Co-delivering Public Services and Public Outcomes

Elke Loeffler

INTRODUCTION

At least until the emergence of the Covid-19 crisis, co-delivery has been a mode of co-production which has generally received much less attention than forms of ‘citizen voice’ such as co-design, public participation mechanisms (such as consultation on new airports or high-speed rail links) or street-level protests, such as the gilets jaunes in France or the worldwide Friday protests by schoolchildren against climate change. While the actions of citizen volunteers co-delivering public services and outcomes ‘behind the scenes’ are often praised in formal presentations by elected politicians, the co-delivery role of citizens is often taken for granted as ‘the fourth pillar’ in the mixed welfare state, in addition to state, market and the voluntary sectors (see also Chapter 12 in this Handbook by Beth Gazley).

However, the global spreading of the Coronavirus since January 2020 has placed the co-delivery role of citizens firmly in the limelight. It has become evident that no government will be able to deal with this crisis on its own but rather requires multiple contributions from citizens in their role as co-deliverers of public services and outcomes—for example, local people are taking joint action with local authorities and third sector organisations to support high-risk groups with the delivery of essentials, parents are teaching their school-aged children at home (with or without guidance from teachers) during lockdown, other citizens are acting as role models for behaviour change.
by encouraging the practice of physical distancing, and some UK citizens have even been making medical gowns and other ‘personal protective equipment’ at home for the use of health and social care staff, given the inadequate preparation by the NHS.

While it is too early to assess the longer term impacts of Covid-19 on co-delivery, there is already evidence that this crisis has also boosted the use of digital forms of co-delivery, e.g. many citizens are keeping in touch through online contacts with vulnerable and isolated people, while school and university classes, seminars and workshops are taking place through video platforms, such as Zoom. Of course, these are not entirely new activities but are now much more prevalent because necessary.

This chapter will provide an overview of modes of co-delivery, including the use of digital technologies. It will then assess the academic evidence on the extent to which user and community co-delivery has improved public value through prevention, detection, treatment of social problems and rehabilitation from them. Finally, it will consider the future potential of user and community co-delivery in the post-Covid-19 world.

**WHAT USER AND COMMUNITY CO-DELIVERY OF PUBLIC SERVICES AND OUTCOMES IS—AND ISN’T**

Co-delivery is about citizen action contributing to the actions of professionals working in public services to improve public services and/or outcomes. This means that in co-delivery co-production partly overlaps with volunteering (Loeffler 2021). Of course, not all forms of volunteering qualify as co-delivery—when there is no input from public service organisations, volunteering is a pure form of user self-help or community self-organising. However, when volunteers get support from public service organisations, then volunteering initiatives turn into co-production. For example, when citizens join in their local sports associations to provide training for young people, this does not qualify as co-production if the sports association is financed by member fees, sets its own regulations and does not receive any support from the public sector. In contrast, the volunteering of citizens at major sports events co-funded by the public sector, such as the Olympic Games, can be considered as co-delivery. At the London Olympics in 2012 70,000 citizens were accepted as volunteers after going through a rigorous application process and put through an orientation day at the Wembley Arena with the 50,000 paid staff—and further venue-specific training was later provided (Tatam 2012). Similarly, at the local level, volunteers often co-deliver important support at sports events in public facilities or with public funding.

The same distinction applies to digital co-delivery in a public service context. When local people connect and provide support to each other through a hyperlocal network (e.g. provided by a commercial provider or based on a free software platform), this is pure community self-help. However, it becomes a form of co-delivery if the online network is funded and evaluated
by public service organisations—as in the online peer support forum SHaRON (2020)—https://www.sharon.nhs.uk/*which was co-designed by clinicians and patients at Berkshire Healthcare NHS Foundation Trust to provide peer support for people with health conditions (initially mental health, now more general).

In the last decade, service providers in both public and private sectors have made increasing use of self-service technologies to encourage citizens to do more for themselves in order to lower staff costs. These self-service solutions have met varying degrees of acceptance by citizens. A comparison of private and public self-service technologies by Collier et al. (2014, 68) showed that ‘customers are willing to take on a partial employee role only if they see a directed benefit to them’. Self-service technologies with such benefits may therefore trigger new forms of digital co-delivery and, where they require professional inputs, should not be simply equated with user self-help or community self-organising.

The following section will provide a typology of different types of user and community co-delivery—both offline and online or mixes of both.

**Types of User and Community Co-delivery of Public Services and Outcomes**

Community co-delivery has played a key role in the development of the concept of co-production. The research by Parks et al. (1981) on policing in Chicago pointed to the impact of community co-delivery on public safety in disadvantaged neighbourhoods: when police officers used cars for policing instead of walking the beat, they lost access to the knowledge and social networks of local communities and the crime rate went up. This research raised awareness that the police needed the community as much as the community needed the police (Loeffler 2018, 212).

While community co-delivery, and in particular volunteering by citizens through non-profit and voluntary sector organisations, has received a lot of attention in the literature (see, for example, Chinman and Wandersman 1999), there has been much less focus on user co-delivery, perhaps because it often takes place in non-public settings and is therefore less visible (Loeffler 2021). Furthermore, user co-production may be taken for granted as ‘hidden work by people outside paid employment’ (Boyle et al. 2006). However, Alford’s (2009) influential book on co-production focussed in detail on user co-delivery in three sectors. Moreover, data from a European citizen survey in five countries showed that significantly more citizens contributed to user co-production, including co-delivery, than to community co-production (Bovaird et al. 2016).

In Table 20.1 a taxonomy of different types of co-delivery is proposed and, for each type, examples are provided of both user and community co-delivery. Moreover, as digital technologies are increasingly being used in co-delivery to supplement or replace face-to-face contacts, digital examples
Table 20.1 Types of user and community co-delivery

| Types of co-delivery                  | Examples of user co-delivery                                                                 | Examples of community co-delivery                                                                 |
|---------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Co-implementation of projects or programmes | Users working with public service organisations to implement projects (e.g. members of Mosaic Clubhouse in London) | Community members working with public service organisations to implement projects (e.g. Digbeth Public Art Project in Birmingham) |
|                                       | Users co-implementing digital projects with public service organisations (e.g. ICT-based cardiac rehabilitation in Huntingdonshire, UK) | Linking community capacity to local needs based on mobile phone apps (e.g. TRIBE in Leicestershire County Council) |
|                                       | Community members working with public service organisations to implement projects (e.g. Digbeth Public Art Project in Birmingham) |                                                                                                  |
| Co-management of projects and public facilities | Tenants co-managing social housing (e.g. Witton Lodge Community Association, UK) | Community asset transfer (e.g. communities co-managing local libraries and community centres) |
| Contributing to (peer) support groups | Service users supported by public service organisations to provide peer support (e.g. in Offenbach Employment Agency, Germany) | Support groups, comprising community members, working with public service organisations (e.g. Mosaic Clubhouse London) |
| Co-influencing behaviour change       | Users with a specific lived experience facilitating behaviour change of other service users and staff (e.g. in Federal Public Planning Service for Social Integration, Belgium) | Trained local people providing coaching for users of public services (e.g. Manchester Community Health Trainers) |
|                                       | Peer support by service users with specific lived experience (e.g. SHaRON mental health platform and app) | Mentoring by trained volunteers (e.g. mentoring scheme for people in financial difficulties in Augsburg) |
| Taking joint action to improve public services | Service users co-delivering services (e.g. young people in youth centres in Surrey County Council) | Community volunteers working with public services (e.g. volunteers teaching children in schools in Japan) |
|                                       | Electronic patient portals helping patients to become active in decisions about their health care | Community volunteers working with public services digitally (e.g. in the digital archives of the National Library in Finland) |
|                                       |                                                                                             | Digital volunteer networks supporting public services in emergency and disaster management (e.g. GoodSAM app recruiting NHS Volunteer Responders for Covid-19) |

(continued)
Table 20.1  (continued)

| Types of co-delivery                  | Examples of user co-delivery                                                                 | Examples of community co-delivery                                           |
|---------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Taking joint action to improve public outcomes | Service users undertaking self-care with support of public service organisations (e.g. via the interactive portal *My Diabetes My Way in Scotland*) Service users making use of e-health and e-care technologies enabling self-care (e.g. *Clevercogs*™ digital platform for people in care homes or getting home care in Scotland) | Parental involvement in primary education NHS Volunteer Responders providing short-term telephone support as ‘check-in and chat’ volunteer to individuals who are at risk of loneliness as a consequence of self-isolation in the context of Covid-19 |

*Source* Adapted from Loeffler (2021)

are also highlighted. All examples are discussed in more detail in the following text.

User and community co-delivery may involve a wide range of citizen actions as Table 20.1 shows. Types of co-delivery include co-implementation of projects, co-management of public facilities, contributing to peer support, co-influencing behaviour change and taking joint action to improve public services and outcomes. These types of co-delivery may overlap to some degree. For example, a specific peer support initiative may not just provide emotional support but may also facilitate behaviour change. However, each type of co-delivery puts a different emphasis on what is co-delivered and which co-delivery mechanisms are used, as the following case studies show.

Co-implementation of public projects through citizen action is a common type of co-delivery. In particular, public service providers working in social care, mental health and housing often enable contributions from service users or communities to specific projects or programmes. An example of user co-implementation is a major refurbishment project of the charity Mosaic Clubhouse in London. Mosaic Clubhouse is part of the international Clubhouse model, which aims at improving the mental health and well-being of its members through co-production between staff and members throughout all its activities. The move to the new building in 2013 gave staff and members the opportunity to work together to fully equip the new building, plant the garden, review all policies and procedures, and carry out all necessary training, particularly training in health and safety and food hygiene, as the new café and information hub were both open to the public (Ness 2014).

In Birmingham, the Digbeth Public Art Project was a two-year project which was co-implemented by a local arts company with local residents, as part of the redevelopment of Birmingham Coach Station (Farrell 2010). This included the joint creation of three permanent artworks which enhance visitor
experience of the coach station and reflect the rich cultural history of the site. Engaging the community in each step of the artwork projects allowed the project to reach more networks, resulting in numerous ‘in kind’ and financial contributions from the public sector and business. The art installations have been praised by public, press and public services alike and are considered to be a key success factor in the ‘place-shaping’ of this regenerating area of Birmingham.

Increasingly, digital technologies are used in the co-implementation of public service projects. An example is provided by Active+, an ICT-supported cardiac rehabilitation project of Huntingdonshire District Council and several health partners, which teaches patients to use remote monitoring technology, including activity trackers, blood pressure monitors, scales and peak flow meters for lung function, to keep an eye on their health and to record routinely how regularly they are taking medicine—patients are taught how to access and review their own data during the eight-week course, which also involves weekly exercise classes at the local leisure centres and a social group after each class to encourage discussions between participants and allow questions to be asked of professionals (LGA 2018, 13).

A similar project, but also involving members of the community, not just service users, in co-implementing public service projects through digital mechanisms is given by a project in Leicestershire which uses TRIBE, a social action technology platform to facilitate social prescribing, to help grow community capacity, and to micro-commission services directly via up-skilled community assets, such as local volunteers, organisations, etc. TRIBE can be downloaded as a mobile app to personal or work phones and tablets or accessed through a web portal, so that people are instantly able to make and see requests for support within the community they live or work in or register their availability to help meet some of these requests (see http://www.healthandcareleicestershire.co.uk/download/Health-and-Care-Integration-Bulletin-March-2020-final.pdf).

Another type of co-delivery involves the co-management of public facilities by service users. In Birmingham, the Witton Lodge Community Association (WLCA), which also acts as a Community Landlord with its own housing association, provides an example of co-management by service users (as tenants of the housing association) (Jones 2012). Witton Lodge was a rundown social housing estate in the 1990s, where many houses faced demolition, since no government grants were available for urgently needed repairs. WLCA was set up in 1994, based on government gifting land, against which capital could be raised to build new homes. It has eight Resident Directors, who play a major role in the management of the Association, giving residents a strong influence on the redevelopment of the estate. By 2000 WLCA was able to negotiate housing allocations with the City of Birmingham, which enabled it to pursue a policy of social integration via housing allocation (Jones 2012).

Just as WLCA benefited from transfer of public sector land, there are now many other examples of community asset transfer, defined as ‘the transfer of
management and/or ownership of public land and buildings from its owner (usually a local authority) to a community organisation (such as a Development Trust, a Community Interest Company or a social enterprise) for less than market value – to achieve a local social, economic or environmental benefit (My Community 2020). In the UK, as a result of public austerity, many public libraries and community centres are now co-managed by local communities with (fewer) public sector staff (and there are also many examples of previously public facilities now being completely managed by local communities, so exemplifying ‘self-organisation’ rather than ‘co-production’).

Another type of co-delivery is co-performing peer support. While this is most common in social care and mental health services, the Offenbach Employment Agency in Germany has launched a peer-support initiative for jobseekers as part of a Governance International Co-Production Training Programme. This part of the project involved small-scale experimentation with six jobseekers who volunteered to be matched in pairs after a careful analysis of their strengths and their areas for improvement (Neseli and Herpich 2020). Each peer support pair kept closely in touch, and had regular meetings with staff to identify milestones to be achieved together. An initial assessment showed that the jobseekers co-performing peer support had managed to improve skills and, most importantly, increase their self-confidence. After the 120 days of the first experimentation phase, all six job seekers had either been placed in a trainee programme or employment.

While some types of user peer support are primarily co-delivered one-to-one, peer support can also provide collective benefits when it is co-delivered in groups (Slay and Stephens 2013, 8). In particular, user peer support may be strengthened through contributions of community members. Mosaic Clubhouse in the London Borough of Lambeth works with people with mental health issues to improve their well-being and employability. It strongly focuses on enabling Clubhouse members to provide mutual support in their journeys towards recovery (Ness 2014). The charity also works with volunteers who are trained to provide specific support services.

An important type of co-delivery involves co-influencing behaviour change. This can occur, for example, when service users with a specific lived experience are supported by public service organisations to facilitate behaviour change of citizens and/or staff working in public services, often through peer support, which may be provided face-to-face or via an online platform, as in SHaRON (2020).

Increasingly, service users with a specific lived experience are recruited by public service organisations to be trained and employed as staff in order to enable their former ‘peers’ to change their behaviours. In Belgium since 2004, the Federal Public Planning Service for Social Integration has been employing trained ‘Experts by Experience’ (EbEs) in poverty and social exclusion to harness their specific experience to improve the access of people living in poverty to public services provided at the Federal level (Van Geertsom et al. 2017). While, at least initially, many public professionals found it difficult
to recognise the expertise and non-academic knowledge of EbEs, there is evidence of behaviour change on the part of staff who now ‘consider service users as people, rather than as ‘cases’ who are legally entitled to a service’ (Van Geertson et al. 2017).

Co-influencing behaviour change can also occur in other ways, often with the help of local communities. Since 2006, Community Health Trainers in Manchester have been supporting behaviour change of vulnerable groups in deprived neighbourhoods towards a more healthy lifestyle (Lawson et al. 2014). This co-production programme is based on a partnership between the NHS, the local authority and local voluntary organisations, recruiting and training people from disadvantaged groups who become paid Health Trainers. They provide personalised support to those most at risk of ill-health using empowerment techniques, so that participants are able to develop and use their own skills to change their behaviour.

Co-influencing behaviour change may also involve trained volunteers mentoring and coaching service users who need support. For example, the local authority of Augsburg has developed a mentoring scheme to provide people with financial difficulties with additional advice and support, going beyond the support provided by social care services (Klopf et al. 2016). The social mentors come from all walks of life, including housewives, students, bankers, etc. They provide many different kinds of support, such as a finance check, identification of available social support, joint drafting of a budget plan, overview of debts and negotiation with creditors who need to get paid. Case managers in the City of Augsburg Council help to support the social mentors, organise their neighbourhood surgeries and facilitate regular meetings of the social mentors for evaluation, training and planning.

When service users or communities improve public services by undertaking joint actions with public service organisations, the contribution of citizens often goes beyond minimal inputs as a passive service recipient. In the services literature, Normann (1984) distinguishes the ‘enabling logic’ in services, which depends critically on mobilising those contributions that users can uniquely provide to enable service outcomes from the ‘relieving logic’, in which providers do the service for the user so that users mainly need to specify their demands. However, as a result of austerity and overly specified service contracts, social workers, especially in adult home care, have had to adopt a ‘time and task’ approach to completing personal care tasks, which can leave little time to enable service users to do things for themselves or others.

There is anecdotal evidence, however, that staff working in services for young people have had more flexibility to enable young people to co-produce public services by taking joint action to improve them. In the UK, there is a statutory duty which protects clear, positive outcomes for young people, rather than prescribing specific services. Surrey County Council has responded by a fundamental transformation of services for young people (Tisdall 2014). In particular, the local authority encouraged Youth Centres to co-deliver public services with the young people attending them (Bovaird and Loeffler 2014).
In health, electronic patient portals are intended to help service users to become active participants in decision-making about their own health care and thereby make health services more effective—successful portals appear to include functions such as secure messaging, patient reminders and prescription refill orders (Shaw et al. 2018).

Public service organisations also take joint action with community volunteers to improve public services in many sectors. In the context of austerity, many public service organisations have reduced staff numbers by recruiting unpaid volunteers to provide services more efficiently, e.g. in library services. Many social care service organisations have also recognised the need to support volunteer carers, e.g. by providing information sessions, training and respite care, turning previously self-help activities into co-production between carers and the public services.

The use of volunteers to co-deliver teaching at elementary school level is less common but in Japan the intergenerational education programme REPRINTS (Research on Productivity through Intergenerational Sympathy) was launched in three local authorities in 2004 (Yasunaga et al. 2016). This provided older people with the opportunity to co-deliver teaching of children through picture book reading, which was considered developmentally appropriate not only for the children, but also for adults. Experienced trainers provided extensive training, ongoing advice and feedback to the senior volunteers about book reading techniques, after which the volunteers participated in group activities with children and read picture books to them at kindergartens, public elementary schools and childcare centres once every one or two weeks. An evaluation showed positive effects on both the older people involved and the school-children and indirect positive effects on their parents.

Local communities may also improve public services through digital co-delivery. The National Library of Finland motivated over 100,000 volunteers to donate over 400,000 minutes of time to help correct errors resulting from the digitalisation of its historical newspaper archive (Miettinen 2012). An online platform, Digitalkoot, asked people to verify the words in a fun and engaging game from their own computers, as a way of helping to preserve Finnish culture. The accuracy of this proofreading of Finnish citizens via Digitalkoot was estimated at over 99%.

Increasingly, digital volunteer networks also support public services in emergency and disaster management. In the UK the GoodSam app is usually used to alert people with medical training to nearby emergencies, so that volunteers can provide potentially life-saving interventions before the arrival of professional emergency services (Crouch 2020). This app is now being used to recruit volunteers supporting the NHS in the Covid-19 crisis. Digital technologies also play an important role to match supply and demand of volunteers. In the context of Covid-19 large national charities in the UK, such as the Trussell Trust, have developed their own online schemes to match volunteers with critically important activities in their local area, such as food
banks (Butler 2020), although, if they do not involve public services or public outcomes, they constitute self-organisation rather than co-production.

As the Public Value Model discussed in Chapter 2 in the Handbook shows, users and communities taking joint action with public service organisations can contribute directly to improving outcomes, not only by helping to improve public services. In particular, people living with long-term health conditions may make important contributions through self-care to co-deliver improved health and well-being. For example, the University of Dundee in Scotland created the new interactive online portal *My Diabetes My Way* in 2008 as the official NHS Scotland online portal, giving people with diabetes and their caregivers information materials to assist them with self-management, access to an electronic personal health record and engagement with peers via social media (Wake et al. 2014).

Furthermore, older and vulnerable people living in residential care in specific local areas in Scotland now have access to ‘smart home’ and e-health and e-care systems such as *CleverCogs™* (Carnegie UK Trust and Just Economics, n.d.), which provide them with better support to deal with daily issues and allow social care workers to monitor and connect with their users more easily. *CleverCogs™* also improves digital participation by providing simplified access to the internet, so that service users with few digital skills can connect with their local communities, supporting both user and community co-production.

Communities as well as service users can make significant contributions to improving public outcomes through co-delivery. As Honingh et al. (2018) point out, there is evidence that parental involvement in primary education is important for the educational achievement of their children. In particular, home involvement programmes supporting parents of deprived communities to read with their children such as the Research in Educational Achievement and Development (READ) co-production project in Aarhus are proven to have a statistically significant improvement effect on children’s school performance (Nørrregaard Jacobsen and Hjortskov 2015). Nevertheless, the school-centred perspective of education, which has also been reinforced by the attention given to the PISA tests of the OECD, has neglected the co-delivery role of parents and other members of the community in children’s educational performance.

Clearly, the current Covid-19 crisis has raised awareness of the contribution of civil society to achieving key public outcomes. In the UK, more than 750,000 citizens responded to a government call for volunteers to support the NHS (Royal Voluntary Service 2020). While some of the tasks of the NHS Volunteer Responders involve co-delivery of new public services, e.g. delivery of food parcels to risk groups who are self-isolating, some also involve short-term ‘check-in and chat’ telephone support for individuals who are at risk of loneliness as a consequence of Covid-19 self-isolation (Royal Voluntary Service 2020).

These examples illustrate that the different types of co-delivery highlighted in Table 20.1 can be found in a wide range of public services. They also show
that digital technologies are now playing a significant role to enable or support each of these different types of co-delivery, so that co-delivery now consists of a mix of face-to-face and digital interactions between citizens and public services organisations.

**The Role of Co-delivery in Pathways to Outcomes—Evidence from Health, Social Care and Public Safety Services**

This section will focus on the contributions of user and community co-delivery to public outcomes within pathways to outcomes. After an outline of the concept of pathways to outcomes in the context of co-production, we will provide examples from social care, health and public safety services as to how user and community co-production improves public outcomes through problem prevention, treatment and rehabilitation. A more detailed analysis of the extent and effectiveness of pathways to outcomes from co-delivery in these services is provided by Chapter 4 in Loeffler (2021).

**Pathways to Outcomes Through Problem Prevention, Treatment and Rehabilitation**

Pathways to outcomes are a familiar concept in health and social care (e.g. McSherry et al. 2010; Jonas et al. 2012) and in many other contexts (especially development studies), albeit often under other labels, such as ‘logical frameworks’, ‘logic models’, ‘strategy maps’, ‘value creation maps’, etc. (Bovaird 2012). The availability of national outcome frameworks for the NHS and social care in the UK has raised the question of which pathways are most effective for achieving these outcomes.

The concept of pathways to outcomes provides a dynamic perspective to co-production. Rather than just focussing on final outcomes, it makes involved stakeholders aware of how co-production processes contribute to intermediate outcomes, which may be equally valuable (see, for example, Jonas et al. 2012). Pathways to outcomes also help in mapping exercises to visualise the contributions to intermediate and final outcomes of various stakeholders, including public service organisations and service users and communities. This can help to overcome perspectives which are overly organisation-centred and which view outcomes solely as the result of public service interventions, neglecting co-delivery by service users and communities. Furthermore, the mapping of pathways to outcomes allows identification of opportunities for better service coordination and integration. Most importantly, involving staff and service user in the mapping of pathways to outcomes may uncover important alternative approaches—for example, the joint development of pathways to outcomes with staff and a local network for people living with dementia showed that not only improved care mattered for people living with dementia but that a key
outcome to be achieved was ‘having more fun’ (Brown et al. 2016). Similarly, a workshop with young jobseekers in the Offenbach Employment Agency in Germany revealed that one key outcome considered to be important from a users’ perspective was improving resilience, given that job seekers often have to deal with disappointments when they are turned down for a job and need to motivate themselves to keep trying, in other words their self-efficacy needs to be bolstered (Loeffler and Schulze-Böing 2020).

Although specific pathways to outcomes need to be developed for each individual service context, there is an underlying pattern to almost all such pathways, since policy interventions typically contribute to solving problems through three different mechanisms, which are shown in Fig. 20.1—they either help to prevent the problem, or to treat it, or to support recovery or rehabilitation after the problem has been treated (Loeffler and Bovaird 2019a).

For each of these three ‘core’ pathways, we can, in turn, map several contributory pathways. Future occurrence of a problem can be prevented by the public sector either by reducing the prevalence of those social conditions which raise the probability of the problem occurring or being severe (e.g. policy can attempt to reduce the prevalence of lung cancer by taxing tobacco or making smoking illegal in public places)—or, alternatively, behaviour change can be promoted among those likely to give rise to the problem, so that they desist from that behaviour (e.g. encouraging people to stop smoking).

Similarly, there are contributory pathways to the core pathway of improving treatment—it is always important to detect the problem as early as possible (e.g. regular health checks of smokers’ lungs) and then to find appropriate treatments.

![Fig. 20.1 A generic model of pathways to tackling social problems (Source Adapted from Loeffler and Bovaird [2019a])](image-url)
Finally, the core pathway to improve recovery and rehabilitation requires the design of suitable programmes to reduce the negative consequences from problems and/or strengthen people’s resilience. Further, the people concerned have to be convinced to follow the rehabilitation pathway.

In the following sections, we discuss how co-production can play a role in each of these core and contributory pathways towards co-delivery.

**Co-delivery in Pathways to Outcomes in Prevention**

In most OECD countries there has been increasing interest in co-production approaches for prevention of social problems. This applies in particular to public health, so we will exemplify co-delivery through prevention by reference to health examples. It has long been recognised that people can contribute greatly to their own health by behaviours which help prevent future health problems arising, not only improving public outcomes but also helping government to reduce expensive health services.

Clearly, many prevention activities of service users or communities are triggered by public sector action, such as the recent public campaign on ‘hands hygiene’ to reduce the risk of Coronavirus infection. Other prevention activities may involve direct collaboration between public service organisations and citizens, as in the falls prevention initiative of the Aberdeen City Health and Social Care Partnership (Thompson and McConnachie 2019). This co-delivery initiative was co-designed with service users at risk of falls who attended exercise classes and volunteered to be trained as ‘Falls Ambassadors’, co-delivering *Stepping Forward Together* sessions with health professionals in local communities to sensitise people at risks of falls and motivate them to take action to improve their self-care.

Another innovative health prevention programme is the *Gesundes Kinzigtal* (‘Healthy Kinzig Valley’) scheme in the Black Forest in Germany, which emerged from a joint venture between a network of physicians in Kinzigtal and a Hamburg-based health care management company in 2006 and targets a population of about 71,000 people in rural areas (King’s Fund, n.d). In particular, it provides targeted care management and prevention programmes for particularly high-risk population groups, such as older people, those living in nursing homes, people with specific conditions, and those with high body mass index, growing from 875 patients in 2006 to 10,190 patients in 2014, most of whom are actively engaged in fitness and other prevention programmes, with an average age of 48 years (and 16% being above 65) (Höhl 2016). Multiple evaluations have shown improving health outcomes—in particular, lower mortality rates for those enrolled. Furthermore, between 2006 and 2010, it generated a saving of 16.9% in one area evaluated, mainly through helping to reduce the growth in emergency hospital admissions by two thirds (The King’s Fund, n.d.).
Nevertheless, in spite of strong evidence of improved outcomes resulting from co-produced prevention activities, such schemes are still not common in Germany or other OECD countries (Gmeinder et al. 2017).

**Co-delivery in Pathways to Outcomes in Problem Detection**

We will exemplify co-delivery through problem detection by reference to examples in public safety. This can be quite controversial, especially in administrative law countries (Loeffler 2018)—for example, a qualitative study comparing modes of co-production in social services and public safety in Germany showed that some focus group participants were very sceptical about opportunities for co-production in most policing activities, given the predominance of hierarchical governance in this service (Loeffler and Timm-Arnold 2020)—but they did believe that co-delivery can play an important role in emergency and preventative services, especially in relation to problem detection.

An extensive literature review on the role of co-delivery in policing and criminal justice shows that crime detection is central to several pathways to outcomes, including crime deterrence and, through punishment of crime, to desistance and removing criminals from the community (Loeffler and Bovaird 2019b). Communities can make an important contribution to crime detection activities of the police through crime reporting and being willing to act as witnesses.

In order to facilitate crime reporting, emergency services operate hotlines such as 999 in the UK. More recently, such mechanisms have been reinforced by internet and social media platforms, which allow the police to crowdsource information for the detection and pursuit of crime (Loeffler 2021). For example, in 2004, Dutch police introduced an online system, CitizenNet (Burgernet) (Meijer 2012, 200), which allows the police to call for information on recent crimes from citizens in the network and passes all information received from citizens quickly to relevant police units. Participants are later informed about the results. In 2012 Burgernet had enrolled more than 1.4 million citizens (9% of the population, across almost all municipalities) and was used in about 600 time-critical situations each month, with 11% of cases being solved through information from Burgernet participants (https://en.wikipedia.org/wiki/Civil_network).

Of course, co-delivery for crime detection or treatment may also lead to undesirable results—for example, when citizens do not respect legal frameworks and turn into vigilantes or stalkers. In particular, in areas such as East Germany people may still remember when citizens had to collaborate with the Stasi to spy on fellow citizens. This reminds us that co-production needs to be guided by democratic governance principles. More research is required on potential governance pitfalls of citizen co-delivery in public safety (see chapter 31 in this Handbook by Steve Smith), particularly with the increasing availability of surveillance technology.
Looking more widely at the role of co-production in treating social problems, we will use health to exemplify the possibilities. Co-delivery of better health treatment is often called ‘self-management’ or ‘self-care’, defined as the care taken by individuals towards their own health and well-being and that of their family and the community (Department of Health 2007), often supported by ‘experts by experience’—e.g. others who have suffered from a similar condition.

Self-treatment (e.g. through drug injection or dialysis) has become much more common over the years, although still much less prevalent than it might be (Patel and Patel 2014). To put this in context, 90% of people in the UK use over-the-counter medicines to manage minor conditions without going to their GP and in 2010 973 million over-the-counter medicine packs were sold by pharmacists, compared to 1028 million items prescribed by doctors (Proprietary Association of Great Britain 2011). GPs have been estimated to spend currently an hour a day seeing patients with minor conditions that could be self-treated—costing the NHS around £2 billion p.a. (Proprietary Association of Great Britain 2010). Indeed, the Department of Health has estimated that 39% of GP consultation time is spent treating patients with self-treatable minor ailments (Colin-Thome 2004, 11). Moreover, there is research evidence that education of patients in self-management can have favourable outcomes—e.g. in cancer care an evidence synthesis suggested that ‘For the most part, self-management education interventions may help relieve symptoms of depression, anxiety, and emotional distress and improve quality of life’ (Howell et al. 2017, 24). The potential for change was highlighted by a 2007 survey, which showed that over 90% of people were interested in developing self-care skills and over 75% believed they would be more confident if they had support from a professional or peer (Department of Health 2007).

Another way in which self-care can be co-delivered is through trained community health volunteers (CHVs). In the very different context of hard-to-reach communities in rural areas in Kenya, a recent study showed that the proportion of CHVs with appropriate skills to examine children for signs of common illnesses improved from 4 to 74% after six months of training—and the proportion of caregivers who first sought treatment from a CHV increased from 2 to 31% (Shiroya-Wandabwa et al. 2018).

However, despite these potential benefits, there is evidence that healthcare professionals do not explore the potential of self-care fully. In 2005, a national survey found that more than 50% of patients who had recently seen a healthcare professional had not been encouraged to develop self-care skills and one-third said they had never received any advice regarding self-care (Department of Health 2005). However, support is now available in the NHS in the UK, e.g. the six-week generic self-management courses in the Expert Patients Programme helps people to develop practical skills and coping strategies to deal with the emotional and psychological impact of living with a long-term condition (Coulter et al. 2013).
By their very nature, many social problems are long-term or even permanent, so ‘recovery’ is generally not an appropriate description and ‘rehabilitation’ is more about learning to live with or stabilising the problems, rather than diminishing them (Loeffler 2021).

A key co-delivery approach to rehabilitation which is widely promoted by social work is peer group support, either in pairs—two individuals helping each other—or in groups, and undertaken through face-to-face meetings or digitally. Such peer support groups to improve rehabilitation have been particularly common in health and social care but occur also in other services. For example, in the UK the charity KeyRing has developed a housing model promoting peer support of vulnerable adults. They form Living Support Networks which each comprise ten people living within walking distance of each other (Parker et al. 2019)—nine are vulnerable adults and the tenth is a Community Living Volunteer who lives rent-free in the network area and provides at least 12 hours each week to help Members with issues such as bills and budgeting, getting into education, employment or volunteering and also promotes peer support between Network Members and links with neighbours, community organisations and local organisations. In some areas, KeyRing also runs Community Hubs where Members can drop in for one-to-one peer support, socialise, plan events or get information and advice. An independent evaluation suggested the KeyRing model provided a 120% return on the original local authority investment (Housing LIN 2018), with improved outcomes including moving people from higher cost support, reducing the need for overall support, avoiding crisis and recovering more quickly from it. Subsequently, variations of the KeyRing model have been implemented in wider settings in the UK.

In Germany, there has been increasing interest in ‘multigeneration houses’ where different generations live together and share communal areas and a range of social and leisure services and activities, so that older and young people can support each other. Originally a housing and social care model but now emerging as a grassroots community movement (Labit and Dubost 2016, 49), by 2006 multigeneration houses were beginning to be co-financed by the federal government. By 2017, there were 540 multigeneration houses with more than 61,000 users (Bundesamt für Familie und zivilgesellschaftliche Aufgaben 2018), with strong federal support. As a visitor to a multigeneration house observed, ‘pensioners volunteer to read books to the children and run a “rent-a-granny” service to relieve exhausted parents. In return, teenagers offer to show elderly people how to use computers and mobile phones’ (Oltermann 2014 cited in Labit and Dubost 2016, 50). Although there is little rigorous evidence about its effectiveness, this kind of intergenerational peer support clearly offers volunteers a wide variety of opportunities to co-deliver services and activities with residents (Bundesamt für Familie, Senioren, Frauen und Jugend 2020).
Perspectives of User and Community Co-delivery in a Post-Covid-19 World

As we finalise the chapters of this Handbook, the whole world is in the grip of Covid-19, with huge infection rates, appalling death rates and the threat of lockdown, at least for the most vulnerable people in the population, for many months ahead. What has this got to do with co-delivery?

At one level, it is very heartening to observe how ordinary people, all over the world, have responded immediately and generously to help their neighbours in practical ways—e.g. by shopping for those who can’t get out to shop for themselves, by telephoning regularly to ensure that the most vulnerable people remain OK and have at least the chance of a short conversation with another human being, and even by taking people to hospital or by looking after other people’s kids, at some risk to themselves.

However, the pandemic of Covid-19 has not led to a universal outbreak of community co-production or even self-organisation. This is most dramatically exemplified by the NHS Volunteers Scheme, for which 750,000 people registered in a matter of days—a heart-warming response and one which demonstrates the willingness to co-produce. However, what happened next is less encouraging. For weeks, few tasks were allocated to this willing volunteer force, as the public services lacked effective mechanisms to identify whether these volunteers were acceptable, what they could best do, who needed such support and how they could best be put in touch with each other to arrange mutually congenial and practical interactions—indeed, in the first month, only 20,000 tasks were allocated (Hodder 2020).

The lessons from Covid-19 are stark and highly challenging—citizens have resources, assets, strengths and capabilities which are relevant to making a significant difference to the outcomes achieved in modern societies. What is more, many of them have a strong willingness to see these capabilities made use of for positive social and public purposes, including the co-delivery of public services. However, we do not yet have a public service system which is designed, organised, incentivised or experienced in making use of the rich potential of citizen contributions. This is the challenge for future policy and research in public management—turning the huge potential of our citizens into the quality of life improvements for those citizens. The examples highlighted in this chapter demonstrate that it can be done. The growing needs of our populations in this crisis cry out for it to be done. There is now a need for citizens to find ways to insist—‘Get it done!’

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