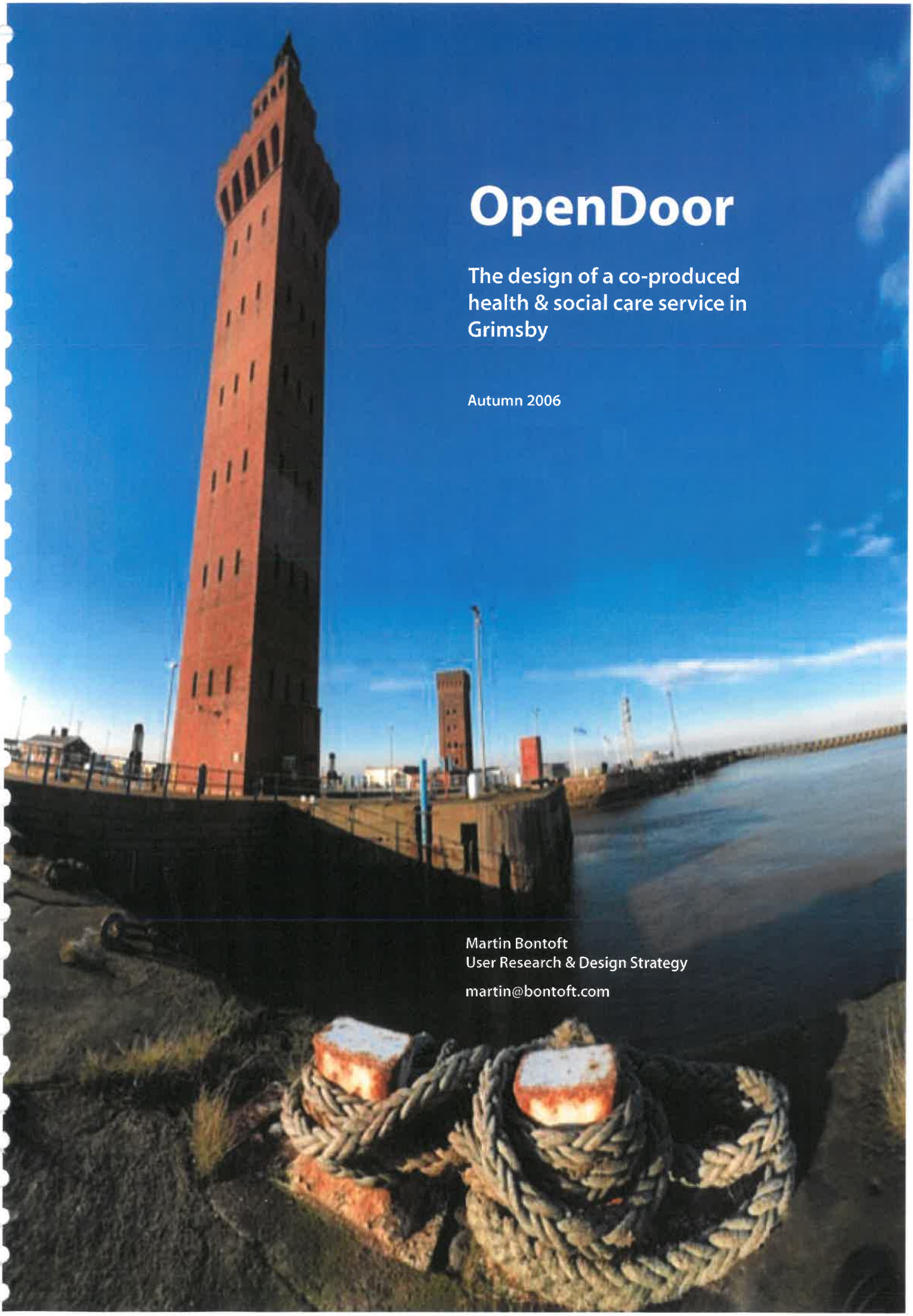


OpenDoor

The design of a co-produced health & social care service in Grimsby

Autumn 2006

Martin Bontoft
User Research & Design Strategy
martin@bontoft.com


OPPORTUNITIES
NINTENDO BRAIN AGE → BASIC SKILLS
GATIE. · VIDEO
Mini jobcentre or Time bank
CREATE CONNECTION POINTS (spaces to talk + share)
ENVIRONMENT: · LESS MEDICAL · LESS NHS
NHS ritual: — noise awareness — define 'patients'
OFFSET · REWARD NON-USE
Pledging your time
STUFF TO GENUINELY OCCUPY ALL AGES
JUST A PLACE TO GO - WARM, LIGHT FRIENDLY
GIVE PEOPLE A HISTORY - explain gaps
How you fill it is up to you.
BUY ENTITY BAG
Use my time productively (if I have to wait)
SOMETHING TO TALK ABOUT CONFIDENTLY (other than drug use)
GIVE A ROLE → NEW IDENTITY
TIME BANK CO-OPERATIVE SERVICES, SKILLS, ETC (TOOLS)
LATE OPENING - COUNCIL SERVICES - BETTER ACCESS
Review the service every 6 months → consult + re-design
EVENTS
Local role models - or relevant to my condition · Stephen Fry · Frank Bruno
Interview your doctor - can I get on with her?
YOU ARE NOT JUST THE SAME
PERSONAL BUDGET AND TARIFF - TO NORMALISE
Platform: · to create self-help groups

Executive Summary

This report describes the co-production of a service that aims to deliver better access to health and social care for people who normally do not attend traditional services. The project was commissioned by North East Lincolnshire Primary Care Trust.

The groups we worked with, in Grimsby during the Autumn of 2006, included problematic drug users, offenders, sex workers, the homeless, asylum seekers and economic migrants.

A variety of research techniques were employed to gather views, issues and problems; the techniques included…
- creating a web page for on-line discussion,
- generating press articles,
- sending out over 200 cards asking for feedback,
- workshops with service users and providers,
- benchmarking visits in London, Manchester & Glasgow,
- interviews and observation with service users.

The research was done independently of the project team to ensure a measure of objectivity. The findings showed that all the groups shared simple needs, mainly concerned with emotional, social and low level mental health issues. The level of disempowerment of the people we worked with was apparent. The findings also indicated the lack of trust exhibited towards the NHS in general, although everyone was able to identify an individual with whom they had a productive relationship.

Against this background, I and the project team developed a set of principles to guide the development of the service, they include…
- we never turn anyone away,
- we help in whatever way we can, not just with health,
- we aim to build self-determination,
- we want the quality of what we do to be self-evident,
- we will demonstrate consistency, reliability and trust.

The service concept that emerged was far an "activity centre" – somewhere you go to engage, be challenged and supported, meet like-minded people, feel part of something, do something useful and be made well.

The "OpenDoor" is the working title and represents the democratic, inclusive and helpful nature of the service.

To guide the detailed design and development of the service, several pages are devoted to describing how we see it being experienced. We cover the measures to be implemented to make people who are unaware become aware, interested and interacting, then to become users, providers and ultimately advocates of the service.

Several usage scenarios were developed to explore issues that might arise and their optimal solutions. The scenarios predict a number of roles, rules and tools that will be needed; these are described in detail. Key areas of the physical space are also detailed - the cafe, activity spaces and family areas.

Finally the report outlines the next steps to ensure successful implementation of the OpenDoor service.

Aerial view of East Marsh district of Grimsby, where most of this work was carried out

Contents

Let me take this opportunity to thank key participants in this work... The service users & providers in Grimsby who helped form these ideas, particularly those at Harbour Place, Clee Youth Centre and Roundabout. The Hope Street project team: Lance Gardner, Annie Darby and Angela Faulding. Esme Macleod & Florence Andrews at We Are Curious. Julia Schaeper at Engine. Colin Burns at Martach Consulting.

Freeman Street, Grimsby

Introduction

Problem Definition

Grimsby's problem is not low income or low employment or high crime.

Grimsby's problem is that its people experience all of these as well as high health deprivation, poor education, barriers to good housing and a poor living environment.

The 2004 Indices of Multiple Deprivation show Grimsby in the worst quartile of local authorities, with 25% of the population living in the most deprived areas.

One consequence is that a girl in Grimsby's South ward aged 15-17 is 3 times more likely to get pregnant than a girl in a neighbouring ward. A man living in an area of high multiple deprivation will die 7 years earlier than the regional average.

From the NHS perspective, it is clear that a person's ill health is likely to be determined by a number of factors – their income, their education, their environment and family background. In Grimsby, it is precisely these factors that, for many people, are highly compromised.

We believe that the best use of NHS funding is to address some of those causal factors and keep people out of ill health, rather than dealing with it after it has occurred.

An Outline Solution

The intention is to develop locally a service based on a social health model of care offering a holistic and integrated service to the diverse groups in the most deprived areas in Grimsby.

The vision is a proactive, empathetic service that pays as much attention to the determinants of ill health as it does the ill health itself.

Run as a social enterprise, it will provide appropriate economic opportunities to its users and help to regenerate the local community.

The service will be inclusive of all communities; although focused on those in most need, it will be available to all.

Research locations

The Approach

Neighbourhood Renewal funding was awarded to complete the first stage of the service development – to establish the needs and collaboratively develop the outline service design.

To be able to work with people in areas of deprivation, the NHS needs to be able to reach them. This project focused on vulnerable people who typically do not access mainstream or traditional health services on the basis that if we can reach these groups, we also reach everyone. If we can satisfy their needs, we deal with serious issues of deprivation and we would be inclusive of 'mainstream' needs. The groups involved were...

- Problematic drug users
- Homeless people
- Offenders (people leaving prison and youth offender institutions)
- Sex workers
- Asylum seekers & refugees
- Economic migrants
- People excluded from GP lists

In addition we tried to include the needs of dependants and supporters of people in these groups.

The success of this service will depend on its acceptability to the groups it serves. The evidence of the NHS Collaboratives, supported by the National Primary Care Development Team, is that service acceptability (ie, take-up and involvement) is likely to be higher if the service is designed and operated in partnership with service users.

A co-production approach was chosen: work with all groups – user and provider – to understand and define the problems, and then to develop and refine the solutions.

This report describes that work, conducted during the autumn of 2006.

The UK Design Council's generalised model of the user-centred design process

Research

Strategy

The overall approach is described in the following illustration; it shows a generalised design process in four stages.

The first two stages describe how designers first tend to open up a problem and investigate all issues before focusing on what appears to be the key issue. The second two stages show how, having defined the problem, designers again open up a number of potential solutions before focusing down on those that appear to be most suitable.

Followed in this way, the process would produce a good design project. The modification we chose was to engage people in this process to ensure that the outcome was "good design" but also acceptable to people – they would be motivated to use it.

The overall approach has been firstly to attempt to gain if not the trust, then at least the acceptance of the target groups, and then to use their acceptance as a means of understanding their behaviour, their motivations, beliefs and values.

We have spent a lot of time simply hanging out in all the research locations, allowing people to become familiar with our presence, giving details of our work and, when appropriate, asking questions to develop our knowledge and understanding.

The full list of research sites, an explanation of their role and what we did there is available in Appendix 1.

Images from the research

Methods

Disposable cameras have been given to youths in the East Marsh; through youth workers we have used their images to get their perspective on life in the area. Cameras have also been given to asylum seekers at Clee Youth Centre and to people at Harbour Place day centre.

We created a web site at www.hopestreetclinic.org, it provides some background information and invites comment and discussion about the project.

Several communications methods have been explored to get the message out to the widest audience; articles have appeared in the Grimsby Telegraph, local community press newsletters and the PCT newsletter.

Over 200 printed cards have been left in doctor's waiting rooms, at day centres, the Salvation Army, the YMCA, Addaction, Grimsby Library, Zam Zam, and the Junction. The cards asked for "gripes" about their past experience of health care; it also pointed people towards the website for further comment.

We have run workshops and group meetings with potential service users and providers, at Harbour Place, DIP, Assertive Outreach, and Roundabout. We have also facilitated a number of sessions with the leaders of this project to help them clarify their vision for the service and what it will provide.

Visits have been made to Bromley by Bow Health Centre in London and the Dawn Centre in Leicester. We have had visits and input from chief executives from a Leeds PCT and the Big Life Centre in Manchester.

Participant observation and interviews have been carried out at all the sites listed in Appendix 1. This has been the most productive method of data gathering; we have used ethnographic methods, spent time with them, listened to their problems, issues, motivations and beliefs and we have done that in their domains and at their pace.

Key Findings

Similarities hidden within differences

Though they would not admit this, all of the groups we looked at share very similar and powerful needs...

- for a place of safety,
- opportunities for socialisation,
- someone to listen,
- simple help and advice,
- to be respected and valued

They would not admit these similarities because, in general, they do not believe they share anything in common with groups they do not know or understand. The sex workers I met were dismayed to be compared with 'drug users' even though some of them were problematic drug users. Grimsby people would react angrily to comparisons with asylum seekers even though they were all homeless, excluded and vulnerable.

On the one hand it makes designing a service very easy as there is a clear and homogenous set of needs to be satisfied. On the other hand it makes it extremely demanding because bringing these groups together might increase the potential for conflict.

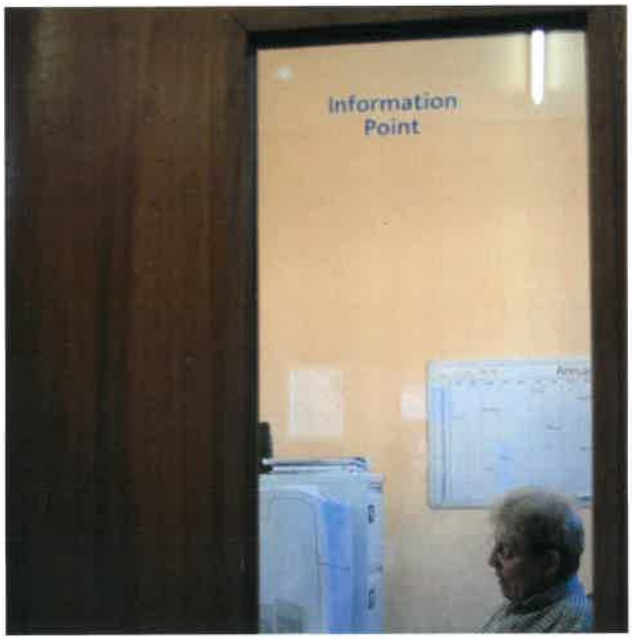
Emotional needs, not medical

In addition we were struck by the simplicity of these needs, particularly as in such a disadvantaged area we expected to find more evidence of need for primary care, or medical, services. In fact, we came to feel that tea & coffee were just as important as antibiotics, but that in treating the most prevalent ailments tea & coffee were far more beneficial.

People would often have someone in the NHS who they trusted, asked why they would usually say, "...because he listens to me".

If the aim of this service is 'making people feel better' then simple, emotional, humanistic and holistic measures will be effective (alongside medicine).


MONDAYS TO
MORNINGS 10.00 TO
EVENINGS
MONDAY
TUESDAY—
THURSDAY —3.30 TO
FRIDAY—
WEDNESDAYS LOSED


Information
Point


Male WC
DUE TO PEOPLE WALKING OFF THE
STREET AND USING THESE
TOILETS WE HAVE TO KEEP THEM
LOCKED. PLEASE ASK AT
RECEPTION FOR THE KEY
MANY THANKS

Disempowerment

There is a sense amongst many in these groups that they are disempowered and isolated, distanced from work or health, and unable to make a positive change for themselves. This arises from several sources...

Behaviour

Some individuals, homeless, drug users or offenders, come from backgrounds where, to be heard, you have to shout, where 'aggressive' behaviour is the norm; they have learned that shouting gets them noticed and often to the head of the queue.

Service providers can feel intimidated by these behaviours, their response can be to see them quickly and get rid of them, which reinforces the behaviour. The provider is not motivated to proactively deal with health or other issues, so the person becomes distanced from sources of help.

It is easy to ascribe these individual behaviours to the entire group to which the person appears to belong – so all drug users are perceived to be loud and aggressive. This serves to distance the group from sources of help.

Economics

Grimsby has a history of poor parenting skills in certain areas and, more generally and recently, the town is recognised as nationally the worst for education and skills deprivation, with 16% of young people not in education, employment or training.

Over the last 2 years the town has also received a large number of economic migrants (estimates as high as 6,000). Their desire for work has put even more pressure on employability and distanced many from the sources of economic recovery.

Substances

The number of 11 year olds drinking alcohol regularly is almost 4 times the national average; a quarter of Grimsby's 11 year old boys are drinking every week.

There were an estimated 1,440 problematic drug users in the Grimsby area in 2005/6, less than half were in treatment at that time. Estimates suggest that these people may be responsible for as many as 1,500 children.

Substance misuse increases behavioural chaos and distances people from health, educational and economic opportunities.

Freeman Street Market, Grimsby

"Care"

We have seen evidence of people being regarded simply by their condition, and of drug users not going to their doctors for an ingrowing toenail because it had nothing to do with their 'condition'. The traditional medical view of people with 'deficits' is not how people see themselves but, over time, they do come to see themselves as "diabetic", rather than a person with diabetes. This medical view tends to ignore their skills and aptitudes, the things they can do; it renders the person a passive recipient of 'care' rather than an active participant in their own health & wellbeing.

Many of the people from these groups have numerous needs and can come to depend on service providers far more than is necessary or healthy. We heard stories of a person waiting more than 3 hours for a free prescription of paracetamol and another waiting more than 6 hours to see a specific doctor even though others were available.

Social

There are few places for people to meet with others who do not share their problems: drug users tend to meet other drug users. They get support and empathy from these important relationships, but they do not always get the opportunity to broaden their circle of experience, to talk about something other than their drug use, or get access to the widest range of people and services.


SPEAK HERE

Identity loss

We have had several good conversations with people about their homelessness, their drug habit or the way they were treated when they first came to the UK. Talking about their 'condition', they were eloquent, funny and clever. On any other topic they had much less conversation.

No blame is implied, we all talk most about the major activity in our lives. But, if your condition is the major thing in your life, it's only appropriate to talk about that with people in similar circumstances or with care professionals. As a topic of conversation in Grimsby, their 'condition' marginalises and labels them. It does not help them to share experiences with the mainstream and, in that way, integrate themselves.

On the other hand, we met people who had valuable skills – a homeless lady who designed web sites, a convicted drug user with a real talent at sketching, an ex-drug user with the experiences and empathy to be a counsellor – but few seem to register the value of these things.

It seems that everyone, the person included, buys into the simplistic stereotype of the homeless, the drug user or the asylum seeker. The truth is far more complex and personal and positive.

It's our fault

A consistent finding is that people's views of the NHS are polarised – they regard clinicians as either extremely bad or extremely good. Their experience is of a few with whom they can relate and form a relationship, and then the rest who "are ****".

Stories of arrogant professionals are common. I met a recently diagnosed schizophrenic who had been batted between A&E and his doctor, receiving no treatment at either, until he turned up at Harbour Place in distress.

Another guy, recovering from a 4 year cocaine addiction, told me he saw a psychologist who spent "20 minutes" silently looking at him over arched fingers. The guy eventually asked him whether he was going to ask him anything. The psychologist replied with, "Do you want me to ask you something?" The guy walked out angrily, probably confirming a preconception about drug users.

Suspicion and polarised expectations

The result is that the NHS is regarded with suspicion; people say "...it's all about money now" or "...don't expect a straight answer from them about anything". There are pockets of trust, good relationships do exist, but the prevailing view is 'only go when it's bad'. So large numbers of people are disengaged from primary care and turn up at A&E in distress. They expect nothing or they expect everything right now.

All photos with the permission of participants

Design Principles

These principles form the basis of much of the design work that follows. They have arisen from two sources – the research work described above and the values of the project's leaders. In workshops they have clearly expressed their values, which we have interpreted and combined with the research findings.

We never turn anyone away

Our target groups are often termed "hard to reach". They are not particularly hard to reach but they don't respond well to the ways the NHS has tried to reach them in the past.

If someone comes to our service with a request we feel they have made our life much easier – they have identified an issue, they have decided to do something about it, and they have selected us as their best guess for an appropriate solution.

It is our intention never to turn anyone away, never to regard someone's request as inappropriate, never to refuse help and this applies to everyone: mainstream or marginalised.

More than health

It's clear from people's current behaviour that their health is not their highest priority; nor do they necessarily trust the NHS when their health does become an issue.

This service will recognise that ill health is the result of several factors and it will try to help with these as well. It will act as a delivery point for existing service providers; it will also listen for unmet needs and seek to find good partners to satisfy them appropriately.

However, before people will engage with the services, they need to become familiar with what are on offer – there needs to be a reason to come in. We will offer numerous ways in which people can participate.

Some of the people we have met have lots of time and it weighs heavily on them; others have skills and aptitudes that we can put to use. This service will place 'activity' at the centre of its provision; not simply 'being physically active' but active in all respects – socially, emotionally, culturally, economically and mentally – with the intention of improving their well-being, self esteem and sense of purpose.


Baby oasis
Please feel free to use our feeding and nursing corner if you would like a little extra privacy.
IKEA Restaurant & Café

Befriending, but with a purpose

Dependence is a constant concern, we will befriend people and provide significant assistance but we want them to build resilience. The support we will offer will be deep, personal and emotional, but it will have a target of self-determination in mind.

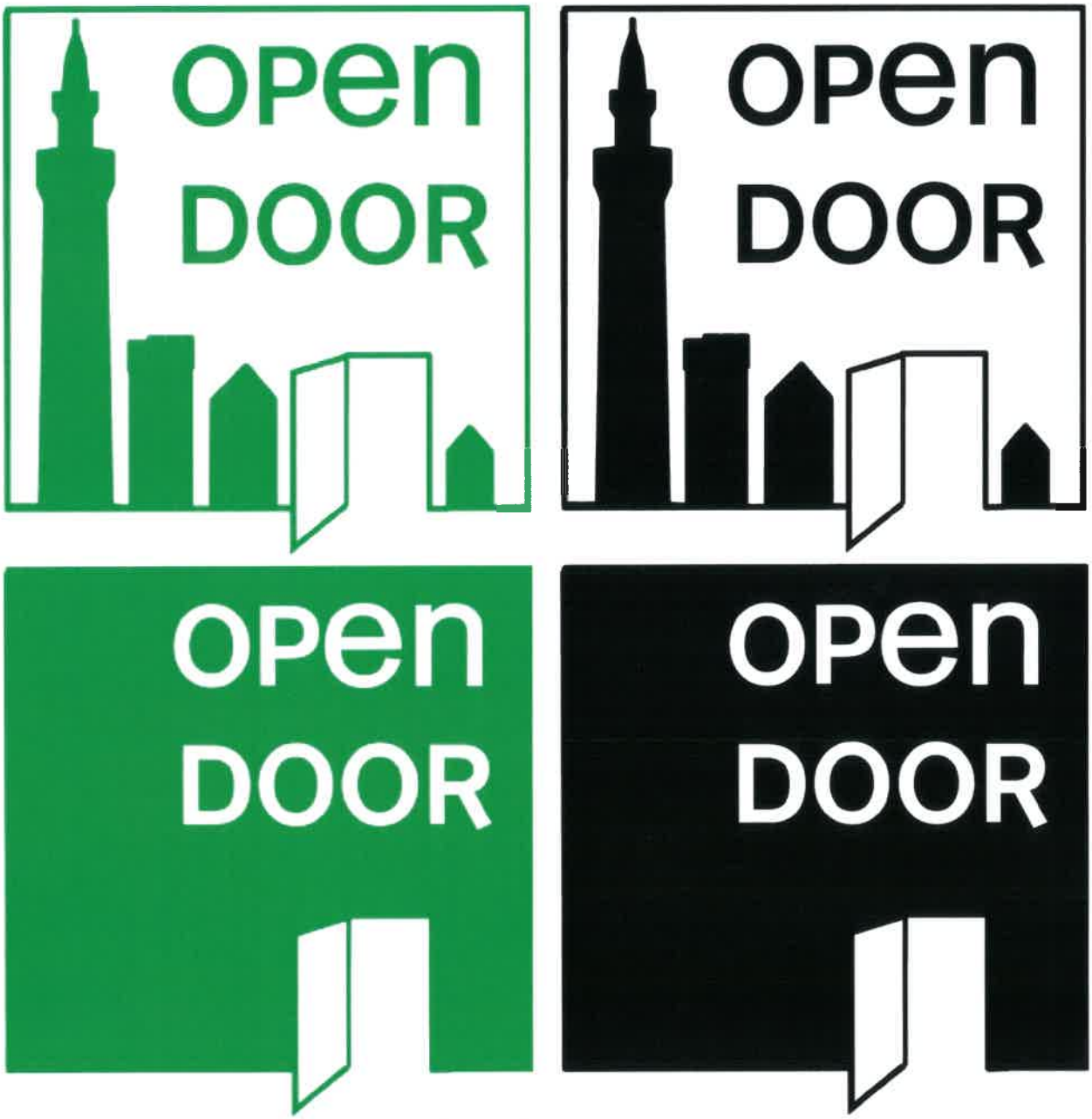
Evident quality

We want people to develop the belief that we value them. We believe that we will do this by ensuring that all we do is to the highest possible standards.

The service will be established as a social enterprise so that all value is channelled back to the community we serve. We will act as a hub for regenerating the area; we hope to spin off new services and companies to help people become economically active.

Consistency, reliability and trust

This is the backbone to the service – we do what we say.



Colour and monochrome versions of the two favourite logotypes

Service Blueprint

Having set out what informs the design of the service, in this section we describe what the service is and how it will be experienced.

To ensure a good understanding we describe the service and its experience in several different ways in the following sections, and the illustrations become progressively more detailed.

The service concept

An 'activity centre' – somewhere you go to engage, be challenged and supported, meet like-minded people, feel part of something, do something useful and be made well.

The "OpenDoor" is the working title and represents the democratic, inclusive and helpful nature of our work.

The service outline

Perhaps the most important aspect of the service is 'befriending'. We think this will be the key to much else that follows, it will facilitate access to other professional services, but it is also an enormously important "health" service in its own right.

To a large extent this is simply an extension of what happens now – numerous agencies try to engage with the community through social interaction and simple assistance, eg, tea, coffee and biscuits, help with form filling, free contraceptives, a place of safety, washing machines and showers.

We recognise that some people will not come into our building; their reasons may be attitudinal (eg, lack of trust or belief we can help, fear of embarrassment or being judged), or economic (eg, their income will suffer, they cannot afford the time). Outreach will continue to engage these people wherever they are.

Having established a relationship with the individuals and their families, it is now possible to engage them further. There may be sufficient trust and goodwill that we can signpost other services or help individuals by advocating on their behalf.

As soon as possible we will involve the person in activities that we will initiate, facilitate and support; our starting point will be the skills, aptitudes or interests of the service users.

The individual and their families will also be accessing traditional physical and mental health services. These will be offered through our clinical team or by agreement with external providers with our support and guidance.

All photos with the permission of participants

Path to Participation

In this model we assume (based on our research) that there are people in the community who each will fall into one of these categories. The service should be designed to have something meaningful to offer each of these people; moreover it will be designed so they are naturally encouraged to move to the right, along the path toward more participation.

We will do this by ensuring we have elements in place (ie, designed aspects of the service) to move people from one stage to the next. The reality is likely to be more fluid and messy than implied here, with people moving through several stages in one jump.

Unaware to Aware

Most people will be in this category, they will not even be aware that a service exists. The reasons may be complex – English may be their second language, they may not read well or they may not consume media in the way or to the extent we imagine. It may also be that our health service is perceived as culturally inappropriate – male-dominated, middle class, requiring "registration", or not as good as at home.

With these potential objections in mind, awareness is best accomplished by broadcast methods:

- Well-crafted articles in newspapers, local newsletters (internal & external), TV & radio,
- High profile events – open days, free food, arts projects, free dentistry, Homeless World Cup or the East Marsh Olympics,
- Posters in places where you can get people's attention, eg, schools, hostels, shopping centres, behind toilet doors, etc
- Flyers or gifts with a message, eg, coffee mats, plastic bags, stickers, badges, posters, etc.

In addition we will work with our peers so that they refer people and signpost them to us. This requires us to be clear about the service we offer and to ensure that we are seen to be effective by their measures.

The Outreach services currently in place are the most effective way of reaching people who don't engage with traditional health services; these will continue.

Aware to Interested

Although aware of the services, people may not believe that we will offer something they are happy to use. We have found significant mistrust born of past bad experiences, "doctors are arrogant"; old information never re-evaluated, "the baby scales were full of wee … you'll have to wait for hours"; and misconceptions, "they can't help you with that".

As many of these beliefs are based on experience, it is only through positive experience that they will be changed. We plan to let them experience the new service through things they will be prepared to trust, simple things such as a warm, safe place to sit, tea and coffee and the presence of their peers.

As people become more familiar with the service we will engage with them through…

- "befrienders" – people with the social skills and life experience to be able to relate,
- simple services – washing machines, showers, internet access, etc
- genuine and appropriate activities – cooking, arts & crafts, car or cycle mechanics, etc.
  [A list of activities we have heard mentioned is given in Appendix 2]


Customer Service
We're here to help just ask...
Our Promise
Customer Service

Interested to Interacting

Amongst the groups we have researched there is a deep well of mistrust, of professionals in general and certainly of the NHS. A key step in getting people to engage with us will be to communicate, in everything we do, that we trust, value and respect them.

This imposes a subtle discipline on the design of the service. The ambience of the space, the behaviours of the staff, the rules and how they are applied and the tone of voice people use – all of these things become relevant.

Throughout this document we show examples of how these values may be communicated through design. For example, we will not refer to a reception desk, we talk about an information point; it will not be a barrier or something to hide behind, but evidently the place to go for help. Security measures will be employed on certain doors but only where necessary and low-key.

Interacting to Using

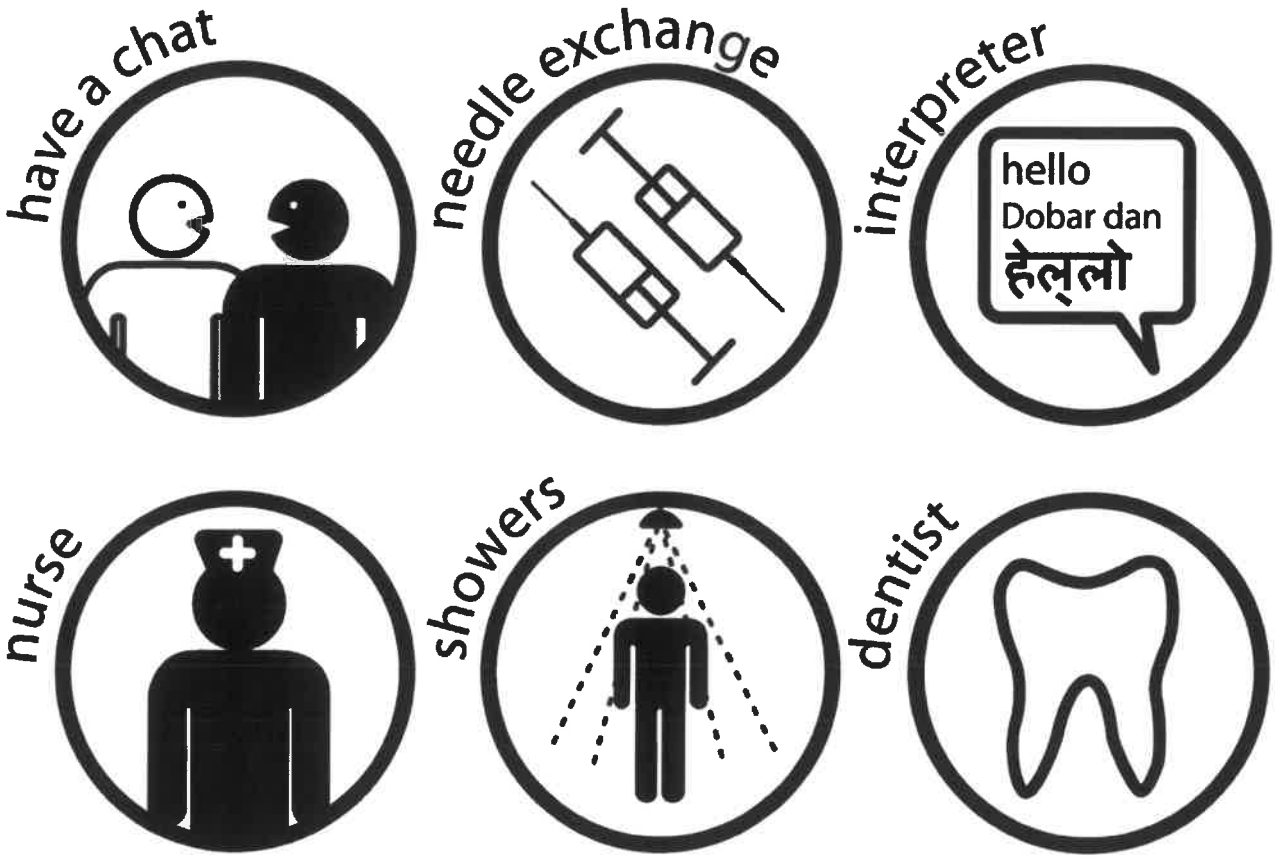
With sufficient trust we believe that people will start to use the service if it provides the help they need. Health needs are often complex: diabetes, obesity, drug use and mental health issues have their roots in diet, activity and lifestyle, education, employment, and parenting. The help people need will be similarly complex.

The service will be open when people want to use it; based on a retail model, not 24/7 but definitely not the traditional NHS model. We plan to offer sessions with experts from other agencies at the times people can attend – evenings and weekends.

The sessions will cover citizenship skills such as tax, migration, employment, banking, as well as specific health issues. They will also cover life skills such as parenting, cooking, shopping, activity, hygiene, etc. The mix will be constantly evolving as we better understand the needs of our users (and this assumes a feedback mechanism, so that as needs are expressed we can create an appropriate response; see Advocating below).

It is at this stage that we foresee people using our health and social care services. Our research indicates that there is significant need of community psychiatric care (much of the service up to this point has been aimed at dealing with low level mental health issues – esteem, boredom, socialisation and exclusion) as well as drug-related and sexual health care. In addition the groups we target share the typical prevalence of long term conditions.


Good
or Bad?
"Tell us what you think.
good or bad."
Thank you for your Ideas & Suggestions!


have a chat
needle exchange
interpreter
hello
Dobar dan
हेल्लो
nurse
showers
dentist

Cherry

Cherry is a 29 year old sex worker. She was referred to the centre with a suspected STD, but really wants to talk about rape. She wouldn't normally access OpenDoor as she has a good relationship with the outreach team who can normally meet most of her needs. She rarely has any time off and with her 11am to 11pm work pattern never has time to access mainstream services.

She is seen by outreach and told that she will have to come into the centre for tests.

Outreach phone to organise an appointment for her.

She arrives at OpenDoor knowing that her appointment is at 10am; her Outreach worker is waiting for her in the café as arranged.

They go together to check in with the General Assistant and Cherry gives her name and appointment time. She is given a spoon with a number and told she can take a seat, get a coffee or use some of the other facilities (eg, library, computers, activities) until someone comes to get them.

A nurse finds Cherry by the number on her spoon and she takes her (with her outreach worker) for tests. In relief she admits to the nurse to having been raped.

The nurse & her outreach worker talk to her and offer support. They offer her access to a specialist rape counsellor in the centre, Cherry leaves to think about this.

Roles
Outreach
General Assistant
Nurse
Rape counsellor

Tools
Booking system
Café
Spoon system
Clinical equipment

Rules
Don't lose sight of the relationship with the individual
We never embarrass you
Discretion
We bring in appropriate skills for your needs
We treat the person first, then needs, then condition

Platforms
Private rooms
Referral system
Café
Links to other medical establishments

Notes
Some appointments may have to be for specific times, others may be for a slot within a time window.

We try to limit the number of disclosures, which might increase the training requirement, ie, multi-skilled nurses.

Jim

Jim runs a small but growing model engine club. He is currently looking for a place from which they can run their club once a fortnight as they've out grown his back room.

Jim is aware that the centre has "hobby spaces" through reading articles in the Grimsby Telegraph and he's seen it driving down Freeman Street.

He drops in to the centre and as he has a direct enquiry, immediately looks for someone to talk to about it.

At the information point he explains that he is looking to hire out some space and is taken to see the Volunteer Coordinator.

The Volunteer Coordinator explains a bit about the centre, what they offer, their rules and their ethos. Jim then goes on to explain about the model engine club's needs.

Together they make a contract specifying what is expected from each party. He agrees to pay the small fee for the space.

Jim is also offered catering provided by the OpenDoor's catering team.

At the model engine club's first meeting in the centre a befriender gives them a guided tour of all the facilities and copies of the 'What's On' guide.

Jim also holds a show and tell session in the activity space to show other service users what they do and encourages them to join.

The model engine club have a feature in the centre's next 'What's On' guide.

Roles
Volunteer coordinator
Café team

Tools
Timetable
Booking System
Information Point
What's On Guide

Rules
We are open to everyone
Negotiated contract
We will promote you
You need to be open and welcoming to new members
You give a presentation for our service users
We give a presentation about our services for your members

Platforms
Space for activities
Café

Notes
We will try to encourage a diverse range of activities in the space and promote them to get service users involved.
This will also reduce the 'ghetto' effect by encouraging a wide mix of people into the centre.


what's on at open door
april - july 2007
01472 609 385
www.opendoor.co.uk
activities // library // health and wellbeing // internet // advice
JUST
WALK IN

Scenarios

Scenarios are a prototyping method for services. We describe a person who might interact with our service, give a few details about their life and then describe their journey through the service based on our knowledge of actual service users.

Beatrice

Beatrice is a 35 year old mother of 5 children, aged between 4 and 17, all of whom are receiving service help. She has a long history of substance abuse, psychopathic tendencies and aggression to care professionals. She has good communication and parenting skills, has a good relationship with her GP and currently works as a mechanic.

Outreach workers call at her home and introduce themselves. They invite her to talk about her experiences of health care and professionals generally; they listen and pay attention to her grievances. They tell her about the OpenDoor service.

They never stay too long, but return frequently and help or do something useful each time.

They build on her obvious care for her kids, telling her about the dentist that calls at OpenDoor.

A contract is negotiated with her; this contains promises from both sides about expected behaviours and penalties if these are not followed.

They encourage her to come into the centre; she comes for a coffee while the kids are at the dentist; her outreach worker is there to greet and support her.

She starts to engage with some activities but on her second visit she argues with another service user, she is asked to take time out in another space until her child is out of the dentist's chair.

Later, every day for a week, she gets barred for different things; her contract says she will not be allowed into the centre for a while.

Outreach continues to work with her at her home until a supported return is appropriate; they give her a Reiki prescription to help with anger.

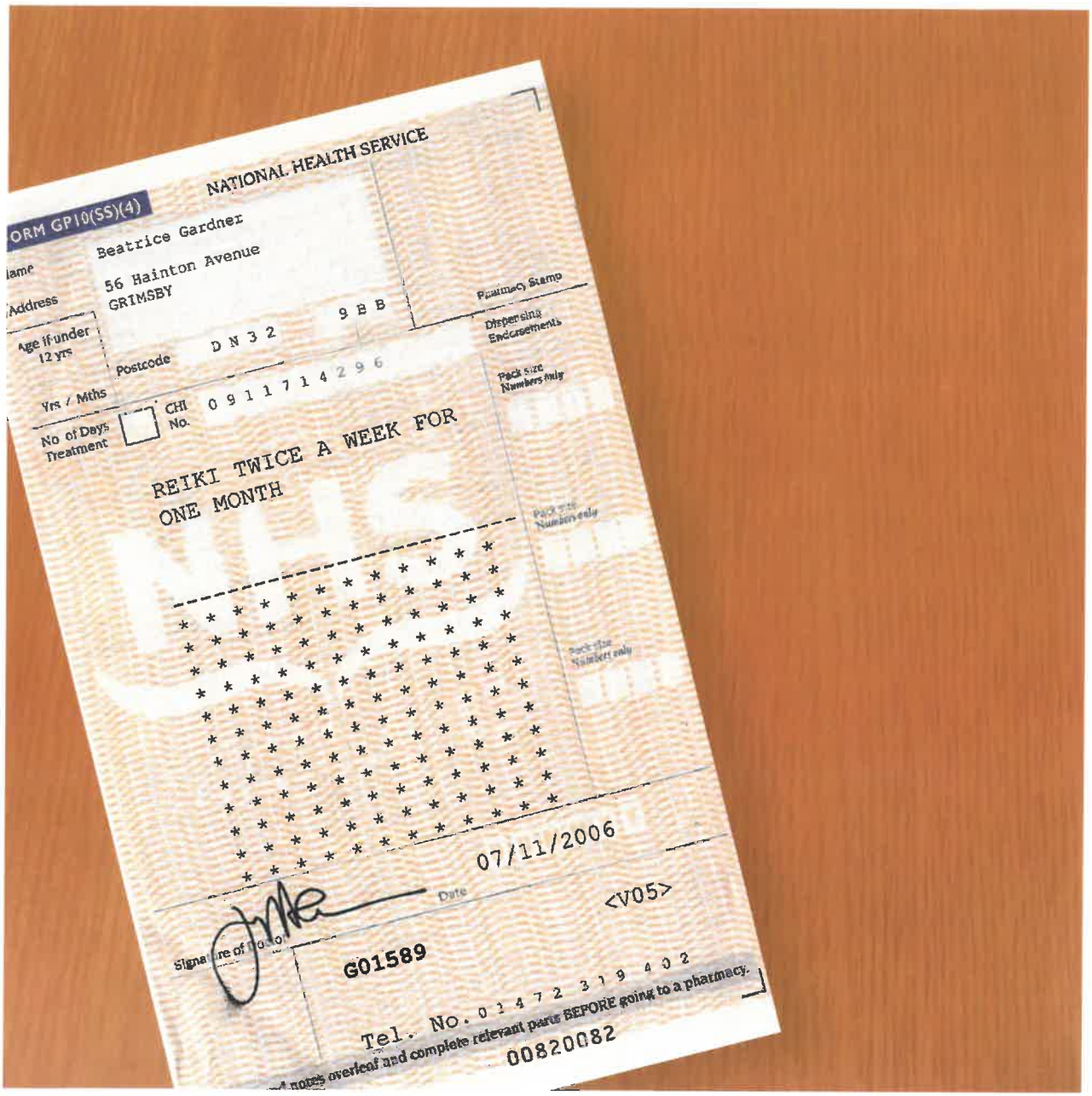
Roles
Outreach x2
Volunteer coordinator
Someone to apply rules
Café team

Tools
Fund for incidentals
Café
'Alternative' prescriptions

Rules
We always try to give value
Inappropriate behaviour is never tolerated
A negotiated social contract
Real penalties, always incurred
We never give up on you
We protect other service users
Work with you at your pace
Don't assume they have health needs

Platforms
Space for dentist
Space for activities
Café

Notes
The intention would be to reverse the "deficit" model, so Beatrice is seen as motivated, capable and skilled. We try to spot the things she is good at and use these to engage her further, maybe through her children.
The rules that apply will always be followed, if a negotiated penalty is called for, it will be applied.


NATIONAL HEALTH SERVICE
ORM GP10(SS)(4)
Beatrice Gardner
56 Hainton Avenue
GRIMSBY
Postcode D N 3 2 9 E B
CHI No. 0 9 1 1 7 1 4 2 9 6
REIKI TWICE A WEEK FOR ONE MONTH
07/11/2006
<V05>
G01589
Tel. No. 0 1 4 7 2 3 1 9 4 0 2
00820082

Using to Providing

Many of the people we have talked to have useful skills and experience; effectively utilising these makes sense for both us and them and reinforces our perception of service users as people with needs, not problems, and abilities, not deficits.

We foresee a key role within the service for a facilitator of activities and volunteers. Their responsibility (along with others) will be to fill the space with genuine activities and to engage people in them. We will develop people so that they can offer support to others. They may be able to lead or support activities; they may also be able to undertake tasks and responsibilities within the service.

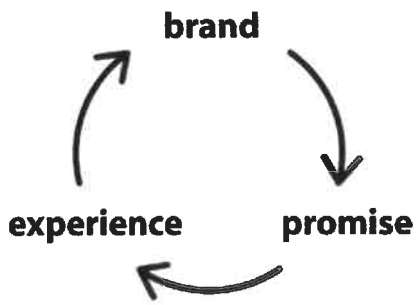
Tukes Café in Grimsby, run by and for people with mental illnesses, provides a good example of the extent to which people, appropriately supported, can engage in service provision, eventually finding a role in mainstream employment.

Providing to Advocating

The service up to this point will have created role models – local people who have migrated from non-use to service use or maybe from service use to service provision. This, in itself, will encourage others to get involved; we simply need to broadcast this message using some of the methods described earlier.

Simple ideas get transmitted furthest and quickest. The brand and its "OpenDoor" identity need to be central to all of our work and communications. The promises made in the name of the brand need to be kept, and we never make promises that we do not believe we can keep. In this way people will develop a belief in the brand and service, and an expectation that all we do is consistently good and appropriate.

But the service will never be "right". It must always evolve to meet the changing needs of the groups it serves. To do this it needs to listen to what people are saying and not saying, watch for who comes to the service and who doesn't, and collaborate with its competitors. If it truly has the interests of its users at heart then it should share its best practice as widely as possible and accept the discipline that comes with that – of constant innovation and development.



Next steps

Circulate document as widely as possible, gather feedback and support.

Identify and pursuit suitable buildings, maintain at least two viable options.

Develop outline business plan, especially the balance sheet, continue to refine it as more information becomes available.

Create a website to inform interested parties locally and nationally.

Maintain local awareness of the project.

Develop brand and identity.


STREET
PARK
OPEN DOOR
MOLSON
CENTRE
CENTRAL HALL
(FISHERMAN'S CHAPEL)

Private rooms

A small number of discrete, private rooms where people can go for privacy, relaxation or refuge. They will be quiet, calm and comfortable.

They will also support a wide variety of clinical activities so they are likely to have installed couches, lighting and specialist services. The dentist, when she visits, may take one of these rooms over for the day. There may be secure access to each and an alternative way out (other than through the café).

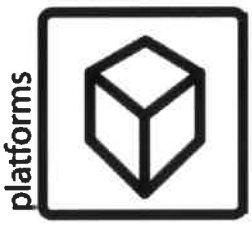
Information point

This is the logical first place to go for someone who needs help or information, it is placed and designed to fulfil that role. It will not be a barrier or something to hide behind; its intention is to reassure and provide a location for providing information and help.

It may have to link with other systems in order to have access to all the information people require, it may house terminals and TV screens and it may be near to or part of the "back office" where records are kept. It manages the "spoon" system, which is the method by which we discretely identify people and link them to their next activity or appointment.

Outreach

This is not a space under our control but it is where we create a significant part of our service. We create the space by being warm, friendly, non –judgemental and by offering value to people. The value may be through simple donations of drinks, etc, through friendship, navigating services or advocating on their behalf.



Platforms

The success of the scenarios relies on the ability for the roles, rules and tools to combine, guided by our aims and ethos, to create something more.

For example, the café is not simply a café, it is a place where we can build trust, respect and get to know people's beliefs and motivations, it is where we will start to engage them in other aspects of the service.

The café is one of the places where the major benefits of the service are created and delivered, which is why it is called a platform.

Their importance lies in the need for the accommodation, the final design of the space, to support these activities.

Café

The place of safety; the warm, dry space where people will feel comfortable, safe and supported; where they come for conversation and to meet their peer group.

It will provide hot & cold drinks, simple hot & cold food; newspapers, magazines and books; internet access, TV and entertainment; in addition they will be able to find washing machines, clothes dryers, toilets, sinks and showers.

In this space they will be greeted and shown the facilities, they can have a conversation with our "befrienders" if they wish or get involved in the activities they will be able to see from the café.

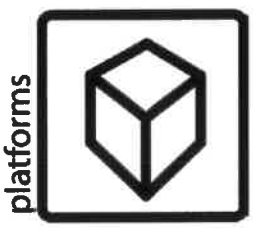
Activity space

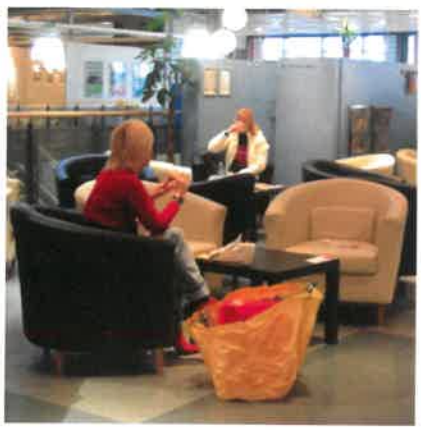
People can migrate from the café into this space and back again; it is where people will feel capable and fulfilled. The space will help draw people into the activities on offer.

A large, flexible space that can support a small number of simultaneous activities (some of the activities are described in Appendix 2). It will be well-lit and have ample power and data sockets, sinks and movable tables.

Family room

Connected to the above spaces, and similar in ambience, this is where people with children can spend time and socialise. The other spaces are visible from here, but this space offers a measure of protection to those who need it.



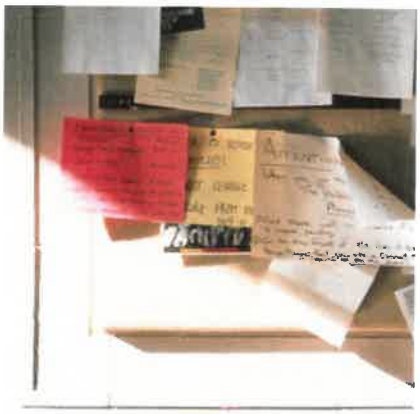


Tools

The scenarios predict that at least the following tools – products, systems, spaces – are available.

- Clinical equipment
- Information point
- Café
- Sofas
- Activities and equipment eg, computers
- Library including multilingual newspapers, books and magazines
- Computers with Internet
- Booking system
- 'Spoon' system
- Toys etc, material to entertain people in the centre
- TV, radio, other forms of entertainment
- Art & craft equipment
- Dental suite
- 'Alternative' prescriptions
- Links to other medical establishments
- Kitchen
- Careers information
- Job Board
- Notice board
- Timetable
- What's On Guide
- Open Door Flyers
- Fund for incidentals


Baby oasis
Please feel free to use our feeding a
comer if you would like a little extra



Rules

The scenarios assume that at least these rules are in place and are accepted and expressed by all staff. We intend that they will also be followed by the agencies we work with and to whom we refer people.

- We are open to everyone
- We never give up on anyone
- We make everyone feel welcome
- We act with discretion and respect
- We never embarrass anybody
- We treat the person first, then needs, then condition
- We always try to give value
- We protect all service users
- We never tolerate inappropriate behaviour
- We negotiate a (social) contract with service users
- We have real penalties and they are always incurred
- We work with everyone at their own pace
- We don't assume service users have health needs
- We support people to use mainstream services
- We give you the time and space you need to talk things through
- We don't lose sight of the relationship with the individual
- We bring in appropriate skills to meet service users needs
- We do what we can for you now and arrange for any specialist care as soon as possible
- We help develop people's skills and interests
- We promote all the activities running in OpenDoor
- We put people in similar situations in touch with each other
- We help people to find training and jobs
- We help people to find volunteers and staff
- We come to service users in the space
- We provide private space when people need it
- We provide specialists to help as much as we can


Welcome

Specialist Activity Workers

Freelance people with special skills in (and enthusiasm for) an activity; they may also have expertise in community engagement or working with a wide range of people.

Advisors

People from external agencies or organisations who are delegated the responsibility for working with our clients and dealing with their related issues; we anticipate this advice will be free and relevant. For example, National Insurance, Home Office, Police, Inland Revenue & Customs, Housing, NEL Council, solicitors, estate agents, careers advice, etc

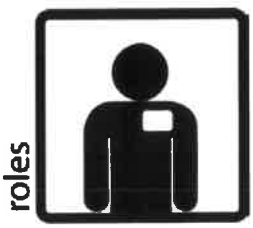
Dentist & other professionals

Provided on a sessional basis.

Café Staff

The style of café we will offer will initially be limited to hot drinks and simple hot & cold food, eg, sandwiches and jacket potatoes. Hot food will also be available occasionally as the result of cooking activities, and this too will be offered through the café.

Based on conversations with Tukes café, to provide a consistent service we will need full-time staff (and not rely on service users). We believe the planned service will need one full-time café manager/server and two part-time café staff; a roughly equal number of volunteer staff, drawn from the service users, would provide good coverage.




HCTB1 05/06
For office use only
Date form was requested
Date form was issued
Date received at:
DWP office date stamp
Local authority office date stamp
A claim form for Housing Be
Council Tax Benefit
If you are just claiming Second Adult Rebate, only fill in Parts 1, 3, 14, 15, 16 and 17 of this form.
Are you (ple
a council ten
a private tena
Part 1 Ab
ou and your part
Do you ha
We use
er who normally lives with you?
o mean
ou are married to or a person you live with
d to them, or
vil partner or a person you live with as if you are c
You
Surname or family name
Other names
Any other names you have used
Title (Mr, Mrs, Ms, other)
Address

Roles

The scenarios predict the roles described below, it is likely that others will become apparent as the service operates. The numbers of each will need to be flexible, within the scope provided by income, to cope with demand that is hard to predict at this stage.

Nurses & health visitors

Nurses and health visitors will provide the leadership for this service. Their skills will be balanced between the social, mental and physical needs of the user population. They will refer, prescribe, diagnose and evaluate; they will also befriend and lead activities. We foresee the need for at least one Community Psychiatric Nurse as well as links to external service providers for crisis and long term serious mental health issues.

General Assistant

This person will provide general assistance to the nurses. They will be responsible for finances, facilities, purchases and communications. They will also provide reception and telephone cover, befriend and lead activities

Counsellors

We can see needs for people skilled in dealing with personal and family issues arising from drug and alcohol abuse, sexual health and parenting. Broader needs exist for advice on anger management, diet and activity, employment and finances, and 'life skills' such as cooking, shopping, birth, death, education, literacy and numeracy.

Outreach

We foresee a continuation of these services to refugees, asylum seekers, drug and alcohol users and sex workers. We also see benefits in connecting with the Assertive Outreach Team for 2 way referrals and support. See also Platforms below.

Befrienders

These people will be present whenever the service is open, they will greet clients, give tours, explain facilities, encourage participation or just chat. Where possible, they will be drawn from the service user population.

Volunteer Coordinator

This person will arrange the programme of activities and ensure there are volunteers or experts to lead and support each activity. They will train Specialist Activity Workers and help them deliver excellence. They will take bookings for the spaces we offer and be responsible for the marketing of the space, facilities and services.

They will help encourage people to get engaged in the activities. They will identify and develop service users who could progress into responsible roles – leading activities, providing security or cleaning in the centre – this will entail organising training and development opportunities.


HELLO
my name is

Mark

Mark is a 24 year old single factory worker and is worried that he may have AIDS. He has a good relationship with his GP but feels embarrassed about talking about his sexual health with him and is worried that his local health centre won't be able to give him the HIV test he needs. He hasn't told anyone else about his concerns and he'd really like to talk to someone.

He first heard about OpenDoor from a friend and he had seen a sticker on the back of a pub toilet door.

He comes into the centre with a friend, goes to the information point and is asked by the General Assistant which of the services he would like to access today: talking to someone, seeing a nurse, etc.

He points to the nurse icon, the General Assistant checks him in, gives him a spoon and an idea of how long he'll have to wait. He's then told about the photography workshops that are on that day and the other facilities that he can use: library, café, pool table, etc.

He goes with his friend to the café and sits down to use the internet.

A nurse locates Mark by the number on his spoon and asks him if he would like to talk here in the café or go somewhere a bit more private. They move to a quiet room where he explains his worries to her.

After talking things through and explaining the process to him and gives him information and contact details of relevant support groups.

She explains that he can collect his test results in 10 days and that a member of the team will be there to give him his results.

Finally she asks if he is OK or would like someone to sit and talk it though with him now. He is made aware that they are there if he needs more support.

Roles
General Assistant
Nurse
Counsellor

Tools
Information point
Café
Library
Computers with Internet
Clinical equipment
Spoon system
Booking system
Activities
Links to other medical establishments/labs

Rules
We'll do what we can for you now and arrange for any specialist care as soon as possible
We'll give you the time and space you need to talk things through
We never embarrass you

Platforms
Café
Referral system
Private rooms
Links to medical institutions/labs