

## Coproduction: A Briefing Paper

The purpose of this briefing paper is to explore the concept of coproduction and look at how to apply the underpinning principles of this in meaningful and practical ways to service developments within a health care setting.

### *What is coproduction?*

There is no absolute definition for the concept of coproduction, but the following is a frequently cited quote which encapsulates the essence of it: “Coproduction means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change” (Boyle & Harris, 2009).

The cost-efficiency of services has become paramount in the current economic climate, but a model of public service provision based on this notion can only deliver short-term reactive benefits and often overlooks the less tangible preventative benefits of other methods. The concept of coproduction has attracted much interest and discussion in recent years due to the potentially substantial economic and humanistic benefits it can offer by providing a radical new approach to transforming the model of public service provision to one based on relational as opposed to transactional methods (Parker & Heapy, 2006). Coproduction embraces interactive and dynamic processes where services “...work with, rather than do unto...” service users (Cummins & Miller, 2007), moving away from traditional top down consultative processes. Rather than viewing service users as passive recipients of care, the philosophy of coproduction emphasises that they should be recognised as experts by experience with unique skills and knowledge; one such example of this in Wales is the *EPP CYMRU (Education Programme for Patients- Wales)* which was derived from the *Expert Patient Programme*. Harnessing these skills and knowledge by actively engaging service users as partners in coproduction to shape services through co-commissioning, co-design, co-delivery and co-assessment (Governance International, 2013), can have far reaching benefits on a number of levels; the extent of which is only just beginning to be researched and unearthed.

### *Benefits of coproduction*

Developing services in coproduction with service users by not merely acknowledging their views, but by incorporating them into service developments, can make them feel valued and empowered (WAG, 2004); this can create more personalised care, leading to increased autonomy and

recovery. Engagement from service users allows for the exploration of issues from a range of different and innovative perspectives, which creates services that better meet the needs of those that use them and makes them more effectual. Shifting the balance of power to those that use or are affected by services, helps build resilient communities that are able to solve their own problems (SCDC, 2011). Service users provide a wealth of previously underutilised resources both in terms of knowledge, skills and manpower and by facilitating their investment in services they are more likely to continue to engage and cultivate services, making them more sustainable.

### *Difficulties of coproduction*

Coproduction necessitates a cultural shift to a holistic perspective of individual needs, which requires an integrated health and social care approach. However currently, most health and social care services in the UK run parallel to each other and to work together co-productively on service developments may bring issues in terms of finance and governance (Boyle, Slay & Stephens, 2010). Because the economic and humanistic benefits of coproduction are not necessarily immediate, adapting successful approaches to scale and creating a body of evidence for people to invest in the approach may take some time. The shift in the balance of power between professionals and service users in coproduction can create anxieties in relation to issues such as risk and with existing policies and procedures acting as barriers as well, this may create organisations that are resistant to change. Ensuring that the philosophy of coproduction is entrenched into the culture of healthcare services requires investment in staff training to help them understand the principles and significance behind working this way, enabling them to feel confident in applying coproduction in practice. Although coproduction does have some difficulties in its current application, the philosophy behind it and evidence to date promises enticing rewards if services can play the 'long game'.

Coproduction can be achieved through a myriad of activities and can take on many forms, but generally it is possible to recognise it as it includes the following six characteristics (Boyle, Coote, Sherwood & Slay, 2010): 1.) Recognising people as assets. 2.) Building on people's existing capabilities. 3.) Mutuality and reciprocity (building reciprocal relationships with service users which have mutual responsibilities and expectations). 4.) Peer support networks (engaging peer support networks is an effective way of transferring knowledge and supporting change). 5.) Blurring Distinctions (blurring distinctions between service users and staff can help build strong working alliances, promoting equality and respect). 6.) Facilitating rather than delivering.

It is also possible to understand coproduction as occurring at three different levels on a continuum from the least to most transformative (Needham & Carr, 2009): Description-Coproduction may be experienced simply as compliance or a transaction between service users and services. Recognition-Coproduction may be experienced as consultative, with services recognising but not utilising the full potential of service user contributions. Transformation-Coproduction may be experienced as a collaborative equal partnership between service users and services, with each being afforded the same level of input, respect and power.

Coproduction is a tailored process and there is no one size fits all approach, however models can provide a useful structure to guide services in how to practically apply the philosophy. Very few models of coproduction exist, but three coherent models are briefly presented below:

- The Common Assessment Framework for Adults (CAFA, 2012) produced a five step model of coproduction:
  - 1.) Identify every group which will be affected by the project or service
  - 2.) Engage with the groups which will be affected by the project or service
  - 3.) Empower participants
  - 4.) Agree how the project will be governed
  - 5.) Deliver.
  
- Dr Alison Hill presented a five step co-production model for health and wellbeing for the NHS Solutions for Public Health department (NHS SPH, 2012):
  - 1.) Involving people and their communities
  - 2.) Forming partnerships with organisations/ elected members
  - 3.) Identifying needs
  - 4.) Identifying and agreeing priority action
  - 5.) Delivering change.
  
- As part of the 1000 Lives NHS Wales 'Tools for Improvement' series of documents, Spencer, Dineen & Phillips (2013) created a six step model of co-producing services:
  - 1) Build the initial team
  - 2) Define and share assets
  - 3) Co-create the vision
  - 4) Co-design the solution
  - 5) Co-delivery
  - 6) Co-Evaluate

Essentially working collaboratively in equal partnership with service users to design, develop and deliver services is at the heart of the philosophy of coproduction. To take this concept back to its basic form, the first step on the path to coproduction is for services to effectually engage service users in this process.

## ***How can services effectually engage service users?***

There is much discussion and emphasis placed on the importance of working with service users in the literature on coproduction; however the realities of doing so are not often detailed. The Five Step Model of Coproduction (CAFA, 2012) states that the first step is to identify all groups that will be affected by the service development both directly i.e. patients and indirectly i.e. carers, families and communities. However this could prove to be an extensive list for a working party, therefore there is a need to balance inclusion with practicality. Prior to approaching service users to engage in the coproduction process it is important to be clear about the purpose and expectation of involvement, which in the true spirit of person-centeredness will allow service users to choose the level of engagement they are willing to offer based on this information (GSCC, CSCI, Skills for Care & SCIE, 2007). The level of agreed engagement will then help inform the stage (Governance International, 2013) and method of engagement.

There are various methods to engage service users, such as approaching established forums, developing bespoke focus groups, conducting semi-structured interviews or administering questionnaires. Approaching established forums or bespoke focus groups can be an effective way to identify a small working party of service user representatives and by involving them directly in meetings they have a chance to not only contribute to but also shape discussions. However one common criticism of forums and focus groups are that they may not provide a truly representative service user sample and foster idiosyncratic groups views, due to being less accessible to those that are less confident and/or articulate and as a result of the proportionately small numbers involved (Gibbs, 1997). Conversely the same argument could be extended to professional working parties, which are usually dominated with managerial/ senior levels of staff rather than front line staff. Conducting interviews and questionnaires means that a potentially bigger and broader spectrum of views can be captured and it may reduce some of the barriers for those that are less confident and/or articulate. However this could be viewed as a tokenistic level of service user involvement as the questions have been predetermined by a professional agenda and therefore the service user involvement cannot effect any real systematic change. Ultimately it may be that several methods are used in tandem to maximise service user engagement.

In order to work effectively in coproduction, it is important to be sensitive towards what will help facilitate service users to feel more comfortable and confident to engage openly and to make adaptations accordingly. Therefore the next issue to address is how to support service users to get involved by building confidence and breaking down barriers. It is important that service users feel able to understand and analyse the information and views presented during meetings to enable them participate fully, one way to do this for those that need it would be to use a buddying system to pair the service user with a professional (NLIAH, 2010). It is important for everyone to be aware of their roles and responsibilities within meetings and generally within the service development project, so there should be a clear coherent written vision that everyone is aware of so that those involved are all 'singing from the same hymn sheet'. A collaboratively created set

of ground rules can help foster an environment of mutual respect, which will hopefully enable service users to feel protected and confident in sharing their views.

It is also important to acknowledge any practical barriers to engagement and explore ways to overcome these. Examples of this may include looking to see whether there are any specific learning requirements i.e. large print materials, avoiding unnecessary jargonistic language, hearing loop induction systems and the accessibility of meetings by providing them in a suitable space and at a suitable time in consideration of service users that may have physical health concerns or experience time of day effects from medications (NLIAH, 2010). If service users are to be expected to contribute their time and expertise it is important that this is recognised and valued, therefore the remuneration of any out of pocket expenses might be an important practical and equitable issue to approach; as it would seem only fair if professionals are entitled to that that so are service users.

Creating an atmosphere of mutual trust and respect is central to building strong working alliances. It is important for all those involved in working parties to receive and respond to feedback appropriately. The views of service users should be incorporated into action plans and if not a rationale should be provided for this, otherwise service users may feel that their views are not being heard and disengage from the process. Communication between professionals often occurs outside of meetings via email and for a variety of reasons service users may not be able to be included in these discussions, which may undermine the effort of coproduction. 'The 4Rs of working together' (NLIAH, 2010) suggest that in order to ensure effective partnership working that all parties bare these four principles in mind: Role, Remit, Relationships and Responsibility.

Below is a simple step by step summary based on the information discussed in this paper, to help services get started on engaging service users to begin the process of coproduction:

- 1) **Identify** who will be affected by the service development
- 2) **Select** who to invite to engage in the coproduction process
- 3) **Be clear** about the purpose and expectation of service user involvement
- 4) **Choose** the level, stage and method of engagement
- 5) **Support** service users in their involvement both practically and emotionally
- 6) **Build** strong working alliances
- 7) Make sure everyone **understands** their role, remit, relationships and responsibility

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