks (mutual support embedded in public services).
- Health champions (trained volunteers).
- Connected Care (participatory service planning and a variety of navigation solutions).
- Navigators (professional navigators and handyperson scheme).
- Village agents (signposting).
- Friends of Hospitals (volunteers).
- Choice Champions (volunteers).[49]

What all these projects have in common is that – like other kinds of co-production – they cross departmental boundaries, act as glue between people and a complex system, and start from

49 These have begun in Wokingham after the Open Public Services report 2012, but are in their early stages.

where the client is. They all, to a greater or lesser extent, involve peer support. They are also dedicated to relieving pressure on mainstream services. There is evidence that projects providing confident, trusted, independent support from fellow citizens are popular and cost-effective, and there is considerable experience now with peer support.[50]

They are also a sub-section of other local voluntary organisations that might be encouraged to get involved in peer support in public services, just as health minister Norman Lamb was recently encouraging Neighbourhood Watch to take on an extra role watching over local older people.[51]

My experience during the Review suggests that there will be no one perfect way of spreading the kind of mutual infrastructure described here through services, but clearly all these methods can be extended to cover other kinds of advice or support – starting maybe in a health centre but rapidly linking up with other aspects of public service.

Any sustainable solution will have to:

- Be funded locally, on the basis of the savings it creates to local funders: common sense suggests that is the best way of connecting the two.
- Involve existing peer-to-peer networks or co-produced services where they exist.
- Be able to impact on multiple problems rather than just copying the boundaries between departments that already exist.
- Knit with, rather than undermine, existing projects that are already working well.

The key question is how we might achieve this. There is no doubt that public and professional awareness of peer support is still low, funding is insecure and bureaucratic and the efforts of the people running these groups is often unrecognised and unsupported, despite the demand for mutual support. Traditional performance management systems also ignore their

50 Safran, Miller and Beckman, 2006, The organizational dimensions of relationship centred care: theory evidence, and practice', see also Department of Health, 2004, Chronic Disease Management: A compendium of information, London.

51 www.telegraph.co.uk/news/politics/10179141/Neighbourhood-watch-groups-should-provide-care-to-miserable-and-lonely-pensioners-says-health-minister.html

importance.[52]

Here are some policy elements that will be needed:

1 - Develop the supportive infrastructure

The necessary infrastructure is going to emerge in three different ways:

- Inside the existing services, often funded by them.
- Outside the existing services, but attached to one or more of them, and independently managed in the voluntary sector.
- Expanding out of existing peer support experiments.

Of these, the first runs the risk that the risk-averse internal management systems will undermine peer support. The second runs the risk that the costs and benefits will not be internalised inside the public service budget. The third one runs the risks that extra funding will have to be extracted.

Experience suggests that the infrastructure will not just appear by itself. Local authorities will require small teams of local area-co-ordinators, and among their tasks should be to see what mutual support infrastructure already exists – and where they might encourage more to begin. The fastest way that time banks spread, as they did so rapidly in local authorities during the last decade, was where local authorities held themselves back from setting them up themselves, but employed a development officer to seek out enthusiasts and encourage them.

The proposal here is that there should not be a blueprint by local government, but that mutual support infrastructure will emerge most successfully where there are enthusiasts who can be encouraged and given some support, and where this coincides with support from the public services they are working with. We should not assume that the voluntary sector will be best placed to make this happen, though it will need their entrepreneurial drive and experience and - the system being what it is – the infrastructure will be classed as voluntary sector the moment it is up and running. The difficulty is that this is a new kind of volunteering, based on mutuality rather than giving, and

52 See for example D Boyle et al, 2010, 'Right here, right now: Getting co-production into the mainstream', NESTA/New Economics Foundation, London.

deliberately trying to rebuild social networks around public services.

The other difficulty is that the existing volunteering infrastructure is overstretched. We must class this new informal, mutual infrastructure as something different.

What we need is the kind of entrepreneurial catalysts who can work in every local authority area, and in every Clinical Care Group, to use what local energy and willingness there is to encourage new ventures, to provide the evidence about the costs and benefits to the decision-makers – and to encourage existing ventures to take on new challenges. The point is to get beyond the language of pilots and to find ways of using the existing energy to roll out infrastructure nationally, in whatever local shape that it works. We need to:

- Extend existing volunteering projects – from health champions to expert patients and friends of hospitals – to provide face-to-face navigation advice, on choice and other options, based in GP surgeries and other centres, to help service users find their way around the complex system.
- Seed fund individual social entrepreneurs in every local authority area to persuade, cajole and encourage the co-production infrastructure we need locally.
- Make sure that social care signposting also directs people to the informal networks they need, rather than just formal carers which require money.

2 - Change the requirements for public sector contractors

This approach implies that every bid for a public service contract will be expected to include answers to the following questions:

- How do you plan to rebuild social networks?
- How do you plan to encourage mutual support among users?
- How do you plan to reduce the level of need for your service year by year?

This is important for other reasons too, because – as things stand – the most powerful inducements on contractors are to increase the level of need, not reduce it. This is an important

shift towards achieving a more preventive service too; but it will also encourage innovative thinking about how to create the kind of social networks around services that we are trying to achieve.

Often what the contractors will do is link up with and fund a time bank, or similar local project, to help plug their service into a network of mutual support. That is the main way by which this supportive infrastructure is going to be funded – but contractors need to explain to commissioners how they will fulfil their obligations to encourage mutual support among their users.

We need to:

- Encourage commissioners to take decisions based also on the willingness and imagination of potential service providers to build social networks that can provide for people's informal needs, in order to minimise their formal needs.
- Require every public service organisation to have a strategy for involving users as partners in the delivery of services, whether it is a time bank or other mutual support system.

3 - Reverse the priorities at assessment stage

At the moment, we have public services which try to cover every relevant need, then we try to plug the inevitable gaps with informal, mutual, friendly support, usually with grant support to the voluntary sector. By contrast, an innovative approach pioneered in Western Australia – and now in some UK cities – reverses this hierarchy.

Local Area Co-ordinators (LACs) have about 60 clients at a time, and take more of a coaching and a cross-departmental approach. They try to build a more informal, mutual and friendly infrastructure *first,* which can respond to people informally and in a human way where it can, and which then tries to plug the gaps in that with formal services.

The informal infrastructure is formed simply by knowing what voluntary support is available, by looking at potential resources from family and friends, and by using other people in their client list.[53] LACs are generalists who support practical, creative

53 R Broad, 2012, 'Local Area Co-ordination', Centre for Welfare Reform, Sheffield.

and informal ways of meeting people's aspirations and needs, increasing the control and range of choices for individuals, their carers and families whilst contributing to systems and structuring reform.

LACs operate at an individual, family and community level and can help individuals, their carers and families to plan, select and receive a range of support and services to achieve their vision for a good life, enormously increasing the flexibility of services and providing users with much broader choices.[54]

The new social care legislation sets out how local authorities will be able to assess needs together with informal resources at an earlier stage, and simplify the assessment process, but policy-makers will also have to find ways to:

- Provide a broader assessment to all those who want one, combining resources from advice, assessment and brokerage services, and ending the silos between services.
- Make self-assessment tools available online.
- Provide a gateway to informal support services by making sure there are local area co-ordinators, or similar, at ward level in every local authority area – whose role will be to bypass formal care packages where possible, to link people to informal support, to encourage people to use their own abilities, based on what they want to achieve in their own lives.

4 - Merge budgets locally

Part of the problem is that commissioning by rival silo, which has tended to dominate the process, means that the externalities tend to creep in. The future seems likely to involve a much more local bundling of local budgets, based on 'community budgets', based on recent experiments with 'place-based commissioning'.[55]

This is a different direction of travel from the trend towards bigger contracts and more distant commissioning, on the basis

54 Peter Fletcher Associates Ltd, 2011, 'Evaluation of Local Area Co-ordination in Middlesbrough', PFA Ltd.

55 resources.cohesioninstitute.org.uk/Publications/Documents/Document/DownloadDocumentsFile.aspx?recordId=173&file=PDFversion

of even more precisely defined outputs. The joint commissioning between health and social care that has been going on in Norfolk since 2009 is a good example of how this might work.[56]

Only when you merge budgets do some of the interconnections become apparent to managers, and hospitals will be able to reach upstream of some of the alcohol problems they deal with, for example – and find strategies to tackle them at source. Again, this will require them to build a preventive mutual support infrastructure around the hospital. That means we need to:

- Encourage local services to bid for preventive projects based on merged budgets and shared savings, like the Lambeth Living Well consortium is managing in mental health.[57]
- Move towards the integration of local services at local level, as far as possible on the same sites.
- Bring them increasingly under local democratic control, whether it is via local government or by taking foundation trust status to its logical conclusion and handing power increasingly over to patients.

5 - Organise a national network

Once this new mutual support infrastructure has begun to emerge, and hopefully to overlap – as it will need to do if it is going to be cross-departmental and, if existing networks become more ambitious about what they can achieve, we need to think about what links it together. Here we might learn from one of the most successful networks of volunteers, the one run by the National Trust, which embeds its volunteers by encouraging local loyalty but supports them with a national branding.[58]

Creating a national network could involve giving the local peer support groups similar local rights. A Cabinet Office discussion document in 2009 proposed the following rights for peer support groups:[59]

56 Norfolk County Council, 2009, 'Joint commissioning strategy for people with physical and sensory impairments in Norfolk 2008-2013'.
57 lambethcollaborative.org.uk/about/living-well-network
58 The National Trust currently uses 60,000 volunteers around the country.
59 M Horne and T Shirley, 2009, 'Co-production in public services: a new partnership with citizens', Cabinet Office, London.

- Use commissioners' and providers' rooms and facilities for meetings.
- Apply for local grant funding based on simple criteria like the number of their signed-up and number of members.
- Publicity by local services and on government websites.
- Automatic enrolment for patients, carers and service users (with an opt-out).
- Flexible working for staff who volunteer to run peer support groups.

Organised correctly, this would provide a whole new dimension to choice, as well as a new dimension to being a patient, parent or service user – an option to give and receive mutual support. Many people will not want to, but the evidence (see below) is that many people will, and it is important that it remains voluntary. Even so, it may become increasingly common for people to expect to give something back in recognition of what they have received, and that it might be considered part of their own recovery to do so.

The other advantage of having some aspects of the new peer support network organised from the centre, apart from the obvious advantages of common training manuals, national advertising and a common identity, is that there could be a way to help those involved develop parallel 'careers' in volunteering.

Part of the difficulty of this kind of work is that people can get stuck doing it. A national network would allow people to develop themselves in their volunteering, to get extra training, and eventually perhaps qualifications that depend partly on the hands-on work they have done in peer support. There need to be links with local further education, paid for by the time people have spent volunteering – and national degree courses through the Open University which, again, can be paid for by the contribution to peer support.

All these would have national costs that have to be paid for, but would arguably pay for themselves by the sheer impact the national peer support service could have on reduced need.

- Give people the choice in public services to give and receive mutual support and advice.

- Set up a national public service volunteering umbrella to provide those local mutual support schemes with national branding and support, but which can also provide training and qualifications for people who become more deeply involved.
- Launch an annual Co-production Prize for local innovation.

There are three obvious objections to the kind of explosion in public sector volunteering that is advocated here.

1. There is no demand from the potential volunteers

The Barriers to Choice Review demonstrated, not only that there are huge potential benefits to this kind of approach, but also that there is a huge appetite among people to do it.60 Grimsby's Care Plus organisation has 270 volunteers providing more than ten hours a week. Newcastle's Hospitals Trust League of Friends has 150 members. The time bank at Rushey Green Group Practice in Catford has 200 members. Health Champions have 17,500 trained volunteers across Yorkshire. They welcome it as a way to feel useful and to get training and experience. Sceptics say that people won't be prepared to volunteer for public services; on the contrary, many people already do.

2. You can't replace professionals with amateurs

This is definitely true, but that is not what is proposed. The co-production approach at its best suggests that people do what *they* are best at and – by doing so – they can broaden and deepen what services can achieve. This can provide services with an ability to reach out into neighbourhoods and visit people when they have just come out of hospital, help children with reading, befriend lonely people, and do all those things that services really ought to do now but actually don't. This approach is not about cutting services; it is about extending them. It uses public services as a backbone for what would otherwise be an amorphous and vague Big Society, to knit communities back together around services on a massive scale.

60 Boyle (2013), op cit.

3. It confuses demarcation lines between services

This is also true. When you work with what people really need, face to face, they don't fit neatly into departmental boundaries. So when you begin a co-production approach, you find that people's complex needs begin to spill across professional boundaries, and all public services begin to be multi-departmental and multi-disciplinary. They make services more all-embracing, more human, more informal and less rigid. That is one of their benefits, not one of their drawbacks.

So that is the objective: a national network of peer support, a mutual support infrastructure, in every public service, managed locally – but supported by national branding and training, and a reward organised through national and local qualifications.

Its purpose would be to unleash energy from public service users capable of underpinning the long term survival of services with a human face, and of broadening the scope of services that are provided. The new mutual support network will not take work from existing professionals or managers, but it will provide the kind of options that services ought to provide – befriending, advising, DIY, changing light bulbs for older people – which they are currently unable to.

The objective here is to reinvent volunteering through public services so that it becomes classless, absolutely ubiquitous, far easier, cross-departmental, and part of the fundamental purpose of those services. The purpose is to mainstream co-production in such a way that it shifts the way services are delivered, so that they can underpin the preventive services we so badly need. It is to unleash the huge, largely untapped resource that exists to humanise public services, to make them more effective and sustainable: the existing ad future beneficiaries, their families, friends and neighbours.