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Coproduction and partnership with people and communities

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INTRODUCTION

‘The only way the...world is going to address... social problems...is by enlisting the very people who are now classified as clients and consumers and converting them into coworkers, partners and rebuilders of the core economy’.¹

Edgar Cahn, 2011

Edgar Cahn, in his open letter to the non-profit sector, proposed a radical shift in thinking among those who ‘help’, away from a top-down approach to providing services to a more asset-based, holistic and pluralistic view, where collaboration and coproduction is commonplace. This paper describes the concept of coproduction, its origins, benefits and how it works at an individual and community level. It argues that partnership with people and communities needs to be an embedded approach for leaders at all levels within healthcare. To truly tackle the scourge of health inequality and really make a difference to people’s lives, organisations cannot afford to work by themselves in a vacuum. Leaders and policy-makers need to unleash the power of people in the workforce and communities by embracing coproduction and personalised care, and growing collaborative, inclusive leadership across the public sector.

The origins of coproduction

Coproduction means ‘delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours’.² Coproduction does not mean talking to other organisations—that is partnership working. Neither does it mean letting communities fend for themselves. The Nobel Prize-winning economist Elinor Ostrom, who is credited with coining the term, said: ‘No market can survive without extensive public goods provided by governmental agencies. No government can be efficient and equitable without considerable input from citizens’.³ It is incredibly pertinent to healthcare today, with global financial crises, pandemics and threats of trade conflicts bringing pressures that call into question the state’s ability to continue with an old-style demand and supply model of service delivery.

The desire for people to have more control over decisions that affect them is also a global trend. Belonging, autonomy and connection are universal interpersonal needs,⁴ and the emergence of social movements for change over the past few decades can be seen as a reaction to the dominance of ‘technocratic decision-making’ which has disconnected policy from the reality in which it is enacted.⁵ Coproduction and personalisation in health and

social care in the UK, for example, can be traced back in part to the independent living movement, a worldwide movement led by disabled people calling for equal rights and opportunities, including choice and control over where they live, the support they receive and decisions about their life.

Alongside these are emerging ideas in the fields of systems leadership and public service management that suggest the need to diverge from traditional ‘top-down’ approaches to more inclusive and collaborative practices, which are much more suited to achieving change in complexity. They are shown in [table 1](#) with typologies of coproduction and can all be summed up as the difference between governments and services ‘doing to’, ‘doing for’ and ‘doing with’ people and communities.

Language matters too—if we refer to people who use services as different to us, or ‘other’, we patronise at best but, at worst, stigmatise and exclude them. High levels of command and control and new public management-type approaches in healthcare deny us all the opportunity to benefit from multiple views on how jointly owned problems can be collectively solved.

Coproduction in health

Coproduction in health has a sound theoretical basis. At the individual level, it helps people to take control of their health as it embodies the fundamentals of Rogerian humanist psychology based on empathy, congruence and unconditional positive regard demonstrated through listening.⁶ It changes the conversation from ‘What’s the matter with you?’ to ‘What matters to you?’ creating a collaborative, relational space, seeing those who use services as equals and experts in their own experience, with both parties involved in making shared decisions, developing shared goals and achieving shared outcomes through different but equally valuable contributions. For people with long-term conditions particularly, the approach can be transformational. Self-determination theory suggests that autonomy and relatedness are intrinsic to well-being in general and also increase the likelihood of behaviour change.⁷ In practice, this has shown to be true—the Chronic Care Model in medicine recognised that health outcomes are better and services are used less when people are supported through collaborative approaches to manage their own health.⁸ Practising in a person-centred way also increases job satisfaction for caregivers.⁹

Coproduction in health can be tricky to sell, as it requires health professionals and leaders to relinquish a part of their professional identity as



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Table 1 Typologies of co-production, systems leadership behaviours and public sector management

	Doing To	Doing For	Doing with
In practice	Top down decisions, telling people what to do	Well-intentioned care or policymaking but with the power differential firmly in place	Mutual respect, equality, and shared responsibility in 121 care and at a strategic level
United Nations public sector administration report (2005) ²⁷	Old public administration model focused on compliance and outputs - 'professionals know best'	New Public Management- emphasis on serving 'customers', in a business-like and efficient way - 'you said, we did'	Responsive governance; empowerment of and partnership with citizens and stakeholders and greater emphasis on participation and collaboration
Arnstein's Ladder of Participation (1969) ²⁸	Informing, manipulating	Placating, consulting	Citizens in control, delegated power, partnership
Carman et al's framework for engagement (2013) ²⁹	Giving information	Consulting through surveys and focus groups; asking about individual preferences; having patient reps to 'advise'	Shared decisions, based on equal relationships; equal representation on decision-making boards, co-leadership of improvement initiatives
Slay and Stephens Coproduction ladder (2013) ³⁰	Informing, educating, coercing	Engaging and consulting	Co-production and genuine involvement
Senge's systems leadership behaviours (1990) ¹⁵	Telling, selling	Testing, consulting	Co-creating

superhuman agents who can fix people and control disease. Yet this has always been a medical myth—the human body is a complex system and so are the contexts in which we live. No person reacts in the same way to a treatment, the evidence on which we base decisions may in any case be ‘fundamentally flawed’ due to bias in design,¹⁰ and even if we could mitigate this, patients do not do what we tell them anyway—only 50% of people take their medication exactly as described.¹¹

Community matters: four elements of a strategic approach

Coproduction does not stop at the 1-2-1 level though. To fully capitalise on the knowledge, skills and gifts of people themselves in improving population health and outcomes it is necessary to take a strategic and systemic approach to coproduction with local communities. For leaders, this means incorporating four important elements into commissioning and delivery of services: including people with lived experience on decision-making groups; ensuring those who work in health have a ‘literacy of community’¹²; the intentional building of social capital within communities as a method of achieving improved health; and a mindset shift in what we mean by ‘services’, so that people themselves are involved in scoping, design and delivery of healthcare and health improvement initiatives—true coproduction.

The first element is fairly well-developed and understood. It recognises that better strategic decisions are made if we involve the people we serve in making them. Diverse teams are better at solving complex problems, perform better and make fewer errors¹³ so it makes sense to include citizen voice on boards and working groups. Strategic coproduction creates an opportunity to explore possibilities, to make better decisions, and to make sometimes unexpected discoveries about what really matters to people and how we as public servants should be spending our time and money.¹⁴

The second element takes the concept of a diverse collective intelligence further. It is simply not possible to deliver or commission the best services without knowing how people really live and experience care in the context of their lives. Coproduction with communities means spending time in neighbourhoods and with groups of people with lived experience to find out what things are really like. If we do not do that, we have limited awareness and end up simply dealing with ‘symptoms’ rather than the systemic causes of complex problems.¹⁵ It also means leaders need to make it their business to know about the groups

and social support networks that exist in their patch, as these act as a vital two-way conduit to develop understanding of the issues and how to get help to those who need it. People are rarely ‘hard to reach’ if you know where to look and make time for it.

The third element means growing and nurturing community capacity as a key means to improve local health and well-being. People with stronger social networks are healthier, happier and less likely to die than those with little social connection.¹⁶ Higher levels of social capital within communities are associated with lower mortality rates¹⁷ and more connected communities may be better able to mobilise resources and solve problems than disconnected ones.¹⁸ When health services have taken community development seriously in this way, neighbourhoods can be turned around. Outcomes from one such programme included better diabetes control, increased physical activity across a population, higher educational attainment, reduced crime rates, improved relationships between statutory services and local people and much higher levels of pride, ownership and social connectedness within communities.¹⁹

The last element takes this one step further and requires a paradigm shift. If we are steeped in a traditional model of service and do not look outside for ideas, the solutions we come up with will always be biased towards providing more or new services. But, as the saying goes in community-building circles, people mainly want a life, not a service.²⁰ Unless we encourage and hand over enough power to enable people, communities and front-line staff to come up with innovative, local, personalised and responsive solutions, and then support them to bring their ideas to fruition, there will never be enough money to provide for unrelenting demand. The unique ability of people and communities to rise to a challenge and help each other can be seen in the huge number of mutual aid groups that emerged during the pandemic—networks of people who wanted to help out their friends and neighbours during lockdown. The challenge now for public services is how to harness and nurture this kind of goodwill to continue when the crisis is over. Truly collaborative practice means coming together and throwing all our collective muscle into the pot, in pursuit of shared goals—doing more with more.²¹

What does this mean for leaders?

The good news for leaders is that the principles espoused here are gaining increasing traction in the corridors of power across the political spectrum. As well as being the right thing to do from an ethical

and evidence-based point of view, co-productive and collaborative practice can help to square the circle of increasing expectations and demand in health with stagnating public finances.²² Nesta's 'People Powered Health' and 'Realising the Value' projects showed how this can be done and why it is worth it, despite the challenges.²³ In the UK, the National Health Service (NHS) Long-Term Plan with its focus on personalised care, is also helping to break down barriers to practice and culture change in healthcare, requiring a system-wide, holistic focus on integrated care through care and support planning, better conversations through shared decision-making, enabling choice and control over care through personal health budgets and focus on support for self-management.²⁴ Aligned with this is the emerging consensus in public sector leadership development that we need to shift from 'individualistic, hierarchical' leadership to, 'collective leadership that creates compassionate and inclusive cultures.'²⁵

Coproduction, building community and personalised care need to be part of the way we do business in health and social care. We need leaders who can create the conditions for the concepts to take root and spread. Leaders need to focus on what matters to people rather than solely relying on the perspective of existing services. They identify what is good and build on it by connecting people together and celebrating great practice. They see the big picture and work to develop common purpose

In practice

Altogether Better has worked with over 130 GP practices in the UK, inviting local people to gift their time and work alongside staff to develop activities, peer support and community-based interventions that benefit all. What might start with a few groups changes the culture of the practice itself over time. People begin to see themselves, and are seen by the practice, as colleagues and partners, cocreating health for the practice community, rather than as passive recipients of services. Altogether Better says: 'The evidence from our whole system work shows that activities delivered by citizens and services working together in GP practices brought about better patient outcomes, increased resilience and ability to adapt, cope and live well with long-term conditions, as well as gaining a better understanding of how to use services... People's needs are met differently, taking pressure off the service, reducing demand for clinical services, and making life better for everyone'.

A key challenge for leaders in health is to ensure that this kind of approach sits alongside 1-2-1 co-productive approaches such as shared decision-making, and to build and grow collaborative partnerships across a place between other organisations, people and groups. A whole system approach includes the people who live and work in the system. We cannot fix everything on our own.

Express checkout

People with stronger social networks are healthier, happier and less likely to die than those with little social connection and health outcomes are better and services are used less when people are supported through collaborative approaches to manage their own health. Coproduction with people and communities needs to therefore be part of a radical change in healthcare leadership and management, away from doing things 'to' or even 'for' people and towards a new model of leading 'with' others, putting people and neighbourhoods at the heart of a new systems leadership, focussing on what really matters.

with others. They have the skill and willingness to work with people in all parts of the system to achieve positive change. They are brave, humble and inclusive. The NHS Leadership for Personalised Care leadership framework describes this in more detail.²⁶ How we all play a part in growing this kind of leadership in healthcare, unleashing people power for good rather than constraining it within our corporate plans, will be a defining challenge in the coming years.

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