Coproducing Health – a briefing

Becky Malby, 2014

"Co-production is an idea whose time has come…people's needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done." Boyle et al 2010

This briefing is the briefest way we could find to describe the excitement and challenges of coproduction for people who are very new to the ideas.

Definitions

Co-production – people who use services contribute to the production of services. Needham, 2009

"[co-production is] about broadening and deepening public services so that they are no longer the preserve of professionals or commissioners, but a shared responsibility, both building and using a multi-faceted network of mutual support" Stephens et al 2012

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way both services and neighbourhoods become far more effective agents of change" Boyle and Harris 2009

Core values

Whilst the NHS attempts to institutionalise coproduction, at its heart coproduction brings the actions of individuals in communities together with those in authority to make decisions – doing with rather than too or for. There is a fundamental shift in power from the hierarchy to a partnership or network relationship. (Dunstan 2009)

Traditionally the label 'service user' demonstrates that the patient is a passive recipient of services and 'professional' is the title for those that deliver the service and thus hold the power (Cummins and Miller 2007). In coproduction both groups become equal partners.

Voice, Choice and Coproduction

Public services have three distinct relationship with citizens. The difference then describes the process by which public services relate to citizens

	When	How
Voice	Where (a) The service delivery is distinctly the responsibility of the services, and you require feedback in order to do your part better (b) Citizens are members of public services and have a day in spending decisions and strategy	Through (a) Surveys, interviews to generate feedback data (b) Public engagement events with members to inform strategic choices
Choice	Where (a) Citizens are offered and can make choices in the nature of the services to meet their need (shared decision-making) for example choosing drugs or lifestyle interventions to treat high blood pressure (b) Citizens choose which provider to access for their services	Through (a) Consultations with professionals using best – practice evidence to show the options and their impact (shared decision-making tools) (b) At consultation or by active access (see Barriers to Choice Review)
Coproduction	Where citizens are equal partners in determining the problem, the solution, delivering the solution, and evaluating the impact of that delivery	Through full participation as an equal player throughout the whole process

What you will see

“Genuine co-production will always:

- Define public service clients as assets who have skills that are vital to the delivery of services
- Define work to include anything that people do to support each other
- Include some element of reciprocity
- Build community (sustainable networks of support)
- Support resilience (opportunities to take risks and learn)”

Stephens et al 2012 p. 16

6 Principles of Coproduction

Assets: Transforming the perception of people from passive recipients to equal partners.

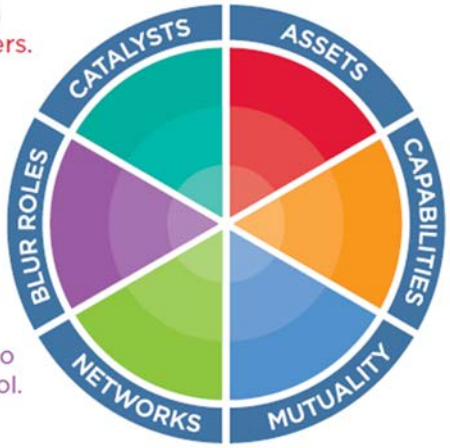
Capabilities: Building on what people can do and supporting them to put this to work.

Mutuality: Reciprocal relationships with mutual responsibilities and expectations.

Networks: Engaging a range of networks, inside and outside ‘services’ including peer support, to transfer knowledge.

Blur roles: Removing tightly defined boundaries between professionals and recipients to enable shared responsibility and control.

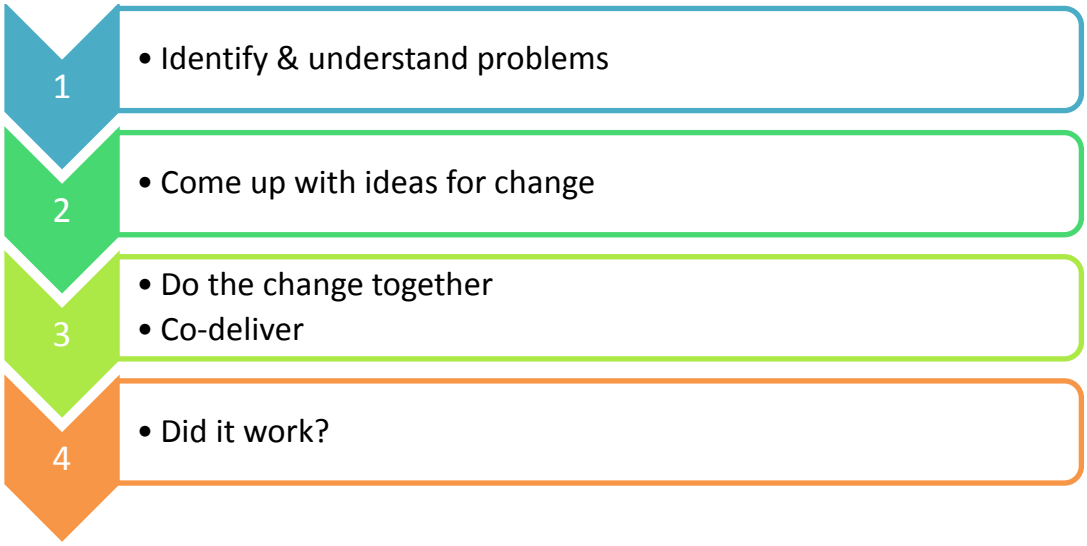
Catalysts: Shifting from ‘delivering’ services to supporting things to happen and catalysing other action.



People Powered Health Coproduction Catalogue

How to do it

There are 4 clear steps:



And some clear principles

- Start with listening
- Treat all people as assets – use everyone's skills and strength to build services; provide opportunities for everyone to develop and grow
- Find out what we are ambitious for together
- Invest in the development of communities so they can be partners – encourage don't judge
- Value and make the most of peoples expertise gained through experience – allow people to be who they really are
- Do with not do too - Challenge 'them' and 'us' we all need to be providers and users; 'givers' and 'getters'
- Professionals - ask how you can help people help themselves
- Take time to get to know each other and find other people who could contribute – build social networks

(Coproducing Leeds – Impact 2011)

Coproduction and Co-design

"The difference between co-design and co-production is that co-design addresses the problem and a solution is identified whereas co-production embeds the solution into reality. Co-creation is identified as the way in which both of these are addressed"

McDougall, 2012.

What difference does it make?

"Increasing evidence shows that engaged and informed patients achieve the best health and quality of life. They are more confident and better prepared to manage their condition – and are often more inspired to work with health professionals toward achieving shared health goals." The Health Foundation, 2008

Research shows that Coproduction:

- Improves Health Outcomes
- Improves Experience
- Improves knowledge
- Relieves pressure on services
- Doesn't cost more and in some instances has been shown to cost less
- Constrains demand which has knock-on effect in terms of sustainability
- SROI can demonstrate equivalent savings but difficult to know if these have materialised (money just gets eaten up elsewhere)

And that

- Professionals roles change from transactional work to building and sustaining relationships between people and services

Lessons from practice

Don’t do coproduction if:

- You think you know precisely the service that you require.
- You aren't prepared to fail.
- You can't leave your agenda (or strategy) at the door.
- You can't regard your critics as your prime resource.
- You can't regard peoples' outrage as important as your evidence, statistics and strategy.
- You haven't got access to all levels and all stakeholders.
- You aren't prepared for this to take far longer than you imagine.
- You can't afford to take lots of small steps to get where you want to go
- You think you might not be able to spot or value people's capabilities, time or energy.
- You haven't got someone facilitating the project that has good connections both above and below in the health organisation.
- You haven't got the funders behind you
- You think coproduction is a way to save money on services.
- You're not prepared to follow through with something meaningful to your participants.
- You feel that getting close to people, or rewarding them for their time and energy, may violate your ethics

Do do coproduction if:

- You detect ‘outrage' among some of your community, if people are banging the table about a service.
- There's doubt about the design of service you want.
- You need the active participation or acceptance of your service users.
- You're happy for your participants to take over your project entirely.
- You need a solution on the same scale as the problem, i.e. how else are you going to deal with obesity?
- You can be honest with people about your priorities and resources.

- You're prepared for ideas to come from anywhere and anybody.
- You're happy to go where your patients take you.
- You have the time and resources to maintain participants' energy during the dark weeks of the project.

Short history lesson

The origins of co-production can be found in the 1970s within the Nobel Laureate Professor Elinor Ostrum's work on fighting crime, when she used the term as a way of explaining why the police need the community as much as the community need the police, and Edgar Cahn's work as a civil rights lawyer, which you can find in his book 'No More Throw Away People' where he describes the asset based approach of time-banking.

It takes in political notions of power redistribution, (between institutions and communities; national and local; professionals and people) and organisational development notions of distributed leadership, systems change, and networks.

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