RESEARCH BRIEFING

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March 2009
Review date: March 2012

Co-production: an emerging evidence base for adult social care transformation

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Key messages

- **Co-production emphasises that people are not passive recipients of services and have assets and expertise which can help improve services.**
- **Co-production is a potentially transformative way of thinking about power, resources, partnerships, risks and outcomes, not an off-the-shelf model of service provision or a single magic solution.**
- **'To act as partners, both usersand providers must be empowered'.[5] Co-production means involving citizens in collaborative relationships with more empowered frontline staff who are able and confident to share power and accept user expertise.**
- **Staff should be trained in the benefits of co-production, supported in positive risk-taking and encouraged to identify new opportunities for collaboration with people who use services.**
- **People should be encouraged to access co-productive initiatives, recognising and supporting diversity among the people who use services.**
- **The creation of new structures, regulatory and commissioning practices and financial streams is necessary to embed co-production as a long-term rather than ad hoc solution.**
- **Learning from existing international case studies of co-production while recognising the contribution of initiatives reflecting local needs is important.**

Introduction

The term 'co-production' is increasingly being applied to new types of public service delivery in the UK, including new approaches to adult social care. It refers to active input by the people who use services, as well as – or instead of – those who have traditionally provided them. So it contrasts with approaches that treat people as passive recipients of services designed and delivered by someone else. It emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to effective public services. In the words of Cummins and Miller, co-production is about how services 'work with rather than do unto users'.[6]

Co-production has been the focus of much recent attention, within both public policy and practice. It relates to the generation of social capital – the reciprocal relationships that build trust, peer support and social activism within communities. Co-production is also being used

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as a way of talking about participation and community involvement in social care services in the context of personalisation. The Putting people first concordat asserts that the transformation of adult social care programmes 'seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage'.[1] This applies to adult social care service providers from all sectors. In proposals for new ways of organising and delivering social care services, people who use services have suggested that 'service user controlled organisations can be a site where social workers are employed working alongside service users in a hands on way'.[7] This encapsulates the essence of co-production in adult social care.

Given its increased profile, it is important to clarify definitions of co-production and assess its impact. Although there are no large-scale evaluation initiatives, a number of reports (from academics, policy organisations and practitioner groups) offer theoretical refinement and evaluation of practice examples, which together give some indication of the potential for co-production to be developed within adult social care. The reports also highlight potential concerns and limitations which need to be addressed when considering co-production as a way of transforming public service development and delivery, particularly in relation to adult social care.

What is the issue?

Public services have always relied on input from their users – be it pupils doing their homework, people remembering to take their medication or neighbourhood watch schemes contributing to local crime prevention. The term co-production itself dates from the 1970s, a time when movements to challenge professional power and increase citizen participation in community affairs coincided with efforts to reduce public spending. Academics in the USA in the 1970s explored how to harness more effectively the input of people who use services, focusing particularly on municipal services such as waste collection, parking, road maintenance and neighbourhood policing.[8–11]

In the early 1980s, the language of co-production largely disappeared from use. UK policy-makers favoured market approaches and an increasingly managerialist culture, which emphasised the separate interests of service producers and consumers, rather than the value of collaboration.[12,13] However, the co-productive insight – that the people who use services have expertise and assets – continued to be evident in a range of reform movements outside the mainstream, including the independent living movement,[14] time banking,[15] mutualism[16] and co-operatives.[17]

The return of co-production – also called co-creation and parallel production – as a mainstream idea in public policy in the last few years has coincided with various pressures for reform including:

- a crisis of faith in target-based and process-driven models of service delivery
- a call for 'double devolution' of power, down to town halls and out to frontline staff and citizens along with the promotion of the idea of 'place shaping' in local government[18–20]
- pressures to increase service efficiency and reduce public spending[21]
- the growing awareness of new types of knowledge, particularly that which is user-generated[22,23]

- a desire to reinvigorate local democracy[17]
- a determination to make social care services more personal though the effective participation of the people who use them.[24]

Co-production has something to offer the implementation of these reforms, which highlights both its popularity and the ambiguities surrounding its definition. Its supporters see it as a different way of thinking about public services, with potentially transformational consequences, as people who use services take control of defining and managing their care.

Why is it important?

Co-production is clearly relevant to a range of recent initiatives within social care policy and practice in the UK. In public services in general, and social care in particular, the government has committed itself to a more collaborative role for people who use services as part of a personalisation agenda, involving people more directly in shaping services, as well as managing the attendant costs and risks.[1,25,26] Person-centred planning, self-directed support, individual budgets and initiatives such as Connected Care have been cited as examples of co-production, given the emphasis on people choosing and managing their own packages of care in partnership with professionals.[6,27,28,29] The emerging Local Involvement Networks (LINks) have the potential to create new roles in shaping service planning and outcomes. The transformation of adult social care will rely on the partnerships with user-led organisations, the involvement of which is clearly cited as necessary by government.[1,30] Together these approaches reflect a broader policy focus on 'public value' rather than narrow, financial definitions of value,[31,32] and on involving citizens in collaborative relationships with more empowered frontline staff.[7,33–35]

However, advocates of co-production warn against its capacity to respond to all aspects of public service reform – some public services may be more amenable than others to co-productive solutions. Although co-production has much in common with initiatives to encourage user involvement, it is not the same as consultation or the types of tokenistic participation of people who use services and their carers which do not result in meaningful power-sharing or change.[7,36,37] Consultation exercises ask for feedback on a service and can often result in no real change for the person using the service.[38] Co-production demands more active involvement and decision-making by the person using a service, and puts more emphasis on 'relational' rather than 'transactional' approaches to delivery.[38,39] In other words, it sees service outcomes as achieved through person-centred relationships on the frontline, rather than mechanised service-centred delivery to a person who can then express satisfaction or dissatisfaction.

There is uncertainty about how far new policy directions in social care can be classed as co-productive. The personalisation agenda, central to the reform of adult social care,[40] can encompass a greater role for the people who use services as 'co-designers and co-producers of services'.[24] However, not all tools for personalisation are necessarily co-productive and much depends on the definition of co-production being used. A recent New Economics Foundation (Nef) report expressed doubt about social care individual budgets[41] being considered a form of co-production, since they have led to individuals being encouraged to 'buy solutions' (including 'buying people to keep them company') 'rather than have an active stake in delivering (or "producing") their own solutions'.[42] Nef's conception of co-production is based on the idea 'that people need to be rooted in mutual support networks, and that not everything can be

bought'.[42] Thus the scope and impact of co-production depends in large part on how it is defined. A key limitation of co-production is its 'excessive elasticity', evident in the various ways in which it has been defined and interpreted.[43]

What does the research show?

This section looks at findings from wider international research on co-production in public services in general.

Although co-production relies on a very simple definition – people who use services contribute to the production of services – the details of how this is applied to public services in general, and social care in particular, are more complex. All of the following aspects of co-production can vary.

Who is co-producing?

Co-production is sometimes described as a collaborative relationship between the people who use services and the formal service provider (be it a social worker, teacher, nurse or housing officer). By emphasising the importance of dialogue and negotiation between frontline staff and the people who use services, it offers an alternative to confrontational or gatekeeping models where citizens petition staff for access to scarce resources.[43] A somewhat different model of co-production envisages it as a form of mutual aid between the people who use services; a corrective and a challenge to the dominant role of the professional: 'the role of the professional needs to shift from being fixers who focus on problems to becoming catalysts who focus on abilities'.[44] Some versions of co-production also envisage the involvement of volunteers, i.e. people who contribute to a project without directly benefiting from it.[8,45]

How many people are involved?

Some accounts of co-production focus on face-to-face relationships between individuals in the frontline service delivery context (user-professional; user-user; user-volunteer), whereas others offer a more collective version involving groups of users and/or multiple professionals.[11,45] Collective forms of co-production are generally seen as more beneficial than individualised forms, either because they affirm the interwoven relationships of multiple stakeholders,[45] or because the assets and skills generated by co-production can be more widely distributed.[46] Some have argued that 'co-production has to be more than a one-to-one relationship between doctor and patient'.[47]

At what stage does co-production take place?

Co-production can occur at the point of service delivery. It is also perfectly possible to involve the people who use services in the early stages of service planning, design and commissioning and in the later stages of managing, monitoring and evaluation.[45] Part of the co-productive challenge to traditional public services is to refute the very notion of 'individual "consumers" at the end of a long delivery chain stretching from Whitehall to the frontline'.[27] Instead there should be a focus on 'interdependent citizens embedded in a wide network of support, including formal public services, as well as a host of less formal interactions and relationships'.[27] Some have emphasised the importance of involvement in 'co-design', 'identify[ing] the kinds of problems to which a service responds, rather than just giving people a say in the answers to pre-defined problems'.[48] Co-production can also be incorporated into management,[49] involving the many people and agencies that co-produce aspects of a service. While some services may need to be delivered on an individual level (for reasons of confidentiality, for example), other

stages of the service process can involve input from groups such as user organisations.[45]

What is contributed?

Co-production may entail different sorts of input from participants including time, activity, skills, expertise and/or social interaction to the service. There is a common emphasis on a creative, productive input from those traditionally positioned as the consumers of services.[8] Some of the contributions may be highly influential but often intangible, such as a contribution to the 'culture' within which a service is delivered[50] or a greater understanding of the constraints that service providers are under.[8,51]

Some contributions from the people who use services may involve making the existing service work more effectively, such as providing information and advocacy to enable choice, whereas others may lead to more transformative models of co-production, such as user-led management or delivery of a service.[16] Some contributions may be generated by people who use services wanting to play a more active role – such as getting involved in the NHS Expert Patients programme or the Commission for Social Care Inspectorate Experts by Experience initiative – whereas others may be about greater responsibilities being placed on the people who use services, such as requiring parents to sign home-school contracts.

There is a tendency in some policies to 'impose' co-production as a solution to some of the difficulties faced by disadvantaged communities.[45] Research on some community-level co-productive approaches to designing citizen-centred governance showed that 'citizens and service users in disadvantaged areas receive considerable demands to become involved in governance of their communities. They face a double disadvantage, as they have to negotiate the complexities of public service delivery to meet their immediate needs and also respond to the many consultation initiatives set up by the various institutions of community governance'.[52]

How does co-production relate to other forms of citizen participation?

Some authors have linked co-production to a general increase in citizen empowerment and democratic invigoration.[17] However, its emphasis on the service delivery process means that co-production is not generally presented as a replacement for other forms of advocacy and democratic involvement. Advocates of co-production argue that it should not be used as a tool to co-opt people who use services into collaborative relationships in order to neutralise challenges to the status quo.[8,45]

What are the different levels of co-production?

Depending on the answers to the questions above it is possible to understand co-production on three different levels from being less to more transformative of services:

1. At its least transformative, the people who use services may experience co-production simply as a **description** of how all services, including those in the private sector, rely on some productive input from users.[49] At the minimum this input may be just compliance with legal or social norms (such as making way for an emergency vehicle or not dropping litter,[53] although it could also encompass children doing their homework or people taking medication. This approach simply restates existing approaches to public services as co-productive, and fails to acknowledge the potential for more effective use of productive capacities or creating social capital.

2. At the intermediate position, co-production can be a tool of **recognition** for the people who use services and their carers, acknowledging their (usually uncosted) input, valuing and harnessing the power of existing informal support networks and creating better channels for people to shape services.[27,44,45] This improvement-focused form of co-production envisages 'more involved, responsible users',[24] who are invited – although perhaps also required – to make a greater contribution to the service.[12] Associated with a broader 'politics of recognition',[54] this approach can promote increased understanding between multiple stakeholders. People who use services come to have a greater understanding of 'the content, costs and limitations of municipal services and their joint responsibility with service agents for their delivery'.[11] Those who deliver services can become more attuned to the individual circumstances, needs and preferences of the people who use them.[55]

   An example of this recognition level of co-production is the Shared Solutions project, commissioned by Unison and the National Consumer Council (NCC). It found that a workshop involving social housing tenants and officers facilitated the identification of problems and priorities and 'allowed frontline staff and service users to share expertise and recognise a common agenda.[43] However, in what was described as an under-funded service, subject to tight performance management from the centre, it was difficult to move beyond the 'mutual recognition' stage to the transformative level with longer-term shifts in power and resources.

   This level of co-production offers a way to acknowledge and support the contributions of service stakeholders, although without necessarily changing fundamental delivery systems. There is a danger that it can be a device to legitimise existing approaches, helping the people who use services better to understand the strains that providers face, rather than changing organisational cultures and improving service provision.

3. At its most effective, co-production can involve the transformation of services. The transformative level of co-production requires a relocation of power and control, through the development of new user-led mechanisms of planning, delivery, management and governance. It involves new structures of delivery to entrench co-production, rather than simply ad hoc opportunities for collaboration. It can be 'a form of citizenship in practice'.[56] It brings professionals and the people who use services together to identify and manage new and existing risks. According to Bovaird, 'the service user has to trust professional advice and support, but the professional has to be prepared to trust the decisions and behaviours of service users and the communities in which they live rather than dictate them'.[45]

   This transformative model is challenging to realise. How the distinctions and dilemmas of co-production play out depends very much on the type of public service: co-production in public transport will generate a very different set of conditions and concerns than co-production in education, health or – the focus here – social care.

What does social care research show?

This section looks at findings from wider research on co-production, specifically in adult social care services.

The nature of adult social care makes co-production particularly apt, but there are distinctive challenges to its implementation. Co-production is especially relevant for areas in which services are individualised, site-specific and of sustained importance to people's lives, requiring ongoing dialogue between many people and agencies and frequent review.[4] Adult social care services meet all of those criteria. People who use services are by necessity strongly involved in the production of their care and notions that they are passive consumers of services produced for them by others are particularly inappropriate.

Thus co-production is not a new delivery mechanism for social care services. It is an approach which affirms and supports an active and productive role for people who use services, and the value of collaborative relationships in delivering the outcomes negotiated with the person using the service.

Over the last 30 years, the service user and disability rights movements have promoted the idea of people who use services as active participants with resources, rather than passive dependents with needs resulting in innovations such as direct payments. The associated move towards 'personalisation' in adult social care services can be seen as a continued response to this need for choice and control.[1] Service user and carer movements, professional bodies and the policy community have called for services to be designed around the people that use them, rather than matching people to services.[40] 'Deep' forms of personalisation within social care have much in common with co-production and raise similar issues.[24] These issues vary, depending on the type of co-production being used and the groups of people involved.

Who is co-producing in adult social care services?

Social care services involve a diverse range of people and many types of service provider including paid and unpaid carers, local authorities, voluntary organisations, user-led agencies, social enterprises and the private sector. Some co-production should already occur in assessment processes, particularly in self-assessment. Good practice in care management is also facilitated by co-production, where the people who use services, service commissioners and providers negotiate an appropriate care package. It is also evident in the daily negotiations between carers and the people who use services. The collaborative dynamic of co-production raises opportunities to think creatively about new types of relationship. For example, some people may be involved in formal or informal staff roles, while also using services themselves.

However, as with user involvement more generally, issues of power are central and need to be addressed.[36,57] In many cases 'service users are still reliant on "expert" providers who define what the service is and who shall gain access to it'.[16] Co-production depends on a redefinition of people who use services as experts rather than dependents. This expertise needs to be recognised and mobilised in ways negotiated with the individual.

A number of authors on co-production warn that professionals may be resistant, unless co-production is associated with an increase of resources rather than a threat to status.[8,58,59] Rather than ignoring tensions or conflicts between professionals and users, or between other sets of stakeholders, they should be 'discussed openly'.[4,5,60]

There is a strong argument that frontline staff are central to the delivery of co-produced services

and should also be empowered.[5,44] 'Staff need more interpersonal, facilitative skills – rather than just having a rigid, delivery focus. To achieve this, staff morale is as important as client morale – in practice, the participation that they are asked to extend to clients is often not extended to them'.[44]

How many people are involved?

Co-production takes both individual and collective forms in social care. Relationships between people who use services and carers (formal and informal) will often be one-to-one and in the home. However, care takes place in a multi-agency context and in different settings (in the home, community and in residential settings), requiring negotiated relationships between a range of planners, commissioners, providers, workers and regulators. If co-production approaches are rooted in the creation of structures for association and shared learning, they can help to address the isolation faced by people who use services and their carers, facilitating peer support and encouraging shared learning. However, it is necessary to be sensitive to and open about differences between the values, incentives or perception of roles between different stakeholders.[45]

What is contributed?

Co-productive approaches assume that people who use services have expertise and assets, which are essential to effective service systems. The resources of people who use services can contribute to meeting either their own needs or those of others. Co-productive approaches also emphasise the expertise of frontline staff and the positive outcomes that come from close and sustained relationships between staff and the people who use services. In such systems the health and care benefits may be incidental to mutual exchanges that build relationships and enhance the power, influence and activity of individuals and communities, sometimes called social capital.[47,61]

How does co-production relate to other forms of citizen participation?

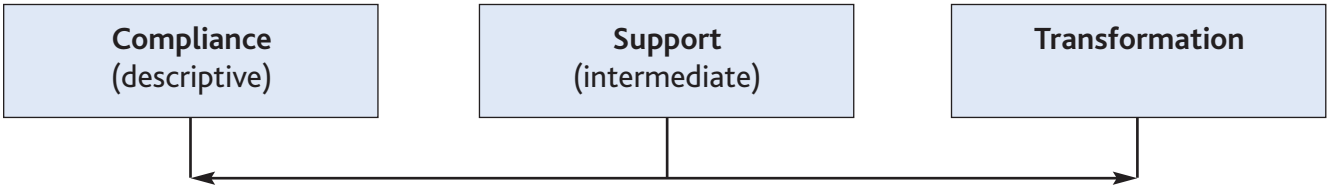
Co-productive approaches emphasise the importance of dialogue and negotiation between people who use services and providers. However, most advocates of co-production in social care are keen to point out that it should complement rather than replace the work that people do individually or in organised groups to challenge and critique existing services.[56]

How does co-production take place in adult social care services?

This section relates to the section above on the different levels of co-production in general (description, recognition and transformation). It examines the different types of co-production in adult social care services (see Figure 1 below).

The research suggests that the three different types of co-production in adult social care services are as follows.

Figure 1 shows how the different types of co-production in social care can fit on a scale:



1. **Descriptive** co-production already takes place at the stage of service delivery, as people who use services and carers collaborate to achieve individual outcomes. The people who use services already make contributions to each stage of the service provision process (assessment, planning, commissioning, monitoring, evaluation) even if it is not recognised as co-production. However, if co-production is to reshape social care services, Hunter and Ritchie are clear that the people who use services must be involved in **problem definition** as well as developing and implementing solutions,[4] Flexibility to the priorities of people who use services may, however, clash with service regimes built on existing targets, funding streams, hierarchies or attitudes to risk.[45,59]

   The descriptive model of co-production in relation to social care involves the insight that care services cannot be produced without input from the people who use services, even if that is only **compliance** with an externally-imposed regime. It has been suggested that some managers may be ignoring even this basic form of co-production, failing to manage inputs and risking staff burnout.[49] However, even with better management, compliance models of co-production offer little substantive change by or for the people who use services – the 'ritual of co-production may very well perpetuate regimes of control/containment for mental health patients that have little efficacy'.[50]

2. The **intermediate** level of co-production involves a much fuller recognition and valuing of the many people who together co-produce care outcomes, with an emphasis on mutual respect. For example, the aims of the NHS and Community Care Act 1990 which recognised the importance of informal carers and required local authorities to create mechanisms of **support**, could fit into this intermediate understanding of co-production.[49] It may include a more expansive role for groups of users in the recruitment and training of professionals and managers.[56] This model may also involve new responsibilities being imposed on the people who use services, leading to concern that co-production can be used as a way to manipulate people who use services or more successfully exploit their labour.[49]

3. The **transformative** level of co-production in social care has the potential to create new relationships between the people who use services and staff and to facilitate new and durable forms of peer support. It repositions the service user as one of the experts and asks what assets they can contribute to collaborative relationships which will transform provision. It takes 'a whole life focus', incorporating broader quality of life issues, rather than just clinical or service issues.[4] The people who use services can be involved in shaping the ethos of care and in empowering frontline staff as well as themselves.[62] However, some people are already able to be active citizens and take advantage of the opportunities that co-productive approaches will offer, whereas others are very disadvantaged, both socially and personally.[7,52] This situation needs to be carefully considered when developing transformative approaches for different people and different social care contexts.

   The transformative approach can come closest to fulfilling the demands of the *Putting people first* adult social care transformation agenda.[1,63] However, when employing this model of co-production, adult social care services should not lose sight of their role in promoting social justice and

should 'aim to achieve a fair distribution of outcomes, paying particular attention to the narrowing of unjust inequalities (such as between people from different social class backgrounds, or of different gender, ethnicity or sexuality)'.[64] Research has also indicated that 'co-production, where it has been happening successfully, has generally been outside nationally funded services that are supposed to achieve this, and usually despite – rather than because of – administrative systems inside public services'.[44] This needs to be considered when forging partnerships with non-statutory agencies, voluntary organisations and user-led organisations in Local Area Agreements.[63]

The extent to which the transformative model of co-production is realisable in practice, given the existing state of adult social care provision and the current lack of research in this area, is not yet clear.

The sections below examine some practice examples from the international research, all of which were described by practitioners or evaluators as forms of co-production within adult social care. Together they indicate the key

Co-production examples in practice

Case studies of co-production from around the world

Members of a **time bank** share skills and companionship, based on time as the currency of exchange. It is an example of the mutual aid model of co-production, although professionals continue to play a key role in managing the credit system and facilitating access. Examples within the UK include the Rushey Green Time Bank and other time banks supported by SLAM (South London and Maudsley NHS Foundation Trust), as well as those outside London such as the Gorbals Time Bank. (For more information see **www.timebanking.org, www.nef.org.uk**)[3,65,66]

The **KeyRing** scheme supports people in their own homes, with a community living worker offering 10 hours of support to nine KeyRing network members per week, and facilitating interaction between members. The role of the professional or volunteer carer is to facilitate self-reliance and mutual support, based on the expertise and skills of the people who use the service.[67]

The French **Villa Family** programme brings an older person with a disability into purpose-built accommodation with a trained host family, within or close to their home village. The older people employ the host family (and have responsibilities as the employer) and can move if not satisfied. The older people are not financially dependent on host families – the state pays them a disability allowance.[45,68]

Western Australia's **Local Area Coordination (LAC)** scheme involves locally based area coordinators, each providing support to between 50 and 65 people with disabilities, and providing financial support, varying from one-off discretionary grants to ongoing and intensive support. The scheme is based on the assumption that services provided by government and community agencies complement and support the primary role of families, carers and communities in achieving a good life for people with disabilities.[69]

features of co-production in practice, highlighting its relevance for schemes that may not explicitly be labelled as co-productive. They also provide an insight into the strengths and limitations of co-production in practice.

Adult social care services which have been described as co-productive include time banking (such as the Rushey Green Time Bank and other time banks supported by SLAM , as well as those outside London such as the Gorbals Time Bank), the KeyRing project, France's Villa Family scheme and Western Australia's LAC programme. Not all of these initiatives have been subject to independent evaluation, but published accounts of some of them do give an insight into what ways and how successfully co-production has taken place.

All of these schemes involve the people who use services taking an active role in the production of outcomes they have had a key role in defining. Broadly, the contributions were of two types:[13]

1. those that facilitated **mutual aid or peer support** between the people who use services

2. those that enabled **collaboration** between professionals and people who use services.

These two approaches need not be mutually exclusive, but most of the practice examples emphasise one or the other.

- **The mutual aid approach** is best exemplified by the time bank model, facilitated and promoted in the UK by David Boyle and the Nef, among others. Members of a time bank share skills and companionship, based on time as the currency of exchange. One example is the DIY time bank in South London in which participants (mostly people who use mental health services) were trained to undertake DIY projects for other members of the time bank. In this model, professionals continue to play a key role – for example, in referring people to the time bank, and in managing the credit system – but the added value in the system comes from mutual aid or peer support between people who use services.[44]
- **The collaboration** approach involves recreating relationships between providers and the people who use services so that they are more collaborative and better meet the requirements of users. The French Villa Family project, the UK's KeyRing scheme and Western Australia's Local Area Coordination (LAC) programme (as described in the case box above) involve placing people who use services in familiar and supportive communities, rather than formal and segregated institutional environments.[45,67,69]

These schemes aim to **transform** the provision of adult social care, and focus on co-production at various stages of service delivery. There are also examples of co-production which can be classed as intermediate – **supportive** – forms, such as co-production as part of a collaborative assessment and review process.[70] Here a team at the University of York developed a template for 'outcome focused assessment and review documentation' in social care, designed 'to give people who use services the lead in their assessment and to direct professionals to act in an assistive and facilitative style'.[70]

Co-production has also been used within service monitoring and regulation. The Commission for Social Care Inspection (CSCI) developed an 'experts by experience' scheme to involve the people who use services as members of inspection teams, taking part in service regulation.[71,72] Again, this is an example of supportive co-production, aimed at improving existing service provision.

Together these practice examples help to draw out some of the key features of co-production, as well as factors which enhance and limit its effectiveness.

Central features of co-production in the practice examples

The following features were evident in some or all of the case studies.

1. **Co-productive approaches can be used with different people who use social care services.** The examples include people with mental health problems, for example, in the time bank initiatives. The Villa Family scheme focuses on older people. Those with physical disabilities are encouraged to co-produce through the outcome-based assessment run by the University of York. People with learning disabilities are supported in the community in schemes such as KeyRing and the LAC programme.

2. All the examples recognise that **the people who use services are experts in determining their own requirements.** KeyRing participants are recognised as 'experts on their own lives'.[67] The LAC programme is premised on the assumption that people with disabilities and their families have 'natural authority and are best placed to be their most powerful and enduring leaders, decision makers and advocates'.[69]

3. The schemes **enable people who use services to play an active role in meeting their own needs**, rather than positioning them as passive dependents. In the case of Villa Family, the older people employ the host family (and have responsibilities as the employer) and can move if not satisfied. The older people are not financially dependent on host families – the state pays them a disability allowance, thereby allowing them a degree of choice and control.

4. **The examples demonstrate mutual aid between people who use services, promoting new mechanisms of peer support.** In the time bank, this aid is formalised in the time credit system, but in other cases, such as KeyRing, the role of the professional or volunteer carer is to facilitate self-reliance and mutual support.[67] The Villa Family scheme places two older people and host families in each housing complex, recognising the support that they can afford each other.[45]

5. **The broader community (including families) are active in the production of support, offering a collective model of co-production.** The Australian LAC scheme is based on the assumption that services provided by government and community agencies complement and support the primary role of families, carers and communities in achieving a good life for people with disabilities.[69] In the Villa Family case, the hosts are monitored and regulated by the government, and overseen by a trust involving the mayor, the doctor, host families, the older people and their families.[45]

6. **They involve a redefinition of what constitutes an 'outcome' in public services, often focusing on less quantifiable, personal aspects**, such as befriending, building relationships and broader quality of life issues.[2,4,44,59] In the Villa Family project, a key part of the job is listening to and talking with the elderly. In the LAC programme, there is a recognition that 'the essence of a good life for a person with a disability is the same as for a person without a disability'.[69]

Strengths of the co-production models

Each of the practice examples presents successes. In particular reported benefits of the schemes included the following.

- **Value for money.** Independent evaluation of the KeyRing project found that it delivered support cost-effectively.[67] According to Bartnik and Chalmers, multiple evaluations of the LAC schemes have shown value for money as well as high levels of satisfaction from the people who use services.[69] The potential for co-production to access assets that were previously uncosted and may have been under-used, means that it may be more cost-effective than traditional approaches to service delivery. However, some authors have cautioned against using co-production simply as a way to deliver services on the cheap.[44,73]

- **Incorporation of expertise from the people who use services.** Evaluation of the outcome-focused assessment scheme found that people who use services valued the 'respectful' nature of the outcome-focused practice with the professional taking the role of assistant in achieving their desired outcome, rather than taking the role of expert assessor.[70] Two evaluation reports of CSCI's 'experts by experience' scheme say that this has 'improved the inspection process and brought real benefits'.[71,72]

- **Health benefits and prevention.** Boyle et al. cite research showing 'clear links between involvement in time banks and reduced levels of medication and hospitalisation'.[44] Evaluation of the time bank based at the Rushey Green GP surgery found that there appeared to be physical and psychological health benefits for participants, although they did note that it was difficult to link time bank participation directly to those benefits.[59] One doctor felt that the time bank offered a positive and sustainable community, as opposed to patient groups which were too focused on illness and tended to die out. An independent evaluation of a mental well-being project at SLAM, which included time banks, found that all targets were exceeded, although the report gives no further detail on this.[74] A recent assessment of co-production concluded that schemes such as time banks have the potential to develop mutual support systems that can tackle problems before they become acute and require the intervention of formal services. Certain co-production initiatives could contribute to the prevention agenda in health and social care.[3]

- **Practical skills.** The review of the time bank case studies noted a number of practical advantages for participants, such as learning DIY skills.[46] The time bank can also be a way to develop more formal skills and opportunities. It is noted as a way to validate people's contributions without affecting their income.[44,47]

- **Social capital.** Several of the schemes had **positive benefits for social capital, through building supportive relationships and increasing personal self-confidence and activity**. The sorts of capital created by the schemes can benefit service providers and the broader community as well as the people who use services themselves. For example, the Villa Family project brings more young families into villages, and helps them to integrate into those communities.[68] The time banks appear to be more effective than traditional volunteering routes at attracting socially excluded sectors of the population and work well as a tool for social inclusion.[75,76] An evaluation of a number of time banks by Seyfang concluded, 'By promoting mutual volunteering, they generate trust, social capital, reciprocity and community self-help among people who would normally be passive recipients of external assistance'.[75]

Limitations of the co-production models

The practice examples also indicate some of the limits of co-production, which need to be considered if the approach is to have broader applicability.

1. **Co-productive schemes need to build as well as reinforce social capital.** Although the practice examples showed the potential for co-productive schemes to enhance social capital, there are clearly limits to the scope for some people to co-produce without support: 'The stock of social capital that an individual has is a major influence on their ability to be effective co-producers'.[6] Just as in social care participation initiatives more broadly, co-productive schemes may sideline groups that have been generally marginalised and underserved, such as people living in poverty, the homeless, black and minority ethnic people, lesbian and gay people, older people, people with cognitive and communication difficulties and those living in residential settings.[7,36,52] In the LAC evaluation, for example, Bartnik and Chalmers note that people from culturally diverse backgrounds may require extra support to participate in the scheme.[69] Poll, the founder of the KeyRing project, acknowledges that the scheme is designed for people who need relatively low levels of support and would need to be modified for people who need more help to live independently.[67]

   There is also some concern that co-production may be better at providing 'bonding' social capital (helping to create links within communities) rather than 'bridging' (making links between different communities). Policy interviewees spoken to by Boyle et al. raised concerns that co-production must not just target poor people.[44] Linked to this is a concern that the collaborative nature of co-production should not be seen too strongly in reciprocal terms, framed as what the people who use services will have to 'pay back' in the future.[44] The point has been made that 'excluded communities should not have to "participate" in order to have the same claim on service quality and provision as other members of society have'.[77] Co-production must not be 'government attempting to dump its difficult problems on users and communities'.[45]

2. **Co-production may challenge existing frameworks of service provision.** The KeyRing project had difficulty fitting in with a regulatory framework which is too focused on outputs rather than outcomes.[67] The tax and benefit regulations have been a problem for time bank participants,[44,47] as is the case for all forms of meaningful participation by people who use services and their carers.[83] Risk-aversion among statutory authorities was noted to be a constraint on innovation in some of the research.[44,47,67] Traditional notions of accountability may also be threatened as public/private, formal/informal resources become more closely linked.[78] However, there may be ways in which accountability to individuals and communities is enhanced through a more open and collaborative approach to service design, commissioning and regulation.[45]

3. **Co-productive schemes require sustained, secure funding and organisational support but also need to be independent.** A Government of Western Australia evaluation of the LAC scheme[79] noted that the multiple demands being made on the scheme (such as to its scope, role, constituency and accountability) threatened its medium- to long-term sustainability. A systematic five-yearly review of the LAC

programme was recommended to keep it 'contemporary and responsive to the emerging strategic environment'.[69] Funding for time banks tends to be short-term and unstable,[65] although such initiatives require organisational support to thrive. The time bank project at SLAM benefited from being part of a big organisation where time banks were valued, as they had the ability to empower the workers.[74] However, Boyle et al. also note that time bank participants may be cautious of getting money from more institutionalised sources such as local authorities in case it compromises the independence of the scheme.[44]

4. **Co-production requires support for staff.** The Australian LAC scheme is only as good as the individual coordinator, highlighting the importance of staff selection, quality and consistency.[69] All the case studies required committed staff support, at least in the early stages, which can be hard to reconcile with other priorities.

   A number of the evaluations reported **resistance from staff**. The evaluation of the Gorbals Time Bank found that local education and health agencies were unwilling to engage with the project.[65] The analysis of the role of user groups in co-producing community care found that officials were reluctant to acknowledge the legitimacy of such groups.[56] Staff working for the SLAM project reported colleague resistance to the time bank projects, particularly where the assumed potential and ability of the people who were using the service were challenged.[44]

   It was also clear that staff attitudes could be transformed through taking part in co-productive projects, such as a greater awareness of the contributions of people who use services and their carers, and greater recognition of the credibility of service users working as outreach workers – although they also acknowledged the pressures of time available to spend on the project.[44]

   A number of the evaluations called for **a new understanding of professional roles to facilitate co-production**: 'Co-production is a specific professional skill, best practice for which is only now being developed'.[59] One author called for:'a new type of public service professional: the co-production development officer, who can help to overcome the reluctance of many professionals to share power with users and their communities and who can act internally in organisations (and partnerships) to broker new roles for co-production between traditional service professionals, service managers, and the political decision makers who shape the strategic direction of the service system'.[45]

   Conversely, others strongly emphasise the need to 'resist temptation to create yet another category of potential professionals' to make co-production happen.[2]

   At a minimum there is **a need for staff training to support co-productive approaches**. Many of the evaluations emphasised the distinctive role that professionals were expected to play. In the LAC case for example, the coordinator is described as 'an eclectic role… It exhibits elements of individual coordination, personal advocacy, family support, community development and direct funding'.[69] Similarly, in the KeyRing project, 'The Community Living Volunteer's role is an unusual one – part good neighbour, part facilitator, part advocate, part support worker'.[67]

   There is **a stronger emphasis on relationships than in traditional service**

delivery systems, making staff continuity important. If staff turnover is high and users have to redevelop relationships over and over again, they are likely to grow tired and 'stop co-producing their service', becoming institutionalised and losing the benefits derived from their input.[80]

As well as building relationships, co-production schemes may require a process of letting go: 'Once service clients and community activists become engaged in the co-design of and co-management of services alongside professional staff, the networks which are created may behave as complex, adaptive systems which behave in ways which professional and commercial providers cannot easily control and indeed may not fully understand'.[13] Certainly positive, supported risk management will be integral to co-production, as professionals allow users to shape their own service provision, along with a recognition that not all risk can be eliminated.[45]

Conclusion

Co-production is of central importance to the personalisation and transformation of adult social care services.[1] It is relevant to all sectors in adult social care (including voluntary and independent sector providers) and for all kinds of people who use social care services.

Although co-production relies on a very simple definition – people who use services collaborate in the production of services – the details of how this is applied to public services in general, and social care in particular, are more complex. Co-productive approaches assume that people who use services have expertise and assets, which are essential to creating effective services and good practice.

Co-production is not a new delivery mechanism for social care services. It is an approach which affirms and supports an active and productive role for people who use services, and the value of collaborative relationships in delivering the outcomes negotiated with the person using the service.

Social care already relies on the productive input of the people who use services, through engagement, care management and peer support. However, often such contributions are undervalued, as organisational cultures can encourage professionals to endorse a 'We'll fix it' approach. Co-production 'is a positive affirmation that people can develop their own futures with the support of others including professionals.[2]

Co-production has much in common with initiatives to increase involvement by the people who use services. However, it is linked to a particular kind of participation in which people are producers rather than critical consumers of service outcomes. Co-production means that people who use services are recognised as active participants in shaping the arrangements for care and support that offer choice and control, both on an individual and collective level: 'Involving users as collaborators rather than consumers enables them to use frontline professionals' skills alongside other assets to develop services that suit them and bring about positive outcomes. This can also significantly enhance staff's experience of their roles, shifting from reluctant rationing of services into supportive collaborators'.[3]

Co-production is not a 'magic fix': 'It does not dispense with the need for promoting equality, enforcing standards or improving delivery. However, it offers a different way to think about the relationship between the state, service providers and service users'.[4]

If co-production is to improve outcomes in social care, it will be at the 'transformative' level, avoiding versions of co-production that simply cut costs, demand compliance or reproduce existing power relations.

Implications from the research

1. Co-production is a complex concept with a range of implications for social care. Rather than offering an off-the-shelf model of social care it:
   - challenges existing service models and delivery patterns
   - questions assumptions of users as the passive consumers rather than the active producers of care
   - supports collective rather than primarily one-to-one service relationships
   - demands renegotiation and restructuring of relationships between people who use services and professionals, which in turn requires the empowerment of both parties

   recognises that social care provision is an iterative and negotiated process, not a simple delivery chain from Whitehall to the front room. The concept can be combined with various forms of user involvement and service redesign, so long as there is a commitment to power-sharing, an active and productive role for the user, and a recognition of the importance of collaborative relationships in delivering service outcomes.

2. A strength of the co-production approach is that it meshes with people's willingness 'to put something back', while at the same time linking that contribution to something very tangible and specific in their lives.[16] Co-producers can be 'everyday makers' as well as 'expert citizens', participating in ways that improve their everyday lives, 'concretely and personally', rather than getting involved in parties or grassroots organisations.[81]

3. Many of the limitations of co-production – including institutional resistance and the need to involve marginalised people – are those of user involvement more generally.[36,57] They are not specific to social care. Surveys and evaluations of co-production case studies outside the social care sector have similarly identified its transformative potential and the need to overcome resource-based and cultural constraints.[33,45,82] Greater dialogue between staff and the people who use services can generate conflict and disagreement as well as supportive collaboration, and those tensions need to be acknowledged and overcome.[43,60,82]

Useful Websites

Social Care Online
www.scie-socialcareonline.org.uk

Putting People First Personalisation Network
www.integratedcarenetwork.gov.uk/Personalisation

New Economics Foundation
www.nef.org.uk

CarnegieUK Trust Publications
www.carnegieuktrust.org.uk/publications

Office for Public Management Resources
www.opm.co.uk/resources/resources.shtml

Compass Publications
www.compassonline.org.uk/publications/

Timebank UK
www.timebank.org.uk/

KeyRing Living Support Networks
www.keyring.org/

Disability Western Australia Local Area Coordination
www.disability.wa.gov.au/forindividuals/disabilityservices/lac.html

in Control
www.in-control.org.uk

Commission for Social Care Inspection Experts by Experience
www.csci.org.uk/about_us/news/experts_by_experience_make_ins.aspx

Joseph Rowntree Foundation
www.jrf.org.uk/

Related SCIE publications

Report 20: Personalisation: a rough guide (2008)

Research briefing 20: Choice, control and individual budgets (2009)

SCIE guide 17: The participation of adult service users, including older people, in developing social care

Race equality discussion paper 1: Will community-based support services make direct payments a viable option for black and minority ethnic service users and carers?

SCIE guide 10: Direct payments: answering frequently asked questions

Joint publication: Social care transformation: elected member briefing

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About the development of this product

Background

Co-production is a concept and term that was introduced to UK policy in the Department of Health's Putting People First policy for personalisation and transformation, and further developed by New Economics Foundation (NEF) (amongst other organisations).

Scoping and searching

Scoping and searching took place April and May 2008, and included international material. Key players including the Cabinet Office and NEF were consulted: policy papers were included.

Stakeholder involvement

The author is a topic expert. SCIE Partners' Council was consulted (day's conference), and the project overseen by Personalisation Project Advisory Group (including people who use services and carers).

Peer review and testing

Personalisation Project Advisory Group, including providers, users and carers, steered production and peer reviewed the product and key messages.

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SCIE research briefings provide a concise summary of recent research into a particular topic and signpost routes to further information. They are designed to provide research evidence in an accessible format to a varied audience, including health and social care practitioners, students, managers and policy-makers. They have been undertaken using methodology developed by SCIE. The information on which the briefings are based is drawn from relevant electronic databases, journals and texts, and where appropriate, from alternative sources, such as inspection reports and annual reviews as identified by the authors. The briefings do not provide a definitive statement of all evidence on a particular issue. A full account of the method used in identifying and organising material for this publication is available at **www.scie.org.uk/publications/briefings/files/researchbriefingguidance2009.pdf**

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25. Children's and young people's experiences of domestic violence involving adults in a parenting role
26. Mental health and social work
27. Factors that assist early identification of children in need in integrated or inter-agency settings
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