Rotherham Metropolitan Borough Council
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South Yorkshire POLICE

NHS

Rotherham's Health and Well Being Strategy

Co-production in Rotherham

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1. Introduction

Expectations and Aspirations is one of the six strategic outcomes we aim to deliver through the Health and Wellbeing Strategy:

All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

Underpinning this is the action "We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions"

This report will examine what co-production is and what it would look like in Rotherham. It includes some examples of where this is already happening across the Borough (albeit to a smaller degree) and those areas nationally where co-production has seen success in delivering services differently

This report covers a suggested two stage approach that would be required to move organisations into a position where co-production of services is a real option and that it is seen as an opportunity as part of any service delivery model and reviewed and explored as part of routine service planning.

Co-production is now a key concept for delivering public services; it can make an important contribution to current challenges and can support:

- Cost effective services
- Improved user and carer experience of services
- Increased community capacity
- Integration
-

Enquiries into abuse and neglect (including the Francis report) highlight the need for services to develop more equal relationships with people who use the services and their carers. Interest in co-production can often be linked with the need to save money; however, there is acknowledgement that the citizen has a vital role in achieving positive outcomes from the services they receive.

It will be important to recognise the role that commissioning plays in delivering services as part of any co-production activity; customers can also play a key role in commissioning services even though they may not be involved in the delivery of those services subsequently.

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2. Definitions of co-production

The term co-production dates from the 1970's but more recently has come to describe ways of working in partnership by sharing power with people using services, their carers and the wider citizens.

Co-production means delivering public services in different ways around relationships with service users, these relationships need to be equal and reciprocal between professionals, the people using the services and their families. Where services are co-produced in this way they are far more effective. – (Nesta 2013)

There are many definitions, and many facets, of co-design and co-delivery. What all of them have in common is an ethos and recognition that those who provide and experience services should have an equal say and role in how such services are designed and delivered" (Nesta 2013)

What co-production would mean in Rotherham

- **Recognising Rotherham people as assets:** seeing people as equal partners in the design and delivery of services, not just passive recipients of our services or even worse as a burden on those public services.
- **Building on Rotherham people's existing capabilities:** rather than starting with people's needs which are often seen as the traditional deficit model, co-produced services start with peoples capabilities and look for opportunities to help develop these further.
- **Mutuality and reciprocity:** co-production is about a mutual and reciprocal partnership, where professionals and people who use services come together in an interdependent relationship which recognises that each are just as invaluable to producing effective services and improving outcomes for the people of the Borough
- **Peer support networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge and supporting change.
- **Blurring distinctions:** blurring the distinction between professionals and recipients, and between service delivery and service use, by reconfiguring the way services are designed, developed and delivered.
- **Facilitating rather than delivering:** enabling professionals to become facilitators and catalysts of change rather than providers of services.

- **Leading to services becoming more preventative**: in the long-term and in ways which leads to service users being empowered.

Research has found that involving patients and service users in their care and wellbeing planning and for them to identify their own goals and aspirations and navigating the services themselves will help them achieve their goals.

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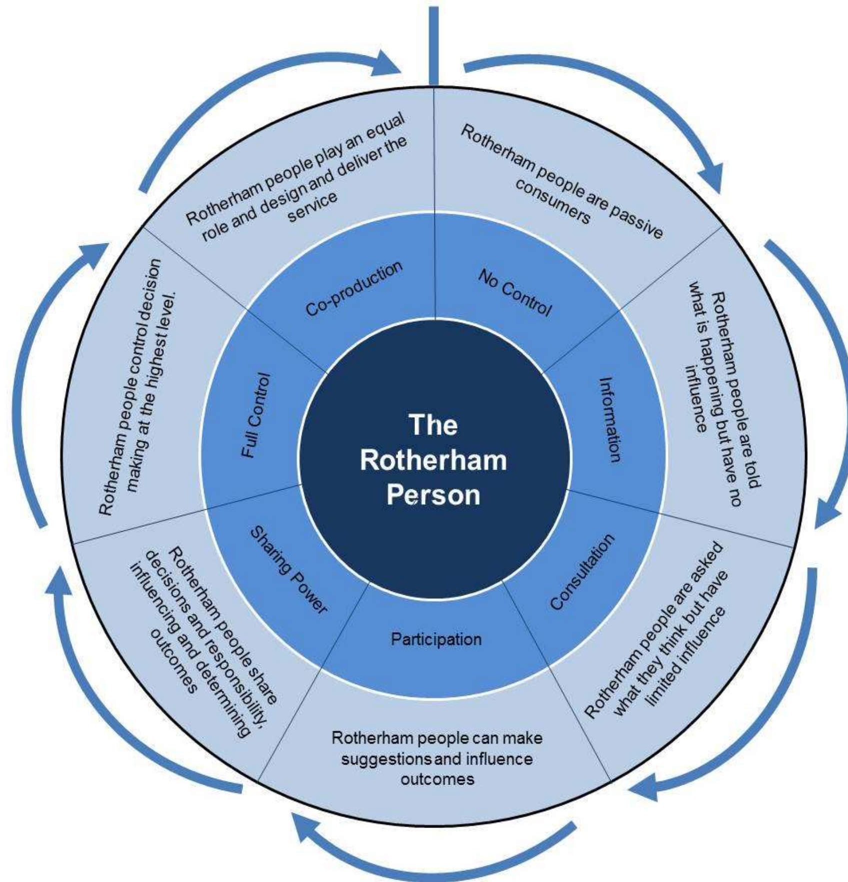
3. The circle of co-production in Rotherham – Figure 1



The challenge for partners in Rotherham is to move services for our customers and citizens from them having "no control" in service design and delivery to where services are "designed, produced and delivered" with and by our customers.

The diagram above shows the direction of travel to be able to achieve the aspiration that the health and wellbeing board has for the co-production of services

4. Examples of Co-production in Rotherham

There are already examples of where co-production is in place, below is a list of examples with more detailed case studies attached at Appendix 1 for a selection of the ones named below **

Lifeline **
Lord Hardy and Davies Court – friends of group
Speak Up **
Charter for the Parent and Child voice **
Social prescribing **
Expert Patient
Education Health and Care Plans
Caring
End of life
Self Care / Self medication
Healthy lifestyles

Personalisation and Person Centred Practice are also examples of a level of co-production of services as our customers are in control of the care that they require and the individual solutions which meet their personal needs.

The Special Education Needs and Disability (SEND) reforms around children and young people with additional needs offer a real opportunity to change how we work with children, young people and their families. The rationale behind the whole SEND reform from a national perspective is around the ethos of co-production. Linking this to the work of the Charter for the Parent and Child Voice is a real opportunity to ensure that co-production is embedded into everything that we do across the partnership of services working with these young people and their parents and carers.

It's important that Commissioning activity in Rotherham includes customer involvement and there are examples nationally where this has been very successful.

Commissioners need to proactively work with providers to develop capacity for co-production over a period of time, as part of market development and market shaping activities.

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5. Challenges for co-production

Moving to a co-produced model of delivery will not be easy and it is recognised that the approach and rational needs to be clear

- **It makes additional demands of people who rely on services** and who are by definition already ‘in need’. However, a response to this is that the active engagement of people who are users of services is often largely positive; this enables them to make services work for them, growing their own confidence and capacity. Nevertheless, it will be important to ensure that it does not put additional burdens on people’s time.

- **It is a cover for the withdrawal of services**; we need to be clear that the reason for co-production is to ensure high quality services with improved outcomes as opposed to there being less money available in the system as a result of public sector efficiencies and government spending reviews.

- **Co-produced services will lead to a postcode lottery**; it is true that services will look different in different areas across the borough but that is to be expected as the assets, resources and needs identified by communities across Rotherham will also look different. There may well still be the need for a central role to ensure consistency in approach and to be clear that everyone is enabled to play a role in co-production but the assumption that identical and generic services produce the best outcomes for people is questioned by co-production.

- **It is just ‘participation’ by a new name**: Co-production is different from ‘voice’ based interventions as it recognises that it is critical for people to play a role in the activity of delivering services, not simply to contribute ideas to shaping new services that rely on professionals to deliver them.

- **There is a need to harness the collaborative working** and embed this approach into all settings; professionals would need to start from the position of not necessarily knowing the right answer which will also be a challenge.

Creating a health and wellbeing system which is driven by the people within it, not by the institutions that provide care requires engagement in all stages - in designing, delivering or using, and in evaluating the service.

This recognises that those who provide and experience services should have an equal say and role in how services are designed and delivered. This requires going beyond 'engagement', 'involvement' and 'person-centered' towards real co-design and co-delivery at every level.

There is often confusion between co-production and service user-design, user ‘voice’ initiatives and consultation exercises.
Many of the ‘voice’ based initiatives involve people expressing opinions and ideas but ultimately still **only** recognise professionals as being capable of providing the work needed to deliver a service.

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6. The proposed approach in Rotherham

The proposal is that all of our organisations decide which services would be suitable for co-production and begin to move to this as a concept of working, (around the circle of co-production) it is clear however that that there are some services which would never be suitable to be co-produced, examples of this would be around some health or protection and safeguarding services i.e. Resuscitation services or child protection investigations / services, however we still need to ensure that families could make comments about the services that they / their relatives have received to help improve or shape the services in the future as opposed to them being involved in the delivery of the services.

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The suggested implementation model is across a staged approach:

Stage 1 – All organisations agree in principle to undertake elements of coproduction and to move around the circle from where they are now towards fully co-produced services (see Rotherham circle of coproduction -Figure 1), this could be a step change or something more radical

Stage 2 – Organisations review on a yearly basis which services are suitable for co-production or to move towards co-production and aim to make the required changes during the year either as part of commissioned arrangements with Service Level Agreements and Service Specifications or changes to in-house delivered services (audit document attached at Appendix 1)

As previously mentioned not every service would lend itself to co-production hence the annual review of services in Stage 2 to ensure that all services and considered and to what levels it would be feasible to apply a co-produced methodology.

Social Care Institute of Excellence (SCIE) recommends four key steps to delivering co-produced services

1. Culture

- Ensure that co-production runs through the culture of an organisation.
- Ensure that this culture is built on a shared understanding of what coproduction is, a set of principles for putting the approach into action and the benefits and outcomes that will be achieved with the approach.
- Ensure that organisations develop a culture of being risk aware rather than risk averse * links to the work of the Dependence to Independence workstream and the development of a "risk taking policy"

2. Structure

- Involve everyone who will be taking part in the co-production from the start.
- Value and recognise people who take part in the co-production process.
- Ensure that there are resources to cover the cost of co-production activities.
- Ensure that co-production is supported by a strategy that describes how things are going to be communicated.
- Build on existing structures and resources.

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3. Practice

- Ensure that everything in the co-production process is accessible to everyone taking part and nobody is excluded.
- Ensure that everyone involved has enough information to take part in coproduction and decision making.
- Ensure that everyone involved is trained in the principles and philosophy of coproduction and any skills they will need for the work they do.
- Think about whether an independent facilitator would be useful to support the process of co-production.
- Ensure that frontline staff are given the opportunity to work using co-production approaches, with time, resources and flexibility.
- Provide any support that is necessary to make sure that the community involved has the capacity to be part of the co-production process.
- Ensure that policies and procedures promote the commissioning of services that use co-production approaches.
- Ensure that there are policies for co-production in the actual process of commissioning.

4. Review

- Carry out regular reviews to ensure that co-production is making a real difference and that the process is following the agreed principles.
- Co-produce reviews and evaluations.
- Use the review findings to improve ways of applying the principles of coproduction, so that continuous learning is taking place.
- During reviews and evaluations, work with people who use services and carers, to think about ways of showing the impact that co-production has, as well as the processes that are involved. (SCIE, 2013)

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7. The costs of co-production

Issues around the costs of co-production are particularly complicated. While there is some evidence that it can reduce costs, the available evidence is inconclusive. This may be something that varies between different organisations and different projects.

Obtaining reliable information on costs is often difficult. However, even in some of these cases there were costs that were significant, such as for training, there are also costs for professionals in taking time to work more effectively with customers and citizens. However, such activities may reduce costs in the long term if services are more fit for purpose and become more effective over time.
Co-production will probably lead to short-term increases in the use of services and other costs as it increases people's knowledge of and access to services. It may also lead to services that are 'more appropriate'.

Potential savings
One of the key arguments about the economic benefits of co-production is the potential returns from a perspective that focuses on prevention and early intervention when people's needs arise rather than letting them get worse. So if there is investment in community services, this means that people are less likely to need more expensive services (such as crisis and emergency services) later on. This will reduce the cost of acute services in the longer term.

Some of the clearest evidence of the potential savings that can be achieved in prevention using co-production particularly around health services has come from Nesta's People Powered Health programme. This programme focuses on ways to improve practice in health services, including peer support and co-design/co-delivery with people who use services. Nesta's analysis of the programme shows that where these approaches are used with people with long-term conditions, they deliver savings of approximately seven per cent through things like reduced and shorter hospital admissions and fewer visits to casualty departments. They also argue that these savings would grow to 20 per cent as the different parts of the programme support each other. (Nesta, 2013)

A few other points to note about co-production and costs are:

Co-production may lead to some costs being reduced and others increased.
It may only be possible to know whether co-production is cost-effective by looking at things over a period of time. If it is cost-effective it will have reduced the number of inefficient, ineffective and unwanted services.

One of the key studies of the economics of co-production looked at three coproduction/ community capacity projects. It analysed them using a method called 'decision modelling'. This compared what happened with the projects in place with what might have happened if they had not existed. The projects were a time bank, a befriending scheme and a community navigator scheme (volunteers who support people to obtain support services). The authors looked at all of the costs and gave a monetary value to all of the benefits. They recognised that there were limitations in their analysis. However, they made conservative estimates that the projects produced net benefits for their communities in a short time.
Economic evaluations of direct payments, individual budgets and—more recently—

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personal health budgets have shown that they are cost-effective. Giving people who use services and carers more control over those services can increase their health and wellbeing. But it is important to give them more support in the form of information, advice and advocacy. This will mean that more people will take up budgets. However, not everyone will benefit from personalised approaches.

Key improvements and savings are around:

•**Spending it on the right things** in the first place (e.g. personal budgets, participatory budgeting)

•**Understanding better what is valued** and how outcomes are achieved (e.g. experts by experience)

•**Accessing and utilising the assets of service users** which may be freely given (e.g. recycling, litter picking, peer advocacy)

•**Adding to the assets of service users** and reducing welfare dependence (e.g. time banks)

•**Reducing formal staff contributions** (e.g. informal carers, breastfeeding support groups,)

•**Improving service quality (**e.g. employment advice service for refugees)

•**Improving long-term health** and well-being (e.g. Expert Patient Programme)

However, it is worthy of noting that it can also cost money by:

•Training for staff, users and other participants

•Generating new demands for the service

As part of the roll out of co-production we need to explore with customers the shared decision making around budgets and any savings that are made as a result, it is important that they are involved with future decisions on how money is spent moving forward.

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8. Examples of National Projects

East Dunbartonshire – advisory clinic for people with dementia

http://www.govint.org/good-practice/case-studies/the-east-dunbartonshire-advisory-clinic-model/

All together Now: Putting people, relationships and outcomes first (Swansea)

http://www.ssiacymru.org.uk/home.php?page_id=3917

London Borough of Lambeth – teenage pregnancy project

http://www.govint.org/english/main-menu/good-practice/case-studies/london-borough-of-lambeth.html

Commissioning:

http://www.cihm.leeds.ac.uk/new/wp-content/uploads/2012/01/Co-producing_Commissioning_NEF-3.pdf

Mental Health Advocacy Service, Kirklees PCT and Council

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9. References

Nesta's July 2013 report "By us for us" - The power of co-design and co-delivery
http://www.nesta.org.uk/publications/us-us-power-co-design-and-co-delivery

People Powered by Health (2013)

http://www.nesta.org.uk/project/people-powered-health

Rotherham's Health and Well Being Strategy www.rotherham.gov.uk (2012)

Rotherham's Charter for parent and child voice www.**rotherhamcharter**.co.uk

Coproduction in social care, what it is and how to do it Social Care Institute for

Excellence www.scie.org.uk (2013)

Cabinet Office Strategy Unit (2009)

East Dunbartonshire – advisory clinic for people with dementia
http://www.govint.org/good-practice/case-studies/the-east-dunbartonshire-advisory-clinic-model/

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London Borough of Lambeth – teenage pregnancy project
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