

How co-production and co-creation is understood, implemented and sustained as part of improvement programme delivery within the health and social care context in Scotland

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EXECUTIVE SUMMARY

CO-PRODUCTION AND CO-CREATION IN THE CONTEXT OF HEALTH AND SOCIAL CARE INTEGRATION

One of the key policy instruments driving the public services reform agenda in Scotland is the National Performance Framework (NPF), which presents a number of high level outcomes for public services to demonstrate their performance against. Refreshed in 2011, 2016 and in 2018 it has become 'a single framework to which all public services in Scotland are aligned'¹. Within this broader context the Public Bodies (Joint Working) (Scotland) Act 2014 became the legislative framework for the integration of health and social care. This created new public organisations ('Integration Authorities') which aimed to break down barriers to joint working between NHS Boards and local authorities. This resulted in the establishment of 31 health and social care partnership areas, each led by a Chief Officer.

As part of the integration agenda co-production and co-creation are recognised by public and third sector bodies in Scotland as important, based on a general view that these approaches can lead to the achievement of positive outcomes for citizens^{2 3 4}. However, little is known about how co-creation and co-production is understood, implemented, and sustained within health and social care

in Scotland. Given the normative centrality of co-production and co-creation for improving public services, it is timely to investigate the extent to which these approaches are understood, operationalised and sustained as part of the integration of health and social care based on the occupational experiences of those tasked with leading and undertaking integration.

An Audit Scotland (2018) report⁵ and the Ministerial Steering Group (MSG) report (2019)⁶ both called for quicker progress to be made on integration and strongly encouraged innovative approaches for doing so (such as adopting co-productive approaches). In this light, the research also links to the broader theme of public sector governance and reform in Scotland (i.e. how the approaches to public sector reform present barriers or facilitators to the adoption and sustainability of co-production and co-creation), based on the perspectives of those leading integration in health and social care areas and within relevant national agencies.

THE STUDY

This report presents the findings of a research study funded by the Scottish Improvement Science Collaborating Centre (SISCC). The study aimed to understand the experiences of those tasked with leading integration within health and social care areas and national agencies in Scotland. In particular, we sought to unearth how co-production and co-creation is understood, implemented and sustained within the health and social care system. In this respect, the focus of the research gravitates around understanding co-production and co-creation at the *meso* (leadership and management level in areas) and *macro* (national agency) levels and their relationship to health and social care integration.

The research team conducted a review of the extant literature (focusing on evidence review studies) to understand how the academic literature articulates and defines co-production and co-creation within health and social care contexts. The review also includes a review of Scottish policy documents to understand the extent to which co-production and co-creation feature within *macro*-policy narratives. This is in order to consider whether there is a national position or a level of consistency about *what* co-production and co-creation mean and *how* to undertake integration/reform. This contextualises the findings from interviews with those in the health and social care context, especially in terms of offering some explanation as to why there is not a consistent or systematic understanding about the meanings of co-production and co-creation and how it can be applied by those tasked with integrating services and programmes across health and social care boundaries.

REPORT STRUCTURE

This report is made up of two parts. Part 1 presents findings from an evidence review, of review studies and policy documents. This part of the study, identifies and presents results from the current literature on co-production and co-creation within health and social care, and narratives from significant policy documentation. Part 2 compliments these evidence narratives, with lived-experiences gathered from qualitative interviews. These were conducted with those leading integration in health and social care in Scotland (at a health and social care partnership level) and with key national agencies with governance, oversight, and leadership roles in Scotland.

SUMMARY OF STUDY FINDINGS

The research questions were:

1. What are the perceived impacts of co-production and co-creation on service improvements?
2. How do service managers/planners evidence the effectiveness of co-production and co-creation?
3. What are the facilitators and barriers to sustaining co-production and co-creation in improvement programmes in Scotland?
4. How does the social, policy and political context shape the sustainability of co-production and co-creation in health and social care in Scotland?

Our analysis of the literature found that co-production and co-creation are largely very similar but co-creation points to the sustainability of the role of the user throughout

the process of programme design, development, implementation and evaluation (not just at the programme development and design stages). To have meaningful co-creation there would be the need to be agile systems, leadership, management and operational capacities and processes to accommodate such an endeavour (see Part 1 of this report for more details). More specifically, in terms of research question 1, the study found that those in health and social care areas perceive co-production as a 'good thing' to do, although there was a lesser degree of familiarity with 'co-creation' as an approach or concept. The qualitative findings highlight some examples of co-design or community engagement approaches, to health and social care initiatives that have worked and the benefits of such approaches. However there is a lack of evaluation on their impacts and the multiple reasons for this, include resource and capacity changes, skills shortages, and the need to wrestle with multiple and, at times, competing priorities.

Linked to the previous point, the findings suggest that the answer to research question 2 is that the evaluation of the effectiveness of co-production and co-creation is generally regarded by participants as an important aspect of planning integration activities (i.e. that evaluation should be built into planning activities), but that this is a major gap in what they do in practice. The findings also elucidate challenges in terms of relationships between health and social care areas and national agencies. There is a sense of a 'national cluttering' of agencies whereby a number of methodologies and approaches for undertaking reform are offered. And, the perception is that there is an unclear knit between the work of

agencies and the methodologies that they promote (interestingly this was a view shared at national level, not just by those in health and social care areas). Moreover, those in health and social care areas who do seek to evidence the effectiveness of what they consider to be co-productive work reported that it was often unclear to them about the availability and nature of evaluation support available and how/where to access it.

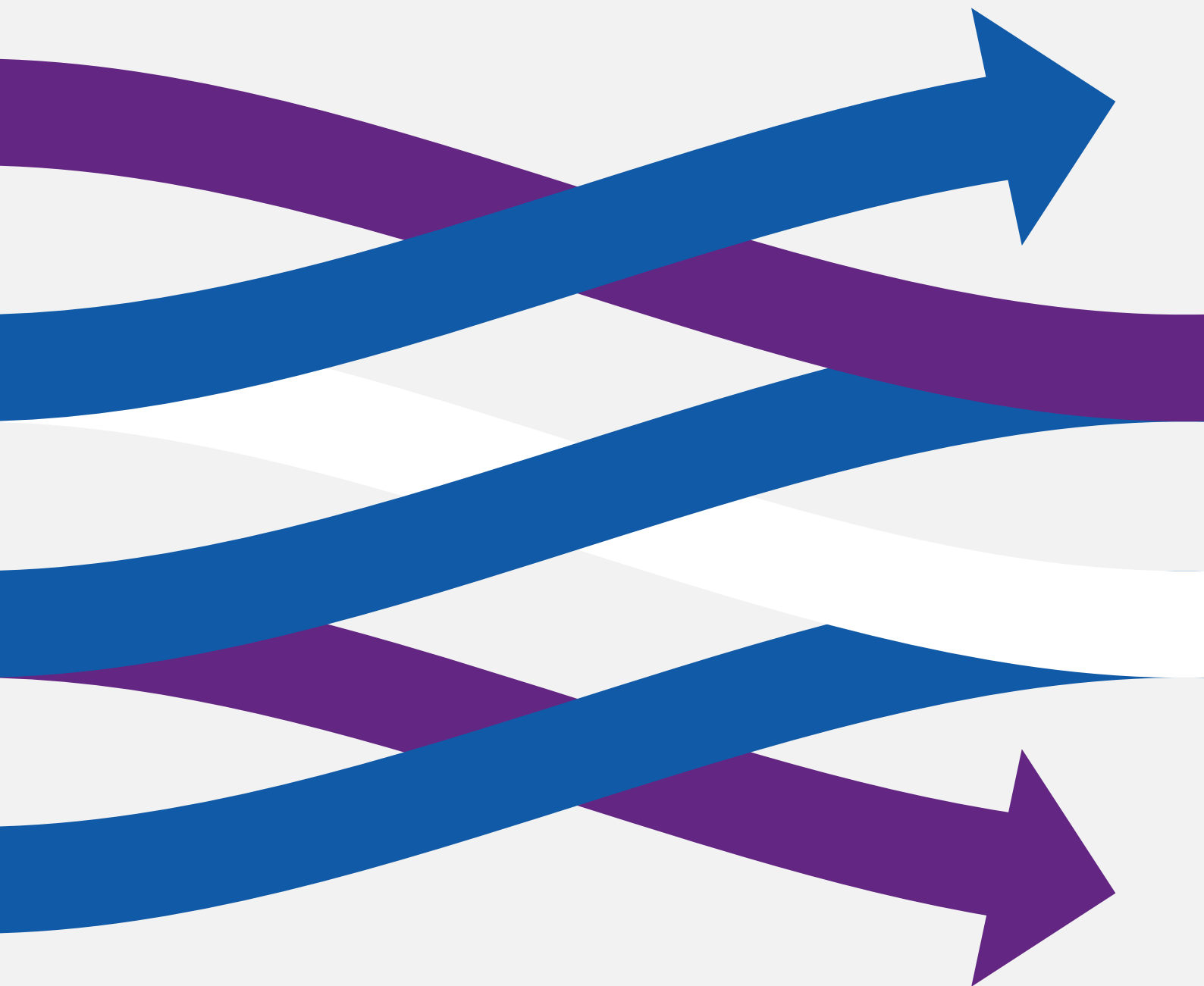
The research found that responses, relevant to research questions 3 and 4, almost became one and the same as they both focused on system-based challenges. Across the health and social care areas involved in the study, there was a spread of socio-economic conditions represented. However, it was highlighted by interviewees from more deprived areas that they face considerable challenges in terms of reaching co-producers of services, especially hard to reach groups who tend not to engage with health and social care integration activities e.g. the re-design of services. Austerity was also reported to be a general political and economic factor which has constrained what could be regarded as more innovative approaches such as co-production (and the evaluation of them).

From a governance perspective, the research reflects the findings of the Audit Scotland and Ministerial Steering Group reports; indicating that the Scottish Government's approach to health and social care integration (from a 'whole of government' point of view) requires reflection. The findings suggest that the perhaps (overly) complex national landscape of agencies (not necessarily in terms of the number of agencies but their remit), compounded with an empowerment/

localism-heavy approach to public services reform, has left Chief Officers and partnership managers in health and social care areas (i.e. those working for the Chief Officers) not always feeling supported. This has had a bearing on the capacities for delivering and sustaining co-production and co-creation as a way to enhance the speed and quality of integration.

The evidence review also points to the virtues of 'being co-productive' and the positive ideas around engaging with communities when making policies and programmes. However, many system-based barriers get in the way of achieving such virtues. Co-creation challenges policy-makers and service planners to rebalance power structures and relationships in order to embed user/citizen involvement in programmes (all the way from programme conception to evaluation and back around again). Although, there were no specific reviews which focus on co-production and co-creation within the context of health and social care in Scotland identified; there is a strong degree of signalling in policy documentation at a national level about the benefits of co-production and co-creation. These policy directives, call for these approaches to be embedded and enabled within health and social care organisations, to have meaning and local impact. Nonetheless, co-production and co-creation are challenging principles for policy-makers and bureaucratic actors to live by and there is the danger that the language of co-production is used as a symbolic mechanism for describing surface-level engagement and deliberation.

PART 1 EVIDENCE REVIEW



INTRODUCTION

The Scottish Government places integration and partnership-working in the public sector, as major drivers for change and mechanisms for improvement under the National Performance Framework¹. There are a number of national levers for encouraging public sector and third sector bodies to work across boundaries and to work with service users and beneficiaries of services, to improve service delivery. Health and social care integration is a major example of a Scottish Government agenda which represents the need for partnership working. The Government, and its agencies, encourage service planners to co-create and co-produce services and programmes in the context of an improvement agenda.

This rapid evidence review, seeks to unearth the available literature on co-production and co-creation within a health and social care context, including the narratives from significant policy documentation. The purpose of this is to try to identify how co-creation and co-production is defined and applied in such a context. In an effort to inform policy-makers and practitioners about the available learning around the issues, practice and complexities around how to undertake such an improvement agenda.

REVIEW QUESTIONS

We conducted two separate but overlapping reviews (a rapid review of reviews and policy document review) in order to help answer the research questions below:

1. What are the perceived impacts of co-production and co-creation on service improvements?
2. How do service managers/planners evidence the effectiveness of co-production and co-creation?
3. What are the facilitators and barriers to sustaining co-production and co-creation in improvement programmes in Scotland?
4. How does the social, policy and political context shape the sustainability of co-production and co-creation in health and social care in Scotland?

RAPID REVIEW OF REVIEWS

METHOD

We conducted a rapid evidence synthesis of any reviews primarily focussing on co-production and co-creation within health and social care, which may provide answers to any of the four research questions. We searched five key online databases (CinAHL, HMCI, Medline, PsycINFO, and Social Science Citation Index) adopting the following search architecture:

- Co-creation or co-production (anywhere in the text).
- Systematic review or literature review (subject headings) or Review (in title).
- No limits.

We did not apply any limits and de-duplicated the results of the search. Two members of the research team independently screened the titles and abstracts of publications found in the search.

Studies were screened according to the following inclusion criteria – included if:

- A review of co-production and/or co-creation in health and or social care.
- A review which includes empirical studies (qualitative or quantitative).
- Provides any data relevant to one or more of the five study research questions.

Of those reviews that met inclusion criteria, we reported the range and nature of the evidence they contain and then mapped their findings to each of the five research questions (RQs). A narrative synthesis of the review findings under each of the RQs was then conducted. The Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre, 2010), approach was adopted for this systematic literature review. Quality and relevance appraisals were conducted and EPPI-Centre weight of evidence (WoE) judgments were applied to each of the included reviews.

Three components were assessed in order to help derive an overall weighting of evidence score (methodological quality; methodological relevance; topic relevance):

- **Methodological quality** assessment determined the trustworthiness of the results judged by the quality of the study within the accepted norms for undertaking the particular type of research design used in the study. This involved asking questions related to a study's reporting, context, sample, design, reliability and validity of data-collection and analysis (including appropriate number and range of explanatory variables in the statistical models), ethics, sample size, risk of bias resulting from selection and maintenance of sample, and generalisability.

- **Methodological relevance** involved determining the appropriateness of the study design for addressing their particular research question/s.
- **Topic relevance** involved assessing the appropriateness of focus of the research for answering the review question(s).

The following scoring system was used to make assessments for each of the three components assessed: 1 = excellent, 2 = good, 3 = satisfactory, 4 = inadequate.

These assessments were then used to inform a judgement of overall weight of evidence (WoE)

based on the assessments for each of the above criteria and by using the same scoring system. Studies classified as good or excellent were included in the synthesis whereas reviews considered satisfactory or inadequate regarding their WoE were not.

RESULTS

The search resulted in 263 citations being found, of which 243 were subsequently excluded (see Figure 1 below).

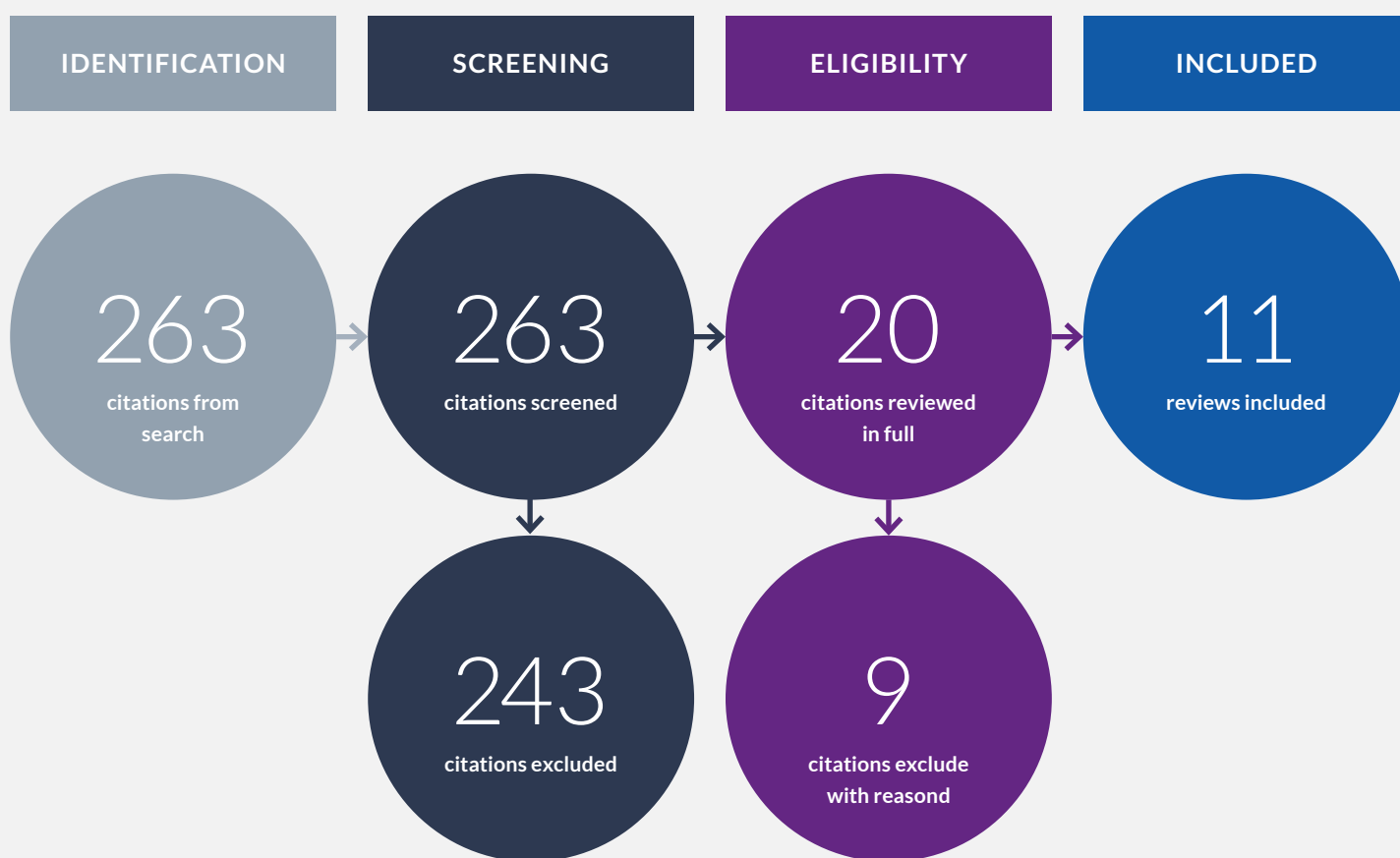


Figure 1: Flow diagram of study selection

CITATION REVIEW

Twenty citations were retrieved in full (1-20). Following detailed scrutiny of the full texts, 9 were subsequently excluded (see Table 1 below for reasons for exclusion); resulting in 11 reviews included within the rapid review of reviews.

Table 1: Citations excluded with reasons for exclusion

Citation	Reason for exclusion
Alzaydi ZM, Al-Hajla A, Nguyen B, Jayawardhena C. A review of service quality and service delivery Towards a customer co-production and customer-integration approach. <i>Business Process Management Journal</i> . 2018;24(1):295-328.	Not health and or social care
Attree P, French B, Milton B, Povall S, Whitehead M, Popay J. The experience of community engagement for individuals: a rapid review of evidence. <i>Health & Social Care In The Community</i> . 2011;19(3):250-60.	Focus on community engagement not co-creation/co-production
Baines RL, Regan de Bere S. Optimizing patient and public involvement (PPI): Identifying its “essential” and “desirable” principles using a systematic review and modified Delphi methodology. <i>Health Expectations: An International Journal Of Public Participation In Health Care And Health Policy</i> . 2018;21(1):327-35.	Focus on patient and public involvement not co-creation/co-production
Bosco A, Schneider J, Coleston-Shields DM, Orrell M. Dementia care model: Promoting personhood through co-production. <i>Archives of Gerontology & Geriatrics</i> . 2019;81:59-73.	Primary focus is on coping with dementia
Freeman LR, Waldman M, Storey J, Williams M, Griffiths C, Hopkins K, et al. Working towards co-production in rehabilitation and recovery services. <i>Journal of Mental Health Training, Education & Practice</i> . 2016;11(4):197-207.	Not a review of the literature
Harris J, Cook T, Gibbs L, Oetzel J, Salsberg J, Shinn C, et al. Searching for the Impact of Participation in Health and Health Research: Challenges and Methods. <i>BioMed Research International</i> . 2018;2018:1-12.	Focus on methods for systematically reviewing the impact of participation in health research
Kislov R, Wilson PM, Knowles S, Boaden R. Learning from the emergence of NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs): a systematic review of evaluations. <i>Implementation Science: IS</i> . 2018;13(1):111-	Not sufficient focus on co-production or co-creation
Lwembe S, Green SA, Chigwende J, Ojwang T, Dennis R. Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: an evaluation of a pilot service. <i>Primary Health Care Research & Development (Cambridge University Press / UK)</i> . 2017;18(1):14-23.	Not a review of the literature
Vindrola-Padros C PT, Utley M, et al. The role of embedded research in quality improvement: a narrative review. <i>BMJ Quality and Safety</i> . 2017;26:10.	Not sufficient focus on co-production or co-creation

Table 2: Characteristics of included reviews

The following scoring system was used to make assessments for each of the three components (methodological quality (MQ), methodological relevance (MR) and topic relevance (TR)) and the overall weight of evidence (WoE): 1 = excellent, 2 = good, 3 = satisfactory, 4 = inadequate.

Citation	Review aim	MQ	MR	TR	WoE	Information/data relevant to research questions
Voorberg et al ⁷ 2015	Systematic review of 122 articles and books (1987–2013) of co-creation/co-production with citizens in public innovation. It analyses (a) the objectives of co-creation and co-production, b) its influential factors and (c) the outcomes of co-creation and co-production processes	2	2	1	1	Most studies focus on the identification of influential factors, while hardly any attention is given to the outcomes. Future studies could focus on outcomes of co-creation/co-production processes.
Brunton, et al ⁸ 2017	Systematic review of community engagement in public health interventions using: stakeholder involvement; searching, screening, appraisal and coding of research literature; and iterative thematic syntheses and meta-analysis. A conceptual framework of community engagement was refined, following interactions between the framework and each review stage.	1	1	2	2	From 335 included reports, three products emerged: (1) two strong theoretical 'meta-narratives': one, concerning the theory and practice of empowerment/engagement as an independent objective; and a more utilitarian perspective optimally configuring health services to achieve defined outcomes. These informed (2) models that were operationalized in subsequent meta-analysis. Both refined (3) the final conceptual framework. This identified multiple dimensions by which community engagement interventions may differ. Diverse combinations of intervention purpose, theory and implementation were noted, including: ways of defining communities and health needs; initial motivations for community engagement; types of participation; conditions and actions necessary for engagement; and potential issues influencing impact. Some dimensions consistently co-occurred, leading to three overarching models of effective engagement which either: utilised peer-led delivery; employed varying degrees of collaboration between communities and health services; or built on empowerment philosophies.

Citation	Review aim	MQ	MR	TR	WoE	Information/data relevant to research questions
Clarke et al ⁹ 2017	Rapid evidence synthesis to identify and appraise reported outcomes of co-production as an intervention to improve quality of services in acute healthcare settings.	2	2	2	2	<p>11 papers were included in the evidence synthesis. One study was a feasibility randomised controlled trial, three were process evaluations and seven used descriptive qualitative approaches.</p> <p>Reported outcomes related to (a) the value of patient and staff involvement in co-production processes; (b) the generation of ideas for changes to processes, practices and clinical environments; and (c) tangible service changes and impacts on patient experiences. Only one study included cost analysis; none reported an economic evaluation. No studies assessed the sustainability of any changes made.</p> <p>Conclusions: Despite increasing interest in and advocacy for co-production, there is a lack of rigorous evaluation in acute healthcare settings. Future studies should evaluate clinical and service outcomes as well as the cost-effectiveness of co-production relative to other forms of quality improvement. Potentially broader impacts on the values and behaviours of participants should also be considered.</p>
De Weger et al 2018	A Rapid Realist Review was conducted to investigate how interventions interact with contexts and mechanisms to influence the effectiveness of Community Engagement.	2	2	2	2	<p>Eight action-oriented guiding principles were identified:</p> <ul style="list-style-type: none"> • ensure staff provide supportive and facilitative leadership to citizens based on transparency; • foster a safe and trusting environment enabling citizens to provide input; • ensure citizens' early involvement; • share decision-making and governance control with citizens; • acknowledge and address citizens' experiences of power imbalances between citizens and professionals; • invest in citizens who feel they lack the skills and confidence to engage; • create quick and tangible wins; • take into account both citizens' and organisations' motivations. <p>An especially important thread throughout the community engagement literature is the influence of power imbalances and organisations' willingness, or not, to address such imbalances. The literature suggests that 'meaningful participation' of citizens can only be achieved if organisational processes are adapted to ensure that they are inclusive, accessible and supportive of citizens.</p>

Citation	Review aim	MQ	MR	TR	WoE	Information/data relevant to research questions
Greenhalgh et al ¹¹ 2016	Narrative review of different models of co-creation relevant to community-based health services. Contrasted their diverse disciplinary roots and highlighted their common philosophical assumptions, principles of success, and explanations for failures.	2	2	2	2	<p>Findings: Co-creation emerged independently in several fields, including business studies (“value co-creation”), design science (“experience-based co-design”), computer science (“technology co-design”), and community development (“participatory research”).</p> <p>These diverse models share some common features, which were also evident in the case study. Key success principles included (1) a systems perspective (assuming emergence, local adaptation, and nonlinearity); (2) the framing of research as a creative enterprise with human experience at its core; and (3) an emphasis on process (the framing of the program, the nature of relationships, and governance and facilitation arrangements, especially the style of leadership and how conflict is managed). In both the literature review and the case study, co-creation “failures” could often be tracked back to abandoning (or never adopting) these principles.</p> <p>All co-creation models made strong claims for significant and sustainable societal impacts as a result of the adaptive and developmental research process; these were illustrated in the case study.</p>
Hughes and Duffy ¹² 2018	Analysis exploring and clarifying the nature and meaning of public involvement in health and social sciences research and identifies operational definitions which can be used to guide, develop and evaluate public involvement in research activity.	2	2	2	2	<p>Five operational definitions were developed from the concept analysis: undefined involvement; targeted consultation; embedded consultation; co-production; and user-led research. Typical examples of each approach were identified from the literature. Defining attributes included having clear and agreed meaning and purpose for any involvement; reciprocal relationships; and value and recognition of the expertise of all those involved.</p> <p>The authors argue the need for researchers to more explicitly incorporate and evaluate details of approaches used. Impact of public involvement on a research study should be identified when reporting on findings to prevent tokenistic practices where involvement is viewed as secondary to the core research process.</p>

Citation	Review aim	MQ	MR	TR	WoE	Information/data relevant to research questions
Slay and Stephens ¹³ 2013	<p>Review of existing evidence in relation to co-production – focusing on when, why and how it has been used across mental healthcare, which aspects of co-production are being developed in the sector, what impact it has had on mental health support and the recovery of people with mental health difficulties</p> <p><i>(Selected literature from an existing database of co-production literature which is kept by NEF and updated regularly with new materials to identify the key literature on co-production in mental health.)</i></p>	2	2	1	2	<p>Defines co-production through work with practitioners and critical friends:</p> <p>“A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities” (p. 3)</p> <p>Six principles which underpin co-production:</p> <ul style="list-style-type: none"> • Taking an assets-based approach: perception of people as active and equal partners, not passive recipients, in designing and delivering services • Building on people’s existing capabilities – to recognise and grow capabilities, with active support to put to use at individual and community level • Reciprocity and mutuality: range of incentives for people to work with professionals and each other, with a range of expectations and responsibilities • Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge • Blurring distinctions: between professionals and service recipients, producers and consumers, by reconfiguring how services are developed and delivered • Facilitating not delivering: public service agencies as catalysts and facilitators, not main providers
Buyck et al ¹⁵ 2017	<p>Poster only.</p> <p>Systematic review searching for papers on patient participation, integrated care and chronic diseases that were published between January 2003 and December 2016. After categorizing the general focus of the articles, the levels and degrees of patient participation that were described in the studies were reviewed.</p>	3	3	2	3	<p>Most papers address patient participation in the creation and/or evaluation of integrated care initiatives or ICT facilitators to achieve integrated care. A small group of articles explores the perspectives of patients on integrated services and policies. Regarding the level of care in which patients are involved, most studies refer to patient participation at the <i>meso</i>-level. Also, in some studies participation at the <i>macro</i>-level is described. Concerning the degree of participation, in the majority of articles patients are consulted to express their views, yet this infrequently leads to the actual co-creation of integrated care initiatives.</p>

Citation	Review aim	MQ	MR	TR	WoE	Information/data relevant to research questions
Bradley ¹⁴ 2015	Non-systematic review providing a brief overview of the literature to date which has focused on co-production within mental healthcare in the UK, including service user and carer involvement and collaboration. Debates the current involvement of carers across mental healthcare and debates whether co-production could be a vehicle to utilise carer expertise, enhance quality and satisfaction with mental healthcare. <i>(Selected literature – no methods described)</i>	4	4	3	3	<p>Despite the challenges, co-production in mental healthcare represents a real opportunity for the skills and experience of family members to be taken into account and could provide a mechanism to achieve the “triangle of care” with input, recognition and respect given to all (service users, carers, professionals).</p> <p>Lack of attention in relation to carer perspectives, expertise and potential involvement could undermine the potential for co-production to act as a vehicle to encourage person-centred care which accounts for social and clinical factors.</p> <p>There is a danger that carer expertise will remain on the margins of mental healthcare, despite representing a real and valuable source of information and support for people living with mental health difficulties and those supporting them. Furthermore, as services increase their focus on self-management and “care closer to home”, the pressure on family members will likely also increase.</p>
Kenny et al ¹⁶ 2015	A critical review drawing upon a body of literature to outline the practical considerations in implementing community participation policy in health settings in rural areas.	3	3	2	3	Despite policymakers suggesting that community participation is good for rural communities, policy enactment must move beyond mandated tokenism for there to be a recognition that meaningful participation is neither easy nor linear.
Costa et al ¹⁷ 2018	Full paper not available – Research Gate request sent (probably not English language) “The systematic literature review presented in this paper had the objective of presenting the data analyzed in the scientific literature on the performance of the patient as a coproducer in the health services.”	?	?	?	?	The analysis of these articles highlights the approach of the theme in three categories: the role of the patient as a co-producer, the education of the patient for co-production, and the relationship between patient and health professionals. The results indicate that the patient’s role as co-producer is directly related to other factors in order to achieve the expected results. It was observed that aspects such as treatment management and the impacts of co-production in the value chain of health services are not yet addressed in depth in the literature.

NARRATIVE SYNTHESIS – RAPID REVIEW OF REVIEWS

From the included 11 reviews, seven reviews were assessed as being **good or excellent** with regard to weight of evidence and these have formed the basis of this narrative synthesis.

They included reviews from a range of settings, i.e. community-based services, acute care, mental health and public participation in research and incorporated a number of approaches including co-creation, co-production, community engagement

and public involvement. The findings from these reviews in relation to the research questions are summarised in Table 3, below.

The analysis of the **good or excellent** reviews identified three key themes within the literature that supported the exploration of research questions around the use of co-production and co-creation within health and social care contexts:

- definitions and underlying principles;
- models and conceptual frameworks;
- assessing impact – barriers and facilitators.

Table 3 – Narrative synthesis, summary of reviews

Citation	Focus	Review
Brunton ⁸ , (2017)	Community engagement in <i>public health interventions</i>	Systematic Review
Clarke et al ⁹ , (2017)	Outcomes of co-production as an intervention to improve quality of services in <i>acute healthcare settings</i>	Rapid Review
De Weger et al ¹⁰ , (2018)	How interventions interact with contexts and mechanisms to influence the effectiveness of Community Engagement	Realist Synthesis
Greenhalgh et al ¹¹ , (2016)	different models of co-creation relevant to <i>community-based health services</i>	Narrative Review
Hughes and Duffy ¹² (2018)	exploring and clarifying the nature and meaning of public involvement in <i>health and social sciences research</i>	Concept Analysis
Slay and Stephens ¹³ (2013)	when, why and how co-production has been used across <i>mental healthcare</i>	Review of selected literature
Voorberg et al ⁷ , (2015)	co-creation/co-production with citizens in <i>public innovation</i>	Systematic Review

DEFINITIONS AND UNDERLYING PRINCIPLES

Slay and Stephens¹³ note that the term co-production is largely absent from the literature, with the exceptions tending to be when the studies reviewed were of initiatives closely aligned with or originating from co-production. Their work¹³ developed a working definition of co-production through work with local practitioners and with a national group of 'Critical Friends'. Co-production is to be understood as '*a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities*'. Six principles which are the foundation stones of co-production are identified:

1. Taking an assets-based approach: transforming the perception of people, so that they are seen not as passive recipients of services and burdens on the system, but as equal partners in designing and delivering services.
2. Building on people's existing capabilities: altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use at an individual and community level.
3. Reciprocity and mutuality: range of incentives for people to work with professionals and each other, with a range of expectations and responsibilities.

4. Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
5. Blurring distinctions: between professionals and service recipients, producers and consumers, by reconfiguring how services are developed and delivered.
6. Facilitating not delivering: public service agencies as catalysts and facilitators, not main providers.

Slay and Stephens¹³ note that a common question about co-production is how it differs from more traditional approaches to engagement or consultation. They adapted Armstein's Ladder of Participation, which depicts different levels of involvement, to reflect how co-production builds on previous user/professional dynamics (figure 2 below).

Doing to: The first stages of the pathway represent traditional services at their most coercive. Here, services are not so much intended to benefit the recipients, but to educate and cure them so that they conform to idealised norms and standards. Unsurprisingly recipients are not invited to participate in the design or delivery of the service; they are simply supposed to agree that it will do them good and let the service 'happen to them'.

Doing for: As the pathway progresses, it moves away from coercion towards shallow involvement. There is greater participation, but still within clear parameters that are set by professionals. Here, services are often designed by professionals with the recipient's best interests in mind, but people's involvement in the design and delivery of the services is constrained. Professionals might, for

example, inform people that a change will be made to how a service is to be run, or they may even consult or engage them to see what they think about these changes. This, however, is as far as it goes. People are only invited to be heard; they are not given the power to make sure that their ideas or opinions shape decision-making.

Doing with: The most advanced stages of the pathway represent a much deeper level of service user involvement that shifts power towards people. These require a fundamental change in how service workers and professionals work with service users, recognising that positive outcomes cannot be delivered effectively to or for people. They can best be achieved with people, through equal and reciprocal relationships. Co-designing a service involves sharing decision-making power with people. This means that people's voices must be heard, valued, debated, and then – most importantly – acted

upon. Co-production goes one step further by enabling people to play roles in delivering the services that they have designed. In practice this can take many forms, from peer support and mentoring to running everyday activities or making decisions about how the organisation is run. What really matters is that people's assets and capabilities are recognised and nurtured, that people share roles and responsibilities to run the service, and that professionals and service users work together in equal ways, respecting and valuing each other's unique contributions.

Voorberg et al⁷ conducted a systematic review of the academic literature regarding public co-creation and co-production with citizens. At the outset, it was noted that co-creation refers to the 'active involvement' of end-users in various stages of the production process and that this is more specific than, for instance, the broad concept of participation, which could also refer

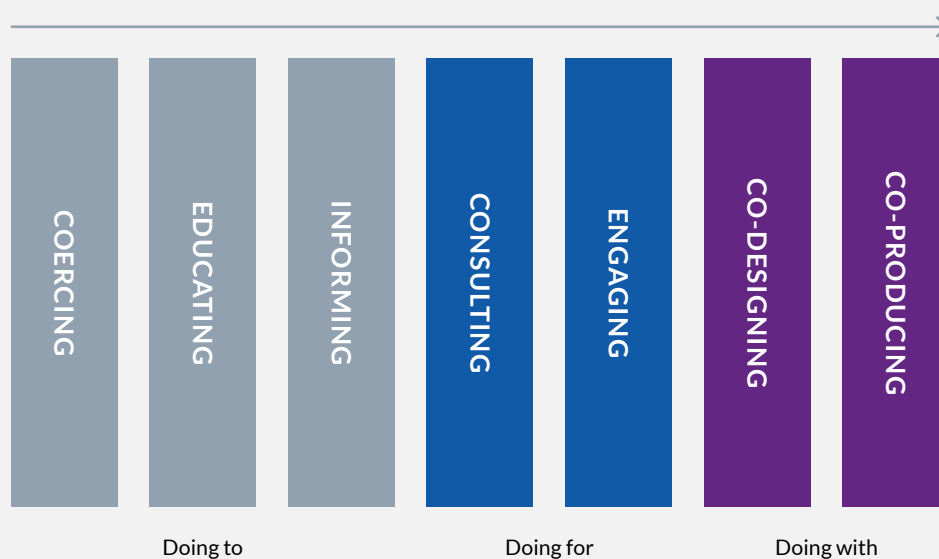


Figure 2: An alternative Ladder of Participation

to 'passive involvement'. The review aimed to provide an evidence-based overview regarding the conditions under which citizens co-create or co-produce and included 122 studies (27 on co-creation and 95 on co-production). Of the included studies, 30 were relevant to healthcare.

Regarding the types of co-creation/co-production found across the included studies, distinguishing three types which differ in their degree of citizen involvement⁷. Type 1 involves the citizen as 'co-implementer' of public services, type 2 the citizen as 'co-designer', and type 3 the citizen as 'initiator'. The distinction between co-production and co-creation does not depend so much on the type of citizen involvement. In both co-creation and co-production studies, the citizen as a co-implementer has been studied the most extensively. Voorberg et al⁷ compared the record definitions of co-creation/co-production, and whilst some authors provided no definition, those that did led to the conclusion that, to a large extent, both are defined similarly. Thus the terms co-creation and co-production are often used interchangeably.

For the purposes of Clarke et al's⁹ review, they adopted the definition provided by Osborne et al¹⁸ who view co-production as '*the voluntary or involuntary involvement of public service users in any of the design, management, delivery and/or evaluation of public services.*'

De Weger et al¹⁰, conducted A Rapid Realist Review to investigate how interventions interact with contexts and mechanisms to influence the effectiveness of Community Engagement. Findings suggest that meaningful participation of citizens

can only be achieved if organisational processes are adapted to ensure that they are inclusive, accessible and supportive of citizens. Eight action-oriented guiding principles were identified:

1. ensure staff provide supportive and facilitative leadership to citizens based on transparency;
2. foster a safe and trusting environment enabling citizens to provide input;
3. ensure citizens' early involvement;
4. share decision-making and governance control with citizens;
5. acknowledge and address citizens' experiences of power imbalances between citizens and professionals;
6. invest in citizens who feel they lack the skills and confidence to engage;
7. create quick and tangible wins;
8. take into account both citizens' and organisations' motivations.

Hughes and Duffy¹² conducted a concept analysis of the nature and meaning of public involvement in health and social sciences research. They developed five operational definitions from their concept analysis:

1. undefined involvement;
2. targeted consultation;
3. embedded consultation;
4. co-production;
5. user-led research.

Co-production was described thus: '*Members of the public with relevant lived experience, are involved as members of the research team as researchers/co-authors or in ways where they contribute to key decisions regarding research processes and*

findings. Typically this includes people contributing to decisions such as the tools used, choice and wording of research questions, how data are analysed, how research findings are presented and how research might be implemented. It may also involve writing plain English (lay) summaries, contributing as co-authors and being part of a steering group.'

This model is characterised by the reciprocal nature of the relationships and collaborative processes involved, even when participants undertake different roles based on their areas of expertise. For collaboration to work and for decision making to be shared appropriately, sufficient training, supervision and support is provided.

MODELS AND CONCEPTUAL FRAMEWORKS

Greenhalgh et al¹¹, identified that co-creation emerged independently in several fields, including business studies ('value co-creation'), design science ('experience-based co-design'), computer science ('technology co-design'), and community development ('participatory research'). These diverse models share some common features: (1) a systems perspective (assuming emergence, local adaptation, and nonlinearity); (2) the framing of research as a creative enterprise oriented to design and with human experience at its core; and (3) an emphasis on process, including the framing of the program, the quality of relationships, and governance and facilitation arrangements, especially power-sharing measures and the harnessing of conflict as a positive and engaging force.

Brunton et al's⁸ synthesis comprehensively examined the 'models, practice, outcomes and economics of using community engagement to improve the health of disadvantaged groups'. Different ways of providing community engagement and some potential underlying models were compared. It is noted that 'community engagement' suffers from a bewilderingly large number of inconsistent and partially conflicting definitions. However, rather than focusing on the overarching heterogeneous concept of community engagement, they⁸ argue that we are better served by identifying the key characteristics of interventions and how these relate to their underpinning models.

They identified two strong theoretical 'meta-narratives': one, concerning the theory and practice of empowerment/engagement as an independent objective; and a more utilitarian perspective optimally configuring health services to achieve defined outcomes. Diverse combinations of intervention purpose, theory and implementation were noted, including:

- ways of defining communities and health needs;
- initial motivations for community engagement;
- types of participation;
- conditions and actions necessary for engagement;
- potential issues influencing impact.

Some dimensions consistently co-occurred, leading to three overarching models of effective engagement which either: utilised 'peer-led delivery'; employed 'varying degrees of collaboration' between communities and health services; or built on 'empowerment philosophies'.

ASSESSING IMPACT – BARRIERS AND FACILITATORS

Clarke's⁹ rapid review of the outcomes of co-production as an intervention to improve quality of services in acute healthcare settings; identified that a variety of terms have become evident in the growing literature on co-production. And a range of related approaches are being enacted in different ways and at various levels throughout public and health sector services.

They note that co-production is an emerging focus for research and evaluation in the health sector but that currently, there is no international agreement on or consistent use of terminology to capture the range and diversity of participative approaches increasingly employed in health services worldwide.

Regarding the facilitators and barriers to co-creation in improvement programmes, this study⁹ examined this question directly. The most commonly reported barriers encountered in using co-production approaches in acute healthcare settings included a lack of support, resources or managerial authority to bring about structural or environmental changes. In addition, practical or logistical problems were identified, for example, ensuring frail elderly people could attend regular co-design meetings. Recruiting patients and carers and retaining them through the different stages of projects were highlighted by a number of researchers. Researchers also identified the need to plan for and manage patients' understanding of what may be a radically different form of engagement with hospital staff, often quite unlike that experienced previously by users of health

services. In the studies reviewed, the frequency and duration of their involvement and also the time it may take to bring about changes in the structures, processes and sometimes the physical environments of services were highlighted as factors to be addressed with participants.

In the majority of projects, staff engagement was in addition to usual clinical or managerial roles; nonetheless, a high level of interest in and commitment to co-production activity was identified in almost all projects. However, this was impacted on in at least five projects by staffs' frustration at the expectation that they would undertake co-production/co-design work in their own time, also that they could not allocate time out of their routine work and that additional support was often not provided by more senior staff. For some staff, this made participation almost impossible; for others, it meant projects did not progress as expected or contributed to tensions in co-design groups or between researchers and participants. The duration of projects also increased the likelihood that staff turnover would impact on project leadership or involvement. The need for structured and ongoing managerial and organisational support was highlighted, but only two studies expressly refer to governance or oversight groups set up to support co-design projects.

Interestingly they⁹ note that despite the barriers, the studies suggest researchers and participants across settings viewed the benefits of this level of patient and staff involvement in structured co-production/co-design projects as outweighing the challenges. In projects where facilitators were engaged formally and funded to manage or oversee projects, it was more likely that projects

maintained momentum and were delivered as planned, engaged and retained patients, carers and staff and generated concrete examples of areas where patients' or carers' experiences could be improved. In some studies, researchers (some of whom were designers) facilitated staff and patient engagement in the projects. Where designers were directly involved, findings suggest that they introduced ways of thinking and working which successfully challenged staff and patients to reconceptualise everyday processes and activities. This was achieved using metaphor games, design experiments, visual storyboards, prototyping, future focus groups and emotional mapping, approaches not familiar to most health service staff.

We found no specific reviews which focus on co-production and co-creation within the context of health and social care in Scotland.

POLICY DOCUMENT REVIEW

METHOD

A narrative synthesis of relevant policies was conducted of pivotal Scottish focused national and local primary (policy) documents referencing co-production/co-creation. These included those that have led to the integration of health and social care, and associated policies. The search strategy also incorporated the review of key Scottish organisations' websites (see Table 4 below), as well as relevant policy documents identified by the

research team and the Project Advisory Group. These primary sources were examined to comprehend how co-production/co-creation is understood and applied in a Scottish context.

Findings from the policy document review were also used to inform some of the interviews that took place later in the qualitative interview component of the study.

Table 4 – Key Scottish organisations' websites

Key organisations to be searched to identify Scottish focused national and local policies	
Audit Scotland	https://www.audit-scotland.gov.uk
COSLA	https://www.cosla.gov.uk
Healthcare Improvement Scotland	http://www.healthcareimprovementscotland.org
Health and Social Care Alliance Scotland	https://www.alliance-scotland.org.uk
Improvement Service	http://www.improvementservice.org.uk
NHS Health Scotland	https://www.publichealthscotland.scot
Scottish Community Development Centre	https://www.scdc.org.uk
Scottish Co-production Network	http://www.coproductionscotland.org.uk
Scottish Government	https://www.gov.scot

RESULTS

Narrative synthesis – policy document review

To better understand how the social, policy and political context has shaped the sustainability of co-production and co-creation in health and social care in Scotland; a review of key policy documents over the last ten years, was undertaken. This section highlights the key points and narratives to emerge, which consider public services reform with comment on the extent to which co-production and co-creation feature. Table 5 (page 28) provides detail of the policy documents included in the review.

Christie Commission¹⁹ (Commission on the Future Delivery of Public Services, 2011):

This seminal report refers to research evidence and submissions gathered on positive approaches to public service delivery, which inferred that public services can *'become more efficient and effective in working collaboratively to achieve outcomes, focusing on: the actual needs of people; energising and empowering communities and public service workers to find innovative solutions; and building personal and community capacity, resilience and autonomy'* (p.26). In relation to the notion of community empowerment, the report argues that *'public services are most effective, and provide best value for money, when users have a pivotal role in designing and evaluating them with better, more sustainable outcomes and higher levels of satisfaction for users and staff also result'* (p.35).

The Healthcare Quality Strategy for Scotland²⁰ (2010):

Although published before the Christie Commission this document, which evolved from Better Health, Better Care²¹ (2007) underpins

the strategic focus of NHSScotland and commits to *'improve the health of everyone in Scotland and to improve the quality of healthcare and healthcare experience'* (p.5). Whilst it does not explore co-production in depth it clearly makes a commitment to delivering person-centred care and states *'We will have to involve the people of Scotland to a greater extent in the 'co-production' of health and healthcare'* (p.8).

Reshaping Care for Older People A Programme for Change²² (2011):

This policy was developed in light of the need to improve the quality and outcomes of models of care, to address the demographic change and increasing service demands and financial pressures. It was intended to provide a long term, strategic approach to support a substantial shift from care in institutional settings to home and community based care; focusing on anticipation and prevention. This strategy published jointly by Scottish Government, Local Authorities and NHS Scotland, built on the Christie Commission and placed co-production at the heart of implementing new strategies, models and commissioning plans.

This document clearly articulated the anticipated benefits of co-production within a health and social care context: *'there is a growing body of evidence on the interventions, approaches and services which are consistent with the principles of co-production and personalisation and which have been shown to contribute to the outcomes we seek'* (p.18) and highlighted the role that co-production would play in delivering this strategy. Local Change Plans would have *'a philosophy of co-production embedded as mainstream practice in both the development and the delivery of all services for older people'* (p.14) and

that this would be achieved through prioritising a co-production approach ‘to develop new community driven models of care to help older people maintain independence whenever possible’ (p18); working with older people, carers and the third sector.

Age, home and community: a strategy for housing for Scotland’s older people²³ (2011):

This strategy has a vision that ‘older people are supported to enjoy full and positive lives in their own home or in a homely setting’ (p3). through progress towards five key outcomes for housing and related support for older people, covering: clear strategic leadership; information and advice; better use of existing housing; preventative support; and new housing provision. Underpinning the strategy, are four key principles: ‘older people as an asset; choice; planning ahead; and preventative support’ (p.3). Building on the principle of ‘older people as an asset’; models of co-production are recommended as the mechanisms to involve older people in the planning and design of services that affect them.

Social Care (Self-directed Support) (Scotland) Bill²⁴ (2012):

This Act enacted legislative provisions to ensure people have a choice about the arrangements of care, support and community care services they receive. The Bill’s policy memorandum places co-production at the heart of driving person-centred care. It intimates that ‘The Bill will help to empower individuals to gain equality of opportunity and to sustain their citizenship. It will ensure that the law plays its part to underpin genuine co-production, to move away from direct delivery models towards person-centred support and a focus on designing solutions on the basis of ensuring improved outcomes for individuals’ (p.16).

Public Bodies (Joint Working) (Scotland) Bill Policy Memorandum²⁵ (2013):

This was one of the documents submitted to parliament in advance of voting on the Bill. In its discussion on partnership working and the involvement of more than just statutory partners, the memorandum argues for ‘Health Boards, local authorities and integration joint boards to fully and appropriately involve non-statutory providers of health and social care with planning and decision-making within the partnership arrangements. This is consistent with principles of co-production, which underpin the Government’s vision for mutual and person-centred public services, which encourage the utilisation of the talents, capacities and potential of all of Scotland’s people and communities in designing and delivering health and social services’ (p.5). As well as specifying that in relation to locality planning, ‘a co-production approach to planning activities and this must also include carers and users of health & social care services’ (p.25).

Co-production in Scotland: A Policy Overview²⁶ (2015):

This overview by Mark McGeachie and Gerry Power, of the then Joint Improvement Team (Loeffler et al. 2013) highlighted the various policies, legislative and strategy mechanisms within with principles associated with co-production were spreading from dementia, to housing, from human rights to regeneration. The summary concludes, ‘that co-production needs to become essential to the way Scotland works if we are to achieve the public services which Christie envisioned and achieve better outcomes for people and communities’ (p.7).

Carers (Scotland) Bill – Policy Memorandum²⁷ (2015):

The purpose of this legislation was to make the provision for the involvement of carers organisations in relation to the planning, shaping and delivery of services and support associated with health and social care integration. It further reaffirmed the role of co-production in delivering *‘the Government’s vision for person-centred public services which use the talents, capacities and potential of all of Scotland’s people and communities in designing and delivering services and support to meet carers’ needs’* (p.5).

Scotland’s Digital Health and Care Strategy²⁸ (2018):

This policy builds on earlier public sector transformation strategies and aims to enhance and transform care through the use of digital technology. This strategy recognises the principle of co-production as *‘the most powerful force for change’* (p.7) and *‘if we are to truly transform how we deliver health and care, our citizens and front-line staff need to be involved from the very beginning for any service redesign’* (p.7). This document also references the Digital First Service Standard, which aims to ensure that services in Scotland are continually improving and users are always the focus with co-production built in. This re-enforces the role of co-production as an essential component to design digital health and care solutions.

Table 5 – Policy documents

Year	Name	Notes	Available at
2010	The Healthcare Quality Strategy for NHS Scotland	This strategy still appears to underpin work in the NHS around safe and effective treatment and person-centred care.	https://bit.ly/2JzP49D
2011	Commission on the Future Delivery of Public Services	This influential commission has shaped subsequent government policy responses in various ways. Aside from consultations, it drew on two key bodies of work, summarised in a Local Authorities & Research Councils’ Initiative (LARCI) report on co-production of local public services & work from NESTA offering a critique of current models of public service delivery & keys to transformation.	https://bit.ly/2UD4W0V
2011	Age, Home and Community: A Strategy for Housing for Scotland’s Older People: 2012–2021	A 2017 progress update did not frame its content around the outcomes or principles.	https://bit.ly/2xFiQac

Year	Name	Notes	Available at
2011	Reshaping Care for Older People A Programme for Change 2011-2021	<p>The strategy variously describes co-production as a philosophy, principles which also indicates that this will be a <i>'long and incremental process of changing to an approach'</i> (p19) that is personalised & based on assets & also person-centred – these being other concepts in use in health and social care. It noted that the philosophy of co-production was <i>'at the heart of the NHS Quality Strategy & is central to the work being taken forward by the Scottish Government in its Independent Living programme. It is also consistent with the aims of Self Directed Support & the ambitions in the Carers' Strategy'</i> (p20).</p> <p>There is a 2013 progress update that focused on developing evidence for the approaches, ensuring partners have skills & experience to undertake this work & sharing of good practice between partnerships available: https://www.gov.scot/publications/reshaping-care-older-people-2011-2021</p>	https://bit.ly/3dKRsrP
2012	Social Care (Self-directed Support) (Scotland) Bill – Policy Memorandum	<p>Whilst the act does not use the word co-production, it's principles with their human rights orientation describes the importance of user/carer participation. A 2018 progress report, highlighted that in relation to commissioning approaches, flexibilities introduced into procurement legislation were being used to develop more innovative approaches to delivery & that as a result <i>'there is increasing understanding of the factors that lead to effective co-production/collaboration, & increasing knowledge of possible alternatives to current processes'</i> (p15). The report also notes in terms of systems supporting the delivery of social care that where national evidence of systems change at local level was emerging, <i>'it is most frequently in addressing the challenge of adapting IT systems to cope with more creative assessments, co-produced support plans, & personal budgets'</i>(p.18).</p>	https://bit.ly/2JwNc1d
2013	Public Bodies (Joint Working) (Scotland) Bill – Policy Memorandum	<p>This document outlines how the development of a legislative framework for integration was informed by the principles of co-production building on the aspirations as articulated in the Christie Commission but also echoed the work of the previous Chief Medical Officer, Sir Harry Burns.</p>	https://bit.ly/2RkgoNx
2015	Carers (Scotland) Bill – Policy Memorandum	<p>The legislative programme of the Scottish Government has sought to embed principles of co-production, including this focus on carers.</p>	https://bit.ly/2JzldNf
2015	Co-production in Scotland – a policy overview	<p>This web information builds on the chapter in the book Co-production of Health and Wellbeing in Scotland, which provided an overview of the policy implications of the journey in relation to co-production in Scotland (Chapter 3 - Co-production in Scotland – a policy update, p34). The policy threads of co-production that have been sewn throughout the work of the Scottish Government and others have been extensive.</p>	https://bit.ly/2UVNnso
2018	Scotland's Digital Health & Care Strategy	<p>As governments focus on the implications for digital shifts to public services and their delivery, this is the most recent policy effort that explicitly acknowledges co-production.</p> <p>Scottish Government, Digital First Service Standard https://resources.mygov.scot/standards/digital-first</p>	https://bit.ly/2wV503v

DISCUSSION

This evidence review highlights how the literature points to the virtues of ‘being co-productive’ and the positive ideas around engaging with communities when making policies and programmes. But this is a challenging process and replete with barriers. Co-creation challenges policy-makers and service planners to rebalance power structures and relationships in order to embed user/citizen involvement in programmes all the way from programme conception to evaluation (and back around again).

Although we have found no specific reviews which focus on co-production and co-creation within the context of health and social care in Scotland, there are, however, a number of policy documents in Scotland which set the public service reform agenda within the frame of co-production, co-creation and the use of improvement methods. Perhaps frustratingly, there are a lack of clear and practical national guidance on **how to do** co-production and co-creation from the academic literature or in national policy documents (from conception to evaluation), despite there being useful learning available from co-production initiatives by the third sector²⁹.

There is a strong degree of policy signalling at a national level about the benefits of co-production and co-creation which do call for such approaches to be embedded, enabled and have meaning locally. However this policy position should be balanced with the interview data captured in the subsequent part of this report, that clearly highlights that, co-production and co-creation are challenging principals for policy-makers and

bureaucratic actors to live by and there is the danger that the language of co-production is used as a symbolic mechanism for describing surface-level engagement and deliberation.

This study highlights that co-production and co-creation are largely very similar but co-creation points to the sustainability of the role of the user throughout the process of programme design, development, implementation and evaluation. To have meaningful co-creation there would be the need to be agile systems, leadership, management and operational capacities and processes to accommodate such an endeavour. Co-production and co-creation, noble in their intentions they might be, will be challenged by the fact that not all citizens will feel like they are candidates for co-production³⁰. That is not to say that co-production cannot be seen as an ‘*intrinsic good*’ or that it does not have the potential to support wellbeing³¹, nor that it cannot be a preventative approach to getting a grip on or diagnosing societal problems before they require policy interventions^{31, 13}. However, there is no getting away from the fact that co-production can be interpreted as a ‘*woolly-word*’ in public policy¹⁸ and there is scarce evidence of its value from an outcomes perspective (be in terms of cost implications or efficiencies accrued) of being co-productive as a service designer⁷.

The politics of co-production is also about the intended and unintended manoeuvring of the use of the term. Bovaird et al.³² argue that much of the rhetoric and practice about co-production privileges the citizen’s voice into public policies and services ‘*rather than getting them to do things for themselves and for each other*’. In other words,

as the New Economics Foundation³³ notes, there are those in policy circles who use co-production as a term to mean no more than consultation, or the involvement of public service users in designing systems. Accusations of the emptiness of the political narrative of co-production is also not helped by the inability to demonstrate the value of co-production beyond specific and often localised sectors, which are contexts that are naturally more ripe for co-productive practice.

The second part of this report, based on qualitative interviews with those working within the health and social care system in Scotland, provides important insights into the issues, challenges, and feasibility with regards to undertaking co-production and co-creation.

STRENGTHS AND LIMITATIONS

The usual caveats associated with the conduct of a rapid review should be borne in mind when reading this report. A more lengthy and in-depth search for studies in this area may have resulted in more evidence being found. However, considerable effort was spent in trying to find relevant studies and information coupled with the national policy document reviews. In this respect, the present report is proportionately robust for the purpose that it serves.

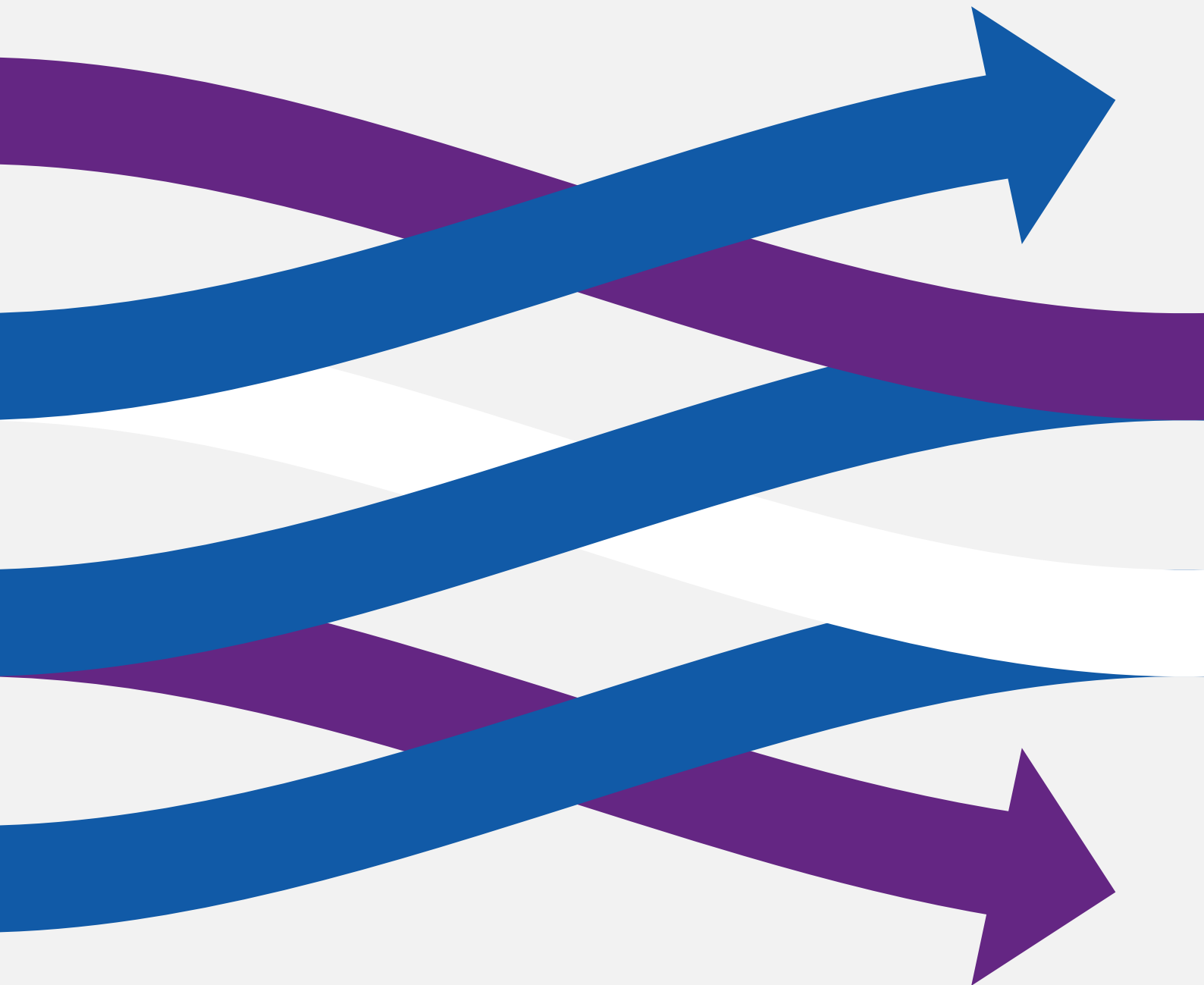
CONCLUSION

The secondary literature is light on the operationalisation of these ideas within health and social care contexts. What does emerge is the need for organisational readiness and flexibility to be prepared 'to do' meaningful and sustainable co-production and co-creation.

The policy narrative around co-production and co-creation are present within many documents regarding public sector reform in Scotland yet **guidance and support** for undertaking co-production and co-creation (including when it is appropriate to do so, in which contexts and with whom) is absent.

PART 2

QUALITATIVE FINDINGS



INTRODUCTION

The first part of this review, examined the evidence within the published literature and policy documents to explore the concepts and impact of co-production and co-creation within a health and social care context. This second part is designed to provide the 'lived experience' perspective from a wide range of cross-sector stakeholders working at leadership levels across the health and social care system.

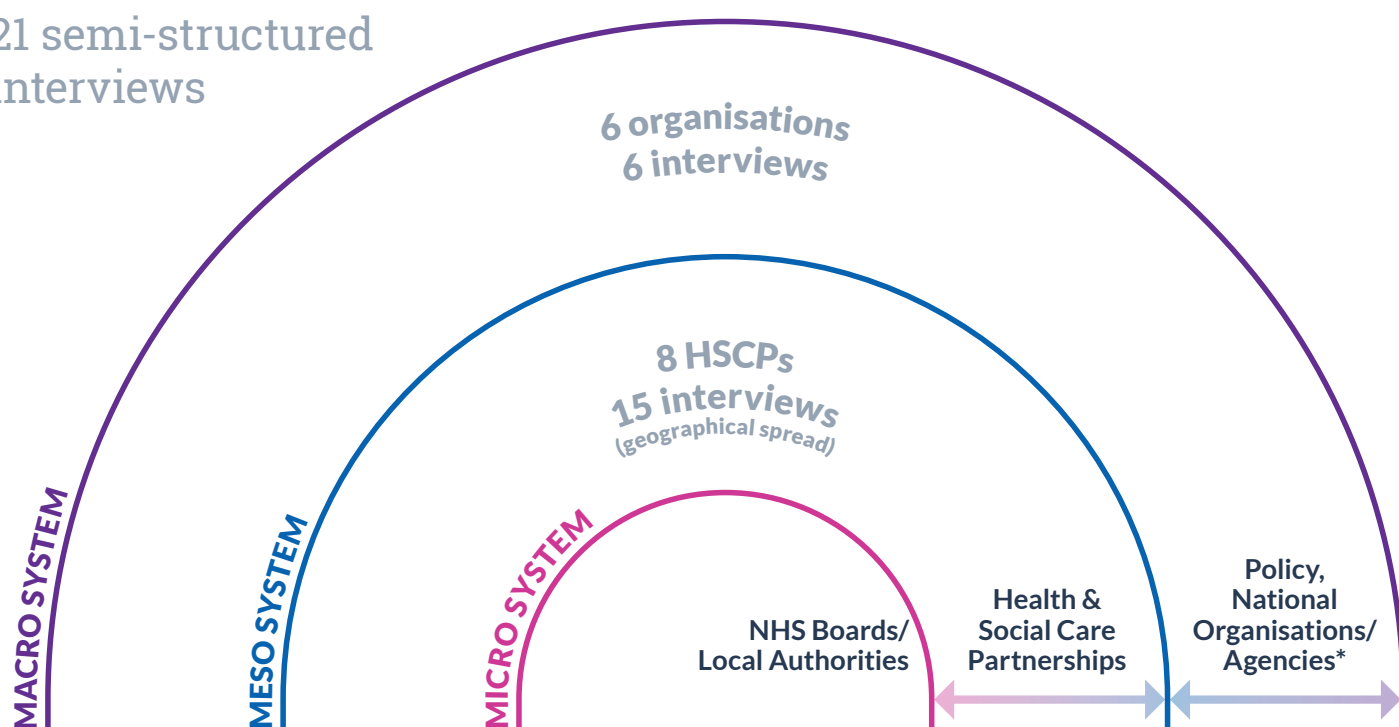
The main focus of this section of the report is to concentrate on the perspectives of those working in senior and service planning roles within health and social care partnership (HSCP) areas – i.e. those who are responsible for delivering local services through co-production and co-creation. The national perspectives, included later within the report, provide the wider context to the interviews from HSCP areas.

METHODS

This cross-sectional study was designed to incorporate the views of organisations involved in supporting and delivering the integration of the health and social care reform agenda. Organisations at different system levels were asked to participate in semi-structured qualitative interviews, to gain a greater understanding of how co-production and co-creation is understood, implemented and sustained within a health and social care context.

This study incorporated views from different levels of the health and social care system. At the *macro*-level, this included actors from either government or national organisations who have key interests in the developments and progress of health and social care integration in Scotland. From the *meso* or partnership level;

21 semi-structured interviews



* National organisations/agencies can work across macro/meso system levels

senior managers from within the HSCPs, i.e. those responsible for leadership across NHS and local authority boundaries and delivering the integration agenda, were interviewed.

The project was overseen by a cross-sectoral Project Advisory Board (PAG) and ethical approval was granted by the University of the West of Scotland School of Media, Culture and Society Ethics Committee.

Sampling and recruitment

From the 31 HSCPs in Scotland, eight were purposively selected; to ensure the study sample was reflective of the geographical and socio-economic spread across health and social care integration areas in Scotland. Sampling was designed to include areas of high and low deprivation, as well as urban and rural populations. The HSCP areas included were:

- Dundee
- Dumfries and Galloway
- East Ayrshire
- Fife
- North Ayrshire
- Renfrewshire
- South Ayrshire
- West Dunbartonshire

Unfortunately, despite the Partnerships in Orkney and Highland being invited; they were unable to participate in the study, however the inclusion of Dumfries and Galloway, provided a rural area perspective.

Individuals were recruited to take part in semi-structured interviews through a mixture of

convenience and snowball sampling. Based on the advice of the PAG, key individuals within each area were contacted and invited to take part in the study. Snowball sampling was then used to recruit other key officials, recommended by those originally contacted.

As well as interviewees from HSCPs, the study also recruited six individuals from Scottish Government and national organisations/agencies to participate in the study to provide a whole system view.

Data collection and analysis

The research team conducted 21 in-depth semi-structured qualitative interviews, lasting approximately 60 minutes on average. All participants gave written consent for the interviews to be audio recorded and were assured of confidentiality and anonymity. Consequently, all participant's contributions have been anonymised in the reporting of the study findings. The local integration area-based interviews are denoted by L01-L015 and the national interviews are N01-N06.

The interviews were conducted between February and July 2019. The interviews with those in HSCP areas were deliberately conducted in the earlier phases of the study in order that emerging themes could then be discussed with officials, charged with national roles. This was important given the focus on *meso-macro* relations and leadership in the study from a systems perspective.

The semi-structured interview guide (**Appendix**), was approved by the PAG. The content represented the main themes of the research study

and provided sufficient flexibility to enable the pursuit of key areas as appropriate, depending on the job roles and responsibilities of interviewees.

The study has produced extensive qualitative data and thick descriptions of contextual factors (both locally and nationally driven) to explain the work, priorities and challenges of leading integration across areas. All interviews were transcribed verbatim and produced approximately 50,000 words of qualitative data which were grouped into themes for the analysis. There was then another filtering of the data in order to draw out dominant themes and issues (including the most relevant extracts from the interviews). The data was managed using NVIVO software.

RESULTS

The research findings are presented in two distinctive sections summarising the key results from the local (*meso*-level) and national (*macro*-level) qualitative interviews.

RESEARCH FINDINGS FROM HEALTH & SOCIAL CARE AREAS (MESO-LEVEL)

Three dominant themes were identified from the analysis of the 15 local HSCP qualitative interviews:

- The meanings and understanding of co-creation and co-production.
- Awareness of improvement methods and the relationship with co-creation and co-production.
- Systematic challenges to the implementation of co-production and co-creation.

In addition, to these dominant themes, a number of subthemes were also identified.

The meanings and understanding of co-production and co-creation

This theme captures the understanding of co-creation and co-production amongst those responsible for leading integration within local areas and their use-in-action in order to elicit knowledge about the terms, i.e. how they are articulated and to ascertain the conceptual clarity of the terms as distinctive, overlapping or blurring; especially through the articulation of descriptive examples embedded within their own experience.

Sub-themes

There is very little understanding of the difference between co-creation and co-production.

There is more awareness of co-production both in an organisational partnership-working sense and in terms of user engagement in co-design.

Meanings of co-production are shaped by specific professional backgrounds and other known agendas such as community development and asset building.

Knowledge of what co-creation means is scarce, if evident at all.

There are cautionary feelings about the value of using what might be seen to be complex terms such as co-creation and co-production and this could, ironically, lead to reduced engagement.

Differences between co-production and co-creation

It became clear through the interviews that there were diverse meanings attached to the idea of co-production, with very little understanding of the differences between 'co-creation and co-production'. Although the vast majority of interviewees recognised both terms from national policy narratives and documentation, there was a sense that co-design was linked to co-production, and the terms were used

interchangeably. Moreover, the interviewees did give the sense that ‘co-design’ was an intrinsically good and beneficial thing to do.

For example, L01 noted that:

...our Chief Officer has very kind of clear views around co-production and ... we need to be doing far less consultation stuff, which I would agree with in general, I think the weight should be towards stuff that is much more genuinely about co-designing ideas, concepts and building on those to deliver services and supports, etcetera.

(L01)

Similarly, interviewee L15 said that:

I don't use any references [for understanding co-creation/co-production], but we're just very aware that it has to be a joint effort, it's not about what I think, or what you think, it's about the people who are going to benefit from the service needing to be involved.

(L15)

The challenge with the understanding and application of the term co-production (and associated terms) was highlighted by L01 as being a word that was over-used which impacted on the clarity and operationalisation of its meaning for those who are expected to implement it:

...the Scottish Government was very clear in all their early communication that they wanted things to be co-produced, so we invested in training for our staff that actually started to talk about it. And I probably read enough about it at the point of inspiration because when I did lots of presentations at conferences that we were doing as part of our strategic planning I would stand up and talk about

co-production to people, and about how we wanted to co-produce, and it became a bit of a verb, you know, so we're going to co-produce this, you know. Well really, what do we mean by co-producing this and, you know, how is it, and is it about just getting hundreds of people in a room and therefore you've co-produced it, or is it about actually going out and having those conversations? And I think it became a bit of an overused word for a while where it got bandied about, but I don't know that it really meant that much after, as with all these words.

(L01)

Furthermore, another interviewee suggested that ‘you could probably put a cigarette paper between co-production and co-creation in many ways’ (L10). That being said, the narratives to emerge from the interviews did suggest a role for co-creative or co-productive activities at a systems level, not only involving service users in service planning and delivery; but also to support integration activities. In other words, although, co-production was seen as ‘about people working together to find a local solution ... It's about not assuming that we are the experts in any field,’ (L15). These meanings seem widened to capture intra-organisational work between teams and inter-organisational activity, especially with the third sector. What this tended to show was a propensity by interviewees to galvanise or wrap up managerial terms together, for example, that co-production is largely synonymous with partnership working:

So co-design in one sense I see as happening in those localities very importantly. And we're on a journey there, it's not perfect. One of the things we need to do better on is how we've got good involvement from the third sector and from different providers of health and social care services, whether

we're really effectively gathering the views of the communities themselves in those localities, I don't think we're there yet ... But co-creation through our localities is a big part of how I see it. (L09)

A broader point was also highlighted by an interviewee:

I think in public sector bodies there's a bit of a thing about when people talk about co-production and I think we think about that being about co-production between an organisation and a community group, or a community of interest, or whatever, but actually, there's a lot that we could do better about co-production [laughs] internally. And particularly probably between, that great divide between strategy folk and operational folk [laughs] (L07)

The themes of co-production as being both a broader change management organisational strategy to foster integration as well as being about citizen/service-user involvement was articulated by several interviewees. Examples of this are:

...there will be different levels of co-production for me. So there'd be co-production at a, an individual level. And, and that's where we're talking about an individual and recognising that they're the expert in their own care ... co-production at an individual level is a bit about, yes, making sure a person's well informed but listening to what that person's priorities are and therefore together, you know, like developing what type of, you know, plan if there is a plan going forward. (L11)

I think it is in the DNA, I suppose, of integration and what integration is about, so it's not just about how we run services and how we redesign services, it's

about the how we do that as well, and doing that in genuine kind of partnership with communities, with the third sector, with other stakeholders ... It's not a quick fix, it's not necessarily easy to deliver, and I suppose I think in [the area], in a number of ways, one way I think is really important is the work we're doing in our localities ... And we're on a journey there. (L09)

My understanding of co-production is to either, you know, to develop services or change services based on working with the people who are delivering those services too. And anybody else who can, you know, contribute to that process. So whether that be, you know, some other organisations in the third sector, or private businesses, or schools, or colleges, or whatever. (L08)

In a similar vein the multi-level dimension of co-production (at least the principle of it) is captured by an interviewee:

So I think about it in two levels. I think about it as a point of how you kind of engage with the public and people who use our services, how you work with them to identify what they think are the issues, which might not be the same as what we think are the issues. And then how you work with them to come up with what some of those solutions might be. But we also talk about co-production as being something which is very multi-agency, so if we quite often think about co-producing with our partners in the third sector and how they might bring things to the table that we might not necessarily have thought about. And I suspect that's not the pure form of it, the pure form of it is much more about members of the public. But I think you should think about the principles of co-production, which is where you get together and you hear what everybody has to say, and you treat

people as equals and partners, and then we like those principles and that approach as being the way that we work collectively together, right across, across the way that we work really. (L01)

Uses of co-production

This breadth of meaning attributed to co-production was understood by interviewees, with some arguing that it's not new but rather re-packaged concepts from past practice. There were associations made between co-production and other approaches such as community development and person-led practice. An interviewee highlighted that many of their colleagues undertake community engagement:

What I wanted, what I was hoping was that, you know, we could've introduced this [co-production] on a strategic basis so that everybody would be co-producing stuff all the time. I have to say though that we talk about co-production a lot, we...the operational staff now wouldn't try and change something or do something differently without using co-production. However, I don't think that they understand that what they're doing is community engagement and not co-production. (L08)

Another interviewee focused on individual user-service relations and noted that:

...we're talking about an individual and recognising that they're the expert in their own care and, you know, talking to them about what their priorities are and how then we put together a health or care plan around that individual. (L07)

Experiential knowledge of co-production

An interviewee emphasised how use of terms are shaped by the professional backgrounds of those expected to undertake it as part of contemporary integration work:

You talk about co-production, as a known community worker I talk about community work. It's good old fashioned community work. (L02)

This is a point that emerged in other interviews:

...there's a lot of people who have been working in those ways, particularly people like community learning and development, people with those sorts of backgrounds, they're working in those ways anyway, so it's not all entirely new, but we've packaged it up in a neat terminology now, in a different way. ... I'm not a social worker, but that's kind of the service I grew up in, there's a lot about co-production that absolutely speaks to the kind of values and the ethics you would expect staff, social work staff in particular, not to say that nursing staff don't have, but social work staff particularly, to do, so I think there's a lot about how we sometimes dress up these concepts as something new and specific, and rather than saying, you know, how we speak with operational staff about this is actually about getting back to your professional, some of the basic values that you have, and using those skills, and focusing on using that, that kind of thing ... So there's some of it that I just think maybe we need a bit more focus about reminding and reconnecting to that this is all the bottom, there's lots of methods and ways to do co-production that actually the bottom line of it is that it should speak to the professional values of the vast majority of the workforce anyway. (L01)

There were several examples provided by interviewees who were less familiar with co-production or co-creation from a conceptual perspective but were able to provide strong examples of co-production in practice. For instance:

We have been looking at what we could've done this winter that would allow us to support more people to remain in their own homes, to depend less on hospitals and unscheduled care from hospitals where they can. So we've been, we've identified 500 local people in [the area] who've got a COPD diagnosis, and we've been asking any of them voluntarily to work with us to establish improved self-care arrangements. ... So we've been working with we think around 250/300 of those people to collaborate with them in understanding their circumstances and then co-produce a different model, which is over the course of the winter. We've worked with all of our [the area] community pharmacists ... And it's had a dramatic effect in terms of the number of admissions to hospital for people with COPD, and one of the single biggest reasons that people go into hospital over the course of the winter, for older people particularly, is because of COPD. So my back story and long-winded story is to say there's an example of how we have collaborated and co-produced a test of change over this winter that will lead to probably a co-produced different way of working. (L04)

Similarly, another interviewee provided an example of using 'engagement' work with regards to addictions and justice services, but admits that 'we've still not really cracked it' (L10). Although these examples do not provide evidence of 'co-creation' (i.e. sustained engagement from inception to evaluation and beyond with service users) they did provide a sense of co-productive work.

Knowledge of co-creation

A significant finding of this study, is that although the notion of co-production has been promoted and used in Scotland for almost ten years, it has proliferated alongside other ideas. Therefore, diverse understandings were evident in the responses of those interviewed, and as noted above extended to embrace notions of wider relationships, including those between peers and other organisations. However, when asked about the concept of co-creation, interviewees had far less awareness, or it was expressed differently to what is typically used in academic literature. For example:

Certainly the word co-production has started to emerge, but co-creation isn't one that's, I'm not sure I've heard that word before ... Collaboration and partnership working are probably the phrases that more obviously bubble up in my memory about that, so co-production may not be in that. But undoubtedly, the only way of delivering on those things is through a process of joint working, partnership working, collaboration and co-production. (L04)

This was a typical perspective to emerge from the interviews and was articulated by an interviewee from who was not familiar with the term co-creation but tried to work it out as something similar to co-production (which is the case) but did not draw out the differences between the two i.e. 'nobody would blink an eyelid if you started using different terms' (L03). The interviewee went to say the following:

...maybe people would think co-creation more focuses on, you know, excludes things like more consultative type mechanisms, rather than things

which are, you know, in that bit in the middle about engagement, which could lean either way, to stuff that's genuinely, you know, participative budgeting, those sorts of things. That kind of side of things. But I don't know. Co-creation. Creating anything takes a whole lot of different types of input ... I think that co-production just tends to be the terminology that's used, but I don't think, like I say, I think that, I don't think people would fall out with the use of the term co-creation either. I think it's, yeah, as I say, I think all things to all people kind of a terminology. So people here would tend to talk about co-production more than co-creation, but I think if you started using co-creation nobody would blink an eyelid at that either. (L03)

Cautionary use of co-production / co-creation language

Also present in a couple of the interviewees, was a degree of cynicism about the use of concepts like co-production, when there are other urgent issues confronting HSCPs:

...throwing words like collaboration and co-production in because you're a Scottish Government civil servant writing a document, adds up to the square root of absolutely nothing. ... Cause the tension will always be there, but you can't have, you can't have the balance between those things so out of kilter where it feels like ministers and others believe that if only so and so worked harder in [the HSCP], he got his team working harder, he could do more collaborative, co-produced, co-created work. That's not the case. Somebody somewhere has got to recognise that we're running out of road here, or money, and we can't keep doing what we're doing in the same old model. You can't just keep talking the language of shifting the balance of care without really, properly understanding what

that means and then enabling it to happen. And I'm not saying that I need more money recurrently, but I certainly need some significant investment to allow me to grow my community-based services, to allow me to release and reduce the demand for, and therefore the cost of acute services. And you need to change, you need to have a collaborative process with the public that says we cannot keep giving you everything that you currently get. (L04)

The language of co-creation and co-production was cited by some interviewees as problematic given that there were sensitivities with regards to the use of such language on two levels.

First, communities or individuals might not be ready to co-produce due to their own personal social circumstances or wellbeing. Second, that terminology used by policy makers and academics might not resonate and therefore create a barrier to the communities and individuals who it is intended to include and support. Some examples of this given by interviewees were these:

...we get feedback from people who feel that women in refuge, for example, are ... an accessible group of people and actually, they don't want to be involved in everything. So there's real challenges about what that, you know, for any given piece of work, or project, or development, or whatever it might be, about how different approaches, different methods, and not just doing one thing, cause one thing is never gonna suit everybody. (L01)

...one of the other things I suppose, if I'm being honest, some of the language here I think is a challenge for us, cause it turns people off. So when we talk to members of the community about co-production or co-design and make an issue about

is this co-creation or co-production, people switch off. So it's probably, it's maybe useful for us as service planners and deliverers and academics, but in terms of the man or woman in the street, I think the danger is it alienates and can put people off. (L09)

What I would say is that co-production and co-creation, you know, once you start giving it names like that and you're trying to talk to ordinary folk, their eyes glaze over as soon as you mention it, you know, so I tend not to use the word co-production or anything when I'm talking to ordinary people that I'm trying to create awareness and get them to, you know, to trust me and to listen. I talk about working together, I talk about changing things for the better. I tend not to use the word co-production straight away, and sort of drip-feed that a bit at a time because there's been so many terms for so many things, you know, that I've noticed it, whenever I use that word, I just see the looks on folks' faces. (L08)

The insights from interviews about their understandings, perspectives and meanings of co-production and co-creation were fairly consistent in terms of the fact that there was more familiarity with the term co-production compared to co-creation. Consequently, there was a lack of clarity in understanding what Scottish Government and its agencies are expecting from health and social care areas in this regard. This provides an important backdrop to the next key theme to emerge from the interviews – how improvement methods relate to co-production and co-creation.

AWARENESS OF IMPROVEMENT METHODS AND THE RELATIONSHIP WITH CO-PRODUCTION AND CO-CREATION

Sub-themes

There are perceived cultural differences between the NHS and local authorities when it comes to the use of improvement methods (it is seen, broadly, as an 'NHS approach')

Improvement methods are seen as being similar to co-production, with little evidence of the difference between them emerging in the interviews.

Key barriers to the sustained use of improvement methods were organisational capacities and the pace of change, and the pressures associated with managing multiple priority areas within HSCP areas.

Public sector approaches to improvement

Overall, there was awareness of improvements methods in all areas included in this study (at least it was a known form of words). However it was often seen as an 'NHS approach', where there are resources and capacity to utilise aspects of an improvement science approach; its use in local authority settings was mostly associated with the area of children and families. These approaches contrasted with other quality improvement

efforts, often associated with inspection and the need to respond to scrutiny reports, whereby the inspection body assists with resources to make local improvements. For example, a health and social care manager noted that:

...we use particular improvement methodologies for particular projects, but I don't think internally to health and social care we have huge capacity in terms of people who have had formal kind of development around that. So the NHS has a big capacity, formal capacity through their kind of improvement kind of support service around that. The Council also will have some, but far less around that. (L03)

Most respondents gave examples of improvement work but again what was meant by improvement varied from more formalised and institutionalised approaches used in the NHS around improvement science, to the Public Sector Improvement Framework (PSIF) (a self-assessment approach to support improvement in organisations), which promotes continuous improvement using organisational improvement tools. An interviewee highlighted this point:

We were big users of PSIF and the models and frameworks. And what we have here is, for want of a better expression, PSIF liked. So we, we would front fill a lot of the service improvement information that, that we would hold corporately and so that the, the key elements of work in relation to quality improvement are, are focused where you want them to be operationally. (L03)

There are other ways in which improvement is viewed. For instance, one interviewee spoke about conducting very small tests of change

and using learning networks to continually understand and improve services:

What they've done is they started looking at, well, what are some of the issues which are going on in our area, what is it that we need to think about in terms of, and how can the group of people we've got around us start to try to work through the improvements that need to be made. And some of that is about processes actually when it comes down to it, so how difficult is it to get into the service and is the service close to where you live, and how do you kind of manage that in a particular way that develops things better? So I think that is actually, cause those learning, I mean they're deliberately called learning networks because it's about understanding, reassessing, working together on tiny, tiny little tests of change, and then kind of continuing to check that out. (L01)

Similarities between improvement approaches and co-production

The interviews suggest that the exposure of local authority staff to more formalised improvement approaches came via the Early Years Collaborative and it appeared they were beginning to utilise it in health and social care collaborations, for example, care home packages. Another example highlighted, is the work of NHS Information Services Division (ISD) who seconded staff to work with social care data to support improvements. Others thought there was still learning required in social care from NHS experiences with improvement, although this was not considered to be a substitute for co-production.

These experiences raise questions with regards to the similarities and commonalities between what might be regarded as improvement approaches and co-production approaches and whether

this needs to be unpacked further as part of the integration work (i.e. when are particular approaches appropriate, useful and necessary). The value of having more of a focus on this in future is captured by an interviewee:

I suppose the challenge for us that I see is it has more purpose and understanding and more of a track record in the health side of our services than it does in social care, and one of the things we've sought to do in [the area] is to begin to think about how we can take the learning in terms of improvement science and improvement, quality improvement into the social care dimension as well. But sometimes that can be a challenge, and for me, quality improvement is around, the power in quality improvement is around putting the power, empowering kind of front line staff and how they engage with their services and their communities, so I think it can be really powerful, but I don't see it as a, as a substitute for that approach around co-creation or co-production ... Part of what I think we need to do as a health and social care partnership is encourage people, our staff in particular, to be innovative, to be, kind of, courageous and creative and work differently, and importantly to work differently together, so to exploit the opportunities that integration brings to work across boundaries in a way that hasn't happened in the past. (L05)

The case for the importance of coordinating an approach to co-production/improvement at a system level is made by another the interviewee:

I think they have to, if not run it parallel they have to dovetail, definitely. And, and I suppose, and I, it's not a term I, that I'm encouraged to use but all of this stuff bleeds into each other. So the, the, the charging policy bleeds into procurement which bleeds into

commissioning. So all of these things, all of these policy drivers, we get individual guidance for but actually impact on a whole range of other things. ... So actually in order to do improvement work you need to understand the broadest spectrum of the, the whole system. (L03)

Viewing improvement activity as complementing the concepts of co-production was common in the interviews. A typical perspective from the interviews was as follows:

...so there's more time now spent on that exploring and finding out and questioning, before we start planning and implementing, whereas before we just drew up a plan and went straight to implementation, whereas now it's tested to see if it works, does it suit ... So you've got to really engage with people before you can have an impact on changing culture and behaviour. ... once you've got that knowledge is looking at how it would work within that area, and that's about speaking to people who are going to be affected, looking at culture and the behaviours and thinking well, how would this impact on them, getting them to be part of that conversation, and getting them to be involved in the development. ... it's not about me knowing everything either, it's about bringing the people to the table of discussions that do have the knowledge in different parts, and how then you bring the people who are really needed as part of that to develop, change things, move things on, various things, you know, that they're all part of that group. (L10)

Barriers to improvement and co-production

The issue of resources to support service improvements was a point made by many interviewees and was viewed as a major barrier to the use of improvement

approaches and co-production. Concerns were expressed about capacity to undertake such work in a meaningful way:

So we're trying to re-design the plane when we're flying it ... So that feels real for us on a day-to-day basis. We have that responsibility for delivering good high-quality services that we're also kind of redesigning them and that finding the space and the time to focus on redesign and improvement in co-creation and co-production when you're trying to make sure that everything's delivering well is a challenge for us, so finding that capacity for change in co-design can sometimes be a challenge. Another is around the kind of money situation, so it does feel for us, and I know speaking to other colleagues we spend a lot of time thinking about how we manage it within budget, how we, and part of the redesign is, of course, about that. It's not just about that, but one of the key drivers in terms of redesign is recognising that if we don't redesign services, they'll very quickly become unsustainable (L09)

The pace of change was also cited as a further barrier. Different temporal horizons (or future timescales regarding delivery) for action appeared to be a common tension, with the pressure to show evidence of fast change, in contrast to the time required to work co-productively:

And [the Chief Officer] talks a lot about, you know, pace of change and particularly around, it's obviously quite a political agenda, and emphasis on health and social care partnerships making a difference and being seen to make a difference quite quickly, but actually... we're only now maybe, it's maybe taken a good 18 months for them to get to a point where they've got a draft strategic plan that they want to consult on more broadly and finalise

and that. It'll be a better strategic plan than if we'd written it in six months and it was done in a much more traditional way, but some of that stuff takes time, and that's not always, doesn't always fit so well with other pressures about getting it done quickly and getting it done. (L01)

Moreover, sustaining improvement approaches in terms of upscaling within and across the health and social care system was considered by an interviewee as fundamentally challenging due to the different priorities within partnerships:

Each local authority area which also has a whole range of priorities ..., where you have an interest in something very specific is very easy to do when you try to upscale across the system, that can be more challenging because every time you, you make a move in one part of the system it impacts on a whole range of things intended or unintended. (L02)

The last three perspectives highlighted in this section move the research findings in the direction of understanding the barriers and facilitators to the use of co-production and co-creation approaches. The next section of the report considers the barriers and facilitators in more depth in terms of leadership and implementation challenges (which are categorised here as systemic challenges). The systematic issues represent a major finding of this report which, in short, impact of the feasibility and sustainability of co-production and co-creation to be operationalised.

SYSTEMIC CHALLENGES TO THE IMPLEMENTATION OF CO-PRODUCTION AND CO-CREATION

This section provides a reflection of the background to the implementation of integration. The interviews highlighted a number of sub-themes, emphasising how the local social and economic context can present challenges when it comes to taking a co-productive and co-creative approach to integration. The dominant narratives, clearly, intersect with the broader challenges of embedding and sustaining reform within health and social care systems.

Sub-themes

The expectations regarding the need to progress/accelerate health and social care integration in Scotland using co-production approaches are out of step with the major complexities that exist with regards to the Scottish public sector, which were not considered fully enough before the roll out of health and social care integration.

Health and social care leaders in Scotland struggle with a 'cluttering' of national agencies and are unsure as to how their areas can be best supported to demonstrate the contribution that their areas could be making to national outcomes.

National governing leadership on the health and social care integration area is highly political and lacks consistent support and an appropriate model for funding accelerated integration.

The Chief Officers of health and social care areas are in a unique position within the Scottish public sector in terms of their multiple and multidirectional accountabilities. They would need adequate leadership levers in order to undertake and promote co-productive governance across their health and social care areas. Unfortunately, there has been a very high turnover of Chief Officers in recent years.

Systematic challenges for progressing integration, let alone co-production, include a lack of joined up organisational systems (e.g. human resources and IT systems) between the NHS and local government, as well as divergent cultures.

Health inequalities remain a deep-rooted challenge across Scotland. Health and social care areas lack the leadership and organisational readiness to make a major contribution to addressing such an endemic challenge to lack of strategic leadership resulting from multiple (at times divergent) national level priorities, systems issues (as noted above), and resource challenges.

Current integration context - the expectation gap and role of co-production

Many of the findings, support the conclusions from the Audit Scotland Report and the Ministerial Committee and many interviews reflect on an 'expectation gap' that exists between the direction of national policies on integration and the local implementation conditions.

The original expectations were, according to an interviewee, based on an original assumption that '*Scotland was actually in the ideal place to*

make this work if people embraced it. It had the right conditions in terms of health of the nation, financial constraints and the inability to be able to run its own budgets, that's a whole other thing' (L09). The interviews show how integration continues to be a mammoth task – one interviewee described it as one of the *'biggest shake ups in public sector since the establishment of the NHS in many ways'* (L10). The national drivers for sustaining integration in Scotland was highlighted by an interview, which indicates how those tasked with leading integration in areas are strongly aware of the national concerns regarding *'accelerating progress'*:

Audit Scotland published their report on integration so far ... that was then followed by the publication of the ministerial steering group kind of review of integration with, I think, 25 recommendations for local areas around how to, I mean one of the key things that I think was important on that is it represented a very clear commitment from government, and also from COSLA representing local authorities that integration is here to stay and we need to accelerate progress around integration and those recommendations were focused on that ... We need to make it a success. (L09)

Recognising the need to lead integration across partnership areas and to share learning as part of this process, a forum (network) for all the Chief Officers across partnership areas to come together to meet, has now been established.

One interviewee noted how the role of the Chief Officer is a very unique position within the Scottish public sector but is an acutely challenging role, which has led to a significant degree of turnover in Chief Officers in recent years *'as you know also*

there's been a number of Chief Officers who for various reasons have, kind of have moved on from their post. It is a tough gig, and it does feel quite unique, and it's an interesting arrangement' (L09). One of the most significant challenges that face Chief Officers in local areas is the need to reconcile and lead through mixed, and at times, contradictory policy messages.

The interviews give a sense of how this can breed frustration at senior levels within HSCP areas in Scotland and that this, along with multiple/complex accountabilities and lack of control over the levers to make change happen, can lead to a degree of stagnation and contribute to resignations. A strong, but rather typical, example of the lack of dovetailing policy imperatives affecting integration was highlighted by an interview (see below). This gives an example of the contradictory messages/directives about how change/improvement ought to happen:

Some of the challenges for us is that those same messages are not always coming through. So the example we often have is that everything about health and social care policy, strategy, political messaging is about everything local, everything at the lowest level possible. Certainly at locality, if not neighbourhood, if not personalisation individual level staff are children and family's colleagues across [the region], their drive is towards regionalism, so how can we reach those services, how can we ... that is really difficult for us. So they've got a drive to, you know, and it's not to say we don't do things at a region wide level ... But again that doesn't always chime well with those national messages of, you know, plan and deliver it as close to the person as you possibly can ... One part of the system is saying localise, localise, localise, and the other part of the system is saying regionalise, regionalise... The Scottish Government have funded a regional

improvement collaborative around children's sides of things so that, it might not be explicit, but it's certainly in the region, that idea of regionalising around children's services has been endorsed by the government in a fairly substantial way. So there's a definite Scottish Government interest in endorsement of that, but that is quite a challenge. Particularly in a partnership where your children's services aren't delegated because all the decisions that are made about that are made in a council governance structure. (L04)

A further sense of the politics of the public sector was highlighted by an interviewee who suggested that a key barrier to sustaining progress in health and social care are political interference framed around making the case for Scottish independence that could be seen to be 'popular' whilst, at the same time, failing to make difficult decisions about public sector governance:

Cabinet secretaries step in and stop you doing what you want to do because that goes against the grain and it loses votes and make them appear like they're not in charge. So, and that's not being cynical, it's not being sceptical, it's being factually true. The Scottish Government has progressed policies that are seeking to be popular, that are increasingly centralising, but they avoid making any difficult decisions that makes the public sector leaner, cheaper, more cost-efficient... Essentially they want to win votes and make people realise or believe that Scotland therefore could become an independent nation and can survive on its own two feet economically. (L06)

An interviewee highlighted the paradox in public service leadership, in that the Scottish Government encourages localism based on an empowerment approach but there is a strong

level of instructional leadership and direction that can trump local governance. For example the national direction to recruit more health visitors or teachers, with no additional central funding; which directly impacts on the HSCP via the Integrated Joint Boards (IJBs), funding allocations:

The types a' things that, that come into us are when we get, at times, external factors. So...if somebody comes to us and, as you know, they have. Scottish Government said that you need tae keep up your teacher numbers so you cannae do that. Or for us, you know, you need tae keep up x number of health visitors. And so you, you end up doing things by requirement that are not maybe what you would want tae do. ... I'm not taking away fae my health visitors, my health visitors are fantastic. But, you know, like the balance is wrong. I'd be delighted tae have forty-two health visitors if I had also, you know, twenty school nurses or whatever. But when people come down and give you know, dictats about how things have tae be, that can be difficult when, you know, you know as an IJB we are funded from both the council and the health board...And we need to take decisions that could be difficult. (L11)

Insights from a different HSCP area illustrated the point about political interference further – perhaps in more blatant terms:

The health visiting body, professional body have been in some bizarre discussion with Scottish Government, so as of the 1st of March, Scottish Government announced that every health visitor in Scotland will suddenly become one grade higher. They'll move from a band six to a band seven. It's gonna cost me £400,000 a year extra by three years from now. So it just means that I won't spend an extra penny actually, I'll just have, I'll end up with ten fewer health visitors

than I need. And then people start to complain we can't get a health visitor, and you say, well, I can't afford it, I can only spend the money I've got. I mean, that's one small example. There are terrible, terrible examples of all that kind of stuff... you must stop this kind of hovering in, landing in the middle of our system and doing stuff to us. If you want a proper relationship with what you say is the flagship organisational model for this government, health and social care partnerships, set the strategic context, give us the money, and then give us the freedom to go away and do the things that you reasonably ask us to do, but the things that we think are the right things to do to deliver the right health and social care services... But you cannot keep meddling in between by doing that, and doing that, and then doing that. You can't do that. (L04)

Organisational and infrastructure barriers to integration

Given there were various tensions between the centre and periphery, expressed in control, knowledge and decision-making power, this has created challenges when attempting to foster a co-productive approach to integration, as these tensions had everyday consequences of the work of those involved. Perhaps the following extract from an interviewee, who is tasked with leading integration programmes across the NHS and local government, captures the dominant issues with regards to the governance challenges with fostering effective integration based on the Scottish Government's approach to public sector reform. The following interview highlights a common view that resource constraints and different cultures, systems and practices between the NHS and local government result in the duplication of work and a lack of efficiencies. It is worth quoting the interviewee at length:

It must be quite difficult for the Chief Officer to manage some of that in terms of still working with a council and a health board who don't necessarily have the same expectations either nationally or locally around working in those types of ways. I think that's evident locally and nationally that people obviously have quite different views about health and social care partnerships, whether they were a good idea or whether they weren't a good idea, and whether it would deliver anything better or not ... but I think there are a number of people locally and nationally would be delighted if we failed. So, you know ... the Council in particular are still really struggling with the concept of health and social care partnerships and just that governance and decision ... So even at a very basic level I think the majority of people who work in a Council side of things still think health and social care partnerships is a Council department [laughs]. So it's really, really challenging. People don't get it a lot of the time [laughs] ... So I think that's a really difficult environment, and there is a sense of, you know, some people waiting for you to fail, others then being desperate to show as quickly as possible big impact, at scale as well. ... That's all reflected in the Audit Scotland Reports and the MSG Report about this kind of almost when the resources weren't delegated and it's like you have to go and ask NHS a favour when you want something, when actually, it was supposed to be they would provide that. They were okay but won't put your staff in, but you'll still get the access to the resource, but that's not how it actually is in practice. And we're still servicing a lot of what we were servicing for those corporate bodies previously. So, you know, sometimes you do feel like you've got your own equality and diversity groups then you've got to go to the Council's corporate group for the employee part of it, and then you've got to go to the NHS, so there's some things where we have

to triple track and things. ... I mean, just at the most basic level, if you do a performance report to the performance and audit committee, so you write it once for there and it goes there, and then it has to go to the Council for information, and they've got health board for information and they both then have got it in a different template so you have to redo the report. Not the actual, but the covering report needs to be done on each template, you know, that kind of just very basic triple tracking of almost everything that you do is really difficult. That's about power and local politics and all that kind of stuff. (L08)

Actually the bigger issues for us is, has been around so what makes integration difficult. It is about having two different employers and know that that's, it's not necessarily found its way on tae the MSG report. It didnae necessarily find its way intae the Audit Scotland report but I understand that it's been a common theme across the piece. And, you know, so because we've gone at it full pelt we now need managers...who are fully versed in the supervision requirements of both organisations, the grievance procedures, the absence management procedures. We need tae know two sets a' procedures depending on which member a' their team it is that's off sick. Do we deal wi' it under the NHS policy or the council policy? And they need tae know both. (L10)

National governance structures

Reflected in a number of interviews, are the new roles national organisations had been asked to undertake by Scottish Government, to support the implementation of health and social care integration. One interviewee noted that although HSCP areas and national organisations have been asked to work together more collaboratively, the aims and strategy for making this effective are unclear.

Extracts from the following three interviews, summarise the challenges of scrutinising integrated service delivery and leadership, without sufficient experience and knowledge of these new approaches. It highlights that a wide range of national organisations have a scrutiny role within the integration context, which has led to a sense of 'clutter' with the potential to stifle rather than accelerate progress:

We'd just come out of a joint inspection of adult services for commissioning and we were...It was Healthcare Improvement Scotland and the Care Inspectorate that came in ... We were the first tae be graded on leadership as well as commissioning and performance. And our experience of that actually was, was not a good one at all. I mean I think that, you know, the report ultimately is a reasonable one but what we, what we found is that maybe in the past you would have inspectors coming from the Care Inspectorate who would have had twenty years, thirty years' experience working in traditional social work departments. They would have a good sense of the challenges but at the same time have that expectation of, you know, minimum standards and what we should be doing and you would have that degree of expertise. And the same in Healthcare Improvement Scotland. You would have people who've had thirty years working in an NHS environment, you know, well versed in quality improvement and blah blah blah. What we found was, and maybe having had a few months tae reflect on it is that a number of the inspectors did not and could not possibly understand some of the challenges because none a' them have managed integration in the way that, so actually a lot, a lot of the expertise around some a' this was from the Health and Social Care Partnership and IJB members as opposed tae from the Care Inspectorate and Healthcare

Improvement Scotland. And there was a sense that actually you guys are playing catch up wi' some a' this because you've no lived and breathed it in the way that maybe historically you would have done. (L10)

The inspectors were probably completely unable to assess leadership. They just didn't have the experience. Unless you have people who've been senior leaders in health and social care doing the inspections, you haven't got a chance. ... There are a number of national bodies who clutter this landscape to some extent. So you've got HIS, you've got NES, you've got the social work professional bodies. So we had, the Chief Officers meet on a two-monthly basis, so we had a presentation from the Director of Improvement for HIS for all primary care health services. The short and long of it is that the Chief Officers have now got to a point where, not too much of a finer word, I'm really pissed off that in Scotland the middle ground is cluttered with organisations trying to do stuff that they think is virtuous and the right thing to do, and when it suits them, Scottish Government have asked them to do it, when it doesn't suit them, it's something else. (L04)

I think it can be quite a busy environment. And I think one of the, the challenges for us is the number of people who have a 'scrutiny' role for us. So the scrutiny role for us is the Scottish Government. That is where the scrutiny comes from but we also have scrutiny from the Council, from the health board. You then have the Care Inspectorate. The Alliance like to ensure that they have a 'scrutiny' role. So for us there is a huge amount of review critical friends, scrutiny, whichever jargon we, we use for it which...isn't often joined up ... we actually have lots of resource nationally for whom we are presented with a range of evaluation techniques and a range of organisations

who will help us with those evaluations. I think if we had a less cluttered landscape nationally ... where we could actually draw down on very specific high quality evaluation which I don't think currently exists. The point I'm making is when, when you get people in who are offering up support ... the quality of what is offered is not good. So in terms of the work that it creates at local level, that can often be a burden as opposed to a help. So I'm not objecting. I think the tools are really helpful and they're really useful. I think there's a range of tools and as I have described I'm a big fan of, of using all the tools that we have, having a look at them. What I have struggled with is the quality of what is offered once they're in situ. And it does create work. (L03)

Systemic challenges to sustaining integration

These interviews outline many of the strategic and day-to-day challenges associated with sustaining integration in Scotland. One interviewee took a degree of comfort that challenges exist in other HSCP areas in some shape and form – 'you look at some of the national reports and think yeah, it isn't just us, you know, everybody's struggling with that corporate body interface, everyone, you know, it's not just, this is just difficult as well. So there's some reassurance in that fact that everybody's struggling, I don't know if that's a positive thing or not' (L01).

Nevertheless, the following interviewee argues that change is required in order for health and social care integration to have any chance of long-term success:

What is clear to most of us who have worked in the health and care systems, we cannot carry on doing what we're doing, cause in the next ten years the system will, it will fall over because we can't keep affording to do what we do free at the point of use. And all the co-production and co-creation and collaboration in the world won't change that unless

we have a different collaborative, co-produced dynamic with the public where we all take on a lot more responsibility ... over the course of the next three to five years we need to invest a lot of time and space to shift the balance of care, but to shift the balance of care, you need to shift the balance of services, to shift the balance of services you need to change the way in which the patient or the public behaves, and the way in which professional staff behave, and you need to create new teams and functionality in the community. That is a huge amount of work. You know, even if you just wanted to have 20 percent fewer people who you could avoid going into hospital, going into hospital when they are old and frail, massive amount of effort to get more district nurses, more community rehab services, more care home services, more geriatricians working in the community, not in hospitals. You know, a huge endeavour required to do that. So there are those kind of arenas where we need to create ... It feels to me that we are in an era just now where we don't need more leaders, but we need more leadership, and that's definitely the case. But I would say we don't need more change, but we need more enablers of change, more people, intelligent enablers who can take us from the status quo to an end point to change position. And that must come from collaboration, from joint working, from partnership working, and you co-produce something at the end of it. (L04)

These concerns relate to the changes required at a systems and leadership level, to deliver the shift required to meet future demand. Interviewees highlight local programmes of work done at local/micro-level that adopted an integrative community approach to planning and delivery, yet there were few examples at the meso (partnership-spanning) level:

We've done a lot with providers as well in terms of provider collaboratives, so around homelessness, learning disability. And again, getting away, I mean we've retained our social care contracts team, which is unusual, and we...defend that to the hilt cause we think it's really important in terms of the procurement and monitoring and contracts, but actually their ethos is very good. (L09)

To be honest we'd, we'd done a lot a' work locally in an integrated way and again locally in a[n area] perspective and particularly with a very strong community planning partnership. So we'd worked hard at relationships because you, it doesn't matter what structures you've got in place. If you don't have the relationships and build and a shared common outcome then it's really, really difficult to move things forward. So a lot a' that pre work had been done and a load a' really good very senior officers across a number of organisations. And one a' the, one a' the dangers for me around integration was that we could have ended up naval gazing completely ... how do we join up health and social care and forget, actually, the role of our housing colleagues, our education colleagues, our police colleagues, fire and rescue etcetera. So that bit about having a community planning partnership approach tae improving the health and wellbeing a' communities was right at the heart a', you know, what we were doing anyway. (L10)

The immediate quote above, emphasises the importance of local relationships between public sector organisations. These collaborative ways of working were also reflected in other interviews:

What helps is having good leadership, and I don't mean the people who are paid, you know, to be managers. What helps is having good leadership.

What helps is tapping into people's wider knowledge, cause we have a lot of people in here who maybe, so have full-time jobs elsewhere and come and work in our service, you know, kind of, like, sessional. What helps, I think, is that the managers are...working, sticking together, that doesn't sound the right word, but they are...they are keeping firm and saying no, we know this is a difficult journey that we've got to go on, but at the end, it will be the right thing to do. And, you know, all of that helps, and to be honest, see just one person that gets a better service from us, that's what keeps you going. And it...I guess it helps when you are able to tap into a small group of people who are saying well, you know, yes I'm willing to be part of that working group, I'm willing to look at how we're gonna change things, because without that then as managers you'll never achieve, you will never achieve unless you have your staff group and the people who use your services on board. (L15)

A programme leader from another HSCP area elaborates on this way of working and the importance of working with the voluntary sector and the role they play supporting co-production:

Integration is about leadership. It's about leadership without authority. It's about leadership within a complex system and a leadership whereby you are providing reassurance and context for people who on the whole don't want to change, don't like change. The management and the supervision of staff systems is what it is but the role of leaders and leadership within this complexity is hugely important. Whether that's leaders within Scottish Care who aren't always as helpful as they could be at a national level but for us at very localised level are nothing but supportive and, and helpful and engaged and part of our leadership team. And the CVS, third sector interface would

be the same. So that localised leadership is hugely important to actually manage people's expectations whether it be public, whether it be staff and to provide reassurance that we are moving in the, the right direction. That we are managing the complexity of governance, accountability, financial management as well as the operational delivery. (L02)

Systemic challenges – beyond health and social care

A major 'wicked problem' confronting all of the health and social care areas is the matter of health inequalities and the role of partnerships in addressing the wider social determinants of health:

Unless we can tackle the issues around employment, poverty, housing, environment, then if we can't get into those kind of social determinants of health then our ability to tackle the health inequalities is always gonna be limited. So I suppose from that perspective the health and social care partnership seeing itself as a player with other community planning partners and being round those strategic tables is really important, so I like to think of the health and social care partnership as a partnership, but also as working in partnership with those other kind of key players, and that's something that's really important for us. (L09)

As outlined in the sub-themes of this section, interviewees highlighted a number of systemic factors that have a direct impact on the work being undertaken to integrate health and social care. Some of these are relational and require changes to infrastructures and processes. However, it was also strongly affirmed that some reach beyond the influence of the health and social care partnerships and unless addressed, will remain a considerable challenge to reach the goals behind integration.

RESEARCH FINDINGS FROM NATIONAL AGENCIES IN SCOTLAND (MACRO-LEVEL)

Although the dominant focus of this qualitative study is to understand the perspectives and experiences of those leading integration within health and social care areas, individuals from national organisations across Scotland, were also invited to participate in the research; providing a reflection of the research questions from all levels of the system.

The cross-sector agencies included are:

- Audit Scotland
- COSLA
- Health and Social Care Alliance Scotland
- Healthcare Improvement Scotland
- Improvement Service
- Scottish Government

This section, summarises the findings from the national interviews, presenting *macro*-level insights into leading co-production and co-creation within the context of health and social care integration.

Four key themes emerged from this national data:

- The meanings and understandings of co-production and co-creation.
- Leadership skills and the role of evaluation.
- Cluttered national landscape.
- Systemic challenges to the implementation of co-production and co-creation
 - capacities and cultures.

THE MEANINGS AND UNDERSTANDING OF CO-PRODUCTION AND CO-CREATION

Sub-themes

There is more awareness about co-production but less so about co-creation. Co-production and co-creation are generally linked to notions of empowerment, shifting the balance of power towards communities, and ‘trusted partnering’. The Christie Commission Report is generally the key reference point for how interviewees think about co-production and the public service drivers for it.

There is a lack of clarity about the co-production terminology in national policy documentation.

The key reference points for promoting co-production and co-creation, mentioned by national interviewees was the Christie Commission and the Community Empowerment Act, 2015; which acknowledges the wider public sector agenda focus on citizen engagement and localism:

And I think that we know as a public sector the direction that we're supposed to be going in. If you follow the principles of Christie and the community

empowerment act and all that, community planning partners as we would describe them at a local level, should also, should all be involved in that co-production process. So your ideal, for example, your ideal sort of rehabilitation or alcohol and drugs intervention would be co-produced, not only between the council, the health board and a provider, a third sector organisation or two but also you would involve justice agencies, Police Scotland whoever else was relevant. Housing associations, the housing part of the local authority, the prison service, whoever it might be, to co-produce what you're trying to commission. So I guess the kinda first one is how I think co-production is normally conceived of at the moment. And the second one [co-creation] is probably where we should be going with it. (N03)

There's also a recognition that adopting a co-productive or creative approach is challenging for HSCP areas:

...there's a line in the Christie Commission...Which is something like services should be designed for and with people in communities not delivered top down for administrative convenience. And I, that I think would be the simplest explanation of co-creation that I could refer to ... It's damn hard. (N01)

N04 expresses similar sentiments and acknowledges the Christie Commission as an important reference point for co-production as it is inextricably linked to the outcomes-focused agenda in the public sector (which the Christie report encouraged); but a novel insight emerged when the interviewee reflected on the fact that if enough progress was made on co-production in the aftermath of the Christie Report, then the Community Empowerment Act might not have been required:

I think where we've come with the Community Empowerment Act is that it's a big bit of legislation with a lot of different things in there that I think sometimes can be slightly confusing in terms of what's being asked of you. However, I think what it does do is introduce a set of principles and guidance that probably is needed, because we had the Christie Commission, which was that kind of focus on outcomes, and I suppose we'd maybe want to ask, well, what progress did we make up till then, and if we'd made sufficient progress would the Community Empowerment Act have been required? So I think that put in place some of the expectations that came out of that. (N04)

Another interviewee noted that the 'smoking gun' for co-production was the Christie Commission report and which, the interviewee recalls, that 'unless Scotland uses all, all of its skills and resources, basically, you know, the, the whole system is, unless we use this whole system we'll buckle' (N05).

Interviewee N03 framed co-production and co-creation more from the lens of community empowerment as a 'big picture view across all public bodies in Scotland'. This was based on the assumption that the Community Empowerment Act 2015 will engage well with communities, 'which is a real cultural shift in organisation ... It's about re-orientating entirely how they do business when it works really well'. The perspective offered, with regards to co-production and co-creation is about shifting the power balance towards communities. The interviewee highlighted, however, there are sectoral differences at play in that the NHS is seen as less developed in its thinking towards co-production – 'I think health's got quite a lot to learn, particularly from some local authorities around the way that they progress that agenda over the years':

[we need] a set of principles of what good community empowerment looks like, because we're away, way beyond, you know, participation or engagement or any of that, or even co-production, into something really quite a different kind of model, which is really exciting and very, very challenging for folk ... It's a kind of, a real, kind of, organisational shift around it. So that's one thing, and another thing is the ongoing nature of it ... There's an assumption that the community are directly involved in these decisions, they've got control over the money, there's some sort of power change at the heart of this, and I think that's the kind of key thing for us is to see that there's some sort of power shift happening there. So we've put together an expert group of people involved in community empowerment to help us understand this, because it is very complex, so this is organisations who are involved in a lot of community-based work, and it's been really interesting some of the discussions we've had with them because it's really challenged us around some of the assumptions we had. So we talk a lot about seldom heard groups and the work that needs to be done to genuinely make this happen, that it cannot be tokenistic, it's a complex thing to get right. So it's just the very start of an engagement we're having around that, but trying just for us to understand when it works really, really well, what does that look like in practice is very complicated. (N03)

One interviewee did not highlight a key reference point or document that shapes their thinking and approach to co-production, but notes the NHS Quality Strategy is an important framework for encouraging such an approach. The interviewee highlighted that their role is to enable positive relationships with partners to help them understand how improvement can sit alongside service design approaches (such as co-production):

I would say that our focus at the moment is very much, it's a bit more on how does improvement sit with the service design methodologies because ...and ... because we're an arm's length organisation from, from the front line, it's about how to rebuild those capabilities to actually be able to have that type of relationship with your services users to, that will carry on into co-production ... It very much does talk about understanding your system from all perspectives before you define what your problem is. But quite a lot of the time because it's been used in a much more traditional technical way, we very much start with let's define the problem together and then we'll go and engage. (N05)

Terminologies

It could be problematic for interviewees, when asked to draw distinctions between co-production and co-creation – ‘*and I don't really distinguish between the two ... you've lost me there actually*’ (N01). This provides an interesting insight into the fact that although Scottish Government promotes both co-production and co-creation as a way to accelerate and sustain integration there is acknowledgement, even at policy level, it can be challenging to differentiate between the terms.

Other interviewees, felt the terminology used in policy documents for encouraging integration in health and social care has been opaque:

Having been involved in, very recently, the drawing up of a couple of key policy documents around health and social care...quite explicitly speaks about co-production. ...It also tries to speak about developing things with the third sector and carers organisations and that kind of thing. And having been quite close to the drafting of those and with the good knowledge of those documents, I would say there's no distinction in

those. So they may be in people's kind of understanding who had been involved in it ... If you were just to pick those documents up and read them, it's not a distinction that's teased out in those policy documents and they're quite significant at the moment. (N02)

N04 had a clear view about the frustrations around how many in the system, conflate terms such as consultation, co-design and co-production. That being said the interviewee had perhaps one of the clearest perspectives of what co-creation means, in that, it is marked by its enduring and sustained relationship:

If I can take it a step back, is that one of the things that used to frustrate me, not in my current position, but when I was ... doing community planning, is that in general, and this is a bit of a sweeping generalisation, but I felt there was a lack of understanding around the differences between the four steps, as I would call it, consultation, engagement, co-design and co-production. And people would use conversation and engagement interchangeably, and people would use co-production and co-design interchangeably, and not exactly understand what it means, and to make it work, what it means. And I'll come back to the kind of, there's something else I wanna mention again from another previous role that might assist as well, is that co-creation is probably one I've only just started to kind of hear, but my thought of it is that it would be co-production but from the very beginning, in that you're actually designing the service and co-producing the service from the start, rather than having a service already in place and looking to co-produce with. So, for example, if you're delivering library services, for example, for me co-production would be involving the community from a volunteer basis coming in and producing that service with you. The co-creation is actually saying well, we've not

got anything, but we need to deliver this service, what's that gonna start to look like? So for me, it sounds like the elements of design, elements of production from that perspective, so that's what I would understand in it. (N04)

One national interviewee preferred to use the term 'community-led support', rather than co-production or co-creation. What this suggests is a preference for the use of terms. However, it also arguably contributes to a terminological morass which overall, could be contributing to a lack of conceptual clarity, by compounding the amount of phrases generally recognised locally and nationally (at least in principle). To be fair, however, the interviewee references examples of community-led work by actually using the term 'co-production':

You know, things like foodbanks and ... and ... co-created, co-supported community services where we have volunteers working together with services to deliver. Actually some of our volunteers deliver training through people who have had lived experiences of particular aspects and then become partners of those in sharing their experiences and training others. I would say quite a co-productive relationship that we had. (N05)

Interviewee N05 was less concerned about aligning themselves to a particular definition when it comes to co-production but prefers such activities to be viewed from an 'assets-based perspective' and the importance of reciprocity in relationships:

But I, I certainly wouldn't want to be, you know, a purist in the sense, you know, I'm happy for anybody to call co-creation and co-production and co-evaluation, co-design, whatever you want to call it, essentially it's the principles that fall on to that in terms of seeing the fact that in, in co-production or co-creation you

recognise that all parties have something to bring the party. That it's an asset based approach and that you seek to identify what those resources and work together in a ... a reciprocal way. One that values the contribution of all parties and one that recognises that, you know, individuals participating in that will have different assets that they can use. Whether that's the, an asset of lived experience, of learnt experience. Whether it's, if it's in terms of organisation, whether, you know, it, it's about people they can bring to it or money or buildings, expertise etcetera. There will be a vast variety of resources that one could identify but in, in determining whether, you know, you know, it's co-creation, it's co-production it doesn't really matter. (N05)

Co-production and commissioning

Another national interviewee when asked about the meaning of co-production and co-creation, felt that the interface between the public sector and the voluntary sector, especially in terms of commissioning, was co-productive. The interviewee noted that *'I don't know if there are many very good examples of that yet although they're emerging'* (N02). This interviewee also suggested, that co-creation is the next phase building on the current co-productive efforts.

A similar point raised, was that although there is willingness to undertake co-productive and co-creative work that, in the end, financial constraints represent a key barrier and, moreover, HSCPs have to ask themselves if, as commissioners of services, if they are going to be a co-producer or a commissioner:

I think given the levels of financial constraint that we're going through at the moment is that it's less, incentive is not the word, but there's a necessity now. I think it was an incentive before, because you were looking to

involve communities more, and third sector in what you were doing, and it's whether, and I know obviously HSCPs have probably got more of their own strategic commissioning than probably most other services, so depending on where you take that to, do you become a commissioner or do you become a co-producer in terms of how you work? I think there's a willingness to do it, and as I say, I think there's more of a necessity now, I think it's just about people really understanding what that means, and really understanding if you're doing it with certain people, co-producing is not palming it off. (N04)

LEADERSHIP SKILLS AND THE ROLE OF EVALUATION

Sub-theme

Less focus should be on structural and geographical concerns surrounding HSCPs but on leadership qualities to enable co-production to be more realisable and meaningful. National agencies recognise that co-production in integration work and undertaking community empowerment requires a new skills-set.

Co-production skill-set

A significant theme to emerge from the interviews was a focus on leadership qualities and the skill-set required to accelerate integration in Scotland. Interviewee N02 suggests that the right skill-sets are needed to lead integration co-productively and that people need *'to move on or retire before you're actually gonna crack this, it's just not gonna happen otherwise'*. N01 reflected that co-production is *'about leadership and it is about having a drive to connect with people rather than attempt to fix the*

problem as fast as possible’. In addition, N04 noted that there is a need to avoid being too focused on structures and geographical considerations surrounding the work of HSCPs as a barrier to change but, rather, to pay more attention to leadership qualities, capacities, and skill-sets:

I don't think we need to change anything structurally, we just need to change things around leadership, around behaviours, around cultures, and if we do that, it'll work, and we've got a real opportunity to do that now. I think there is a challenge, absolutely, but I think where we are at the moment in realising that the challenges we face are more, are common, whereas before they might have been more distinct because we had the capacity to deliver on our own. I think then there's the onus on us to work a lot better in terms of how we work across partnerships and across communities. (N04)

A leadership barrier, or perhaps challenge, for co-production is cited by the interviewee as requiring conversations ‘*where the power is taken out of relationships ... That's much harder*’ (N04). This means that service planners/managers need to be able to give up of control, to a degree, which is not something that is always easily done due to the occupational roles and responsibilities which put individuals in the mind-set of being the deliverer of programmes and services. The reason why this is difficult in and of itself is because there needs to be the space for such conversations to take place. Moreover, in the healthcare sector the skill-sets of those leading improvement work are often borne out of their professional expertise and disciplinary backgrounds, rather than the management of relational aspects of co-production:

I came to a programme already comfortable in that skillset and but developing just nonetheless. But a lot

of the people who lead who are in the programmes are there because of their clinical specialty or their knowledge of a particular, you know, focus on dementia. You know, there'll be people who understand dementia so they're likely to sometimes be clinical people. And, you know, we have other programmes like mental health. There are people who understand mental health or, or who are really good at leading improvement. So they don't necessarily have those skills and understanding about how to apply involvement, engagement participation and co-production across the spectrum of how they set up their programmes of work. (N04)

Another insight into why clinicians can find co-production challenging, is because it requires time (which there is often a shortage of) and that co-production assumes that those, the health professionals are co-producing with, are in a position to take ownership of the knowledge relating to their health and enter into dialogues about their care (N05).

N04 also highlights the issue national leadership and how leadership nationally is important for instilling co-production across the system:

I think leadership is a big issue around, you know, belief and prioritisation of that. And I think the case for co-production isn't clear enough in, in the terms by which leadership can, can hold the line around it. So they're, and there's, I think some of the ... things which make it really difficult for them to, to do this is the speed and pressure to change that is, that is on them from the Government. And, and I think there are some things which, which unintentionally challenge the ability to co-produce with people, with anybody ... And telling someone to do it this way or to put them under pressure to, to change

without them really having that full opportunity to be involved in how it's applied is a big barrier. (N04)

Evaluation

In terms of integration, an interviewee highlighted a recommendation from the Ministerial Steering Group (MSG)⁶ report, which called 'for integration authorities to better evaluate services with the prospective of how they're engaging third sector and independent sector organisations but also about carers and users' (N05). This interviewee reflected on how integration can be evaluated and that this will require a change in stakeholder views of the value of qualitative evidence, especially in light of the fact that health research has tended to view qualitative evidence as 'nice to know, not necessary to know' (N05). That being the case, co-production, like integration itself, will not be a quick win but a long-term agenda requiring the scope and collective leadership to reflect, learn and ask questions – particularly within strategic groups and the Integrated Joint Boards:

You know, I, I think you, you...you have to think long term as well. You have to think, and I think, you know, some third sector organisations, some individuals think that, you know, this should all be fixed tomorrow. The, one of the goals that came out from our, and I think it's been going elsewhere is this is the change for a generation. This is not something that's gonna happen overnight. But you have to get your, your mind around it. And it's maybe about not just trying to work in partnership but trying to think how you work in partnership, how you work co-productively. ...How do we work co-productively before jumping into a project and thinking about, 'well what, what would this mean? How would we think? How would we act? How would we plan co-productively?' And getting people around a table before, you know, to understand that. (N05)

Another major challenge highlighted, was the Ministerial views on the role of evaluation in the public sector (N01). The interviewee noted that there had been a 'diminution' and 'reduction in Ministerial confidence in the usefulness..., practicality of such work' (N01) and this is because of the perception that evaluations are difficult to scale and replicate. This is an important point in that the National Performance Framework is only meaningful to the point that areas are able to demonstrate their contribution to them and, therefore, evaluation might be an aspect of integration work that could have been regarded as crucial, yet it does not have Ministerial support.

CLUTTERED NATIONAL LANDSCAPE

Sub-themes

There is a cluttered landscape of improvement-focused national bodies. This is not in terms of there being too many, but there being a lack of clarity over roles and responsibilities, which do not help local health and social care partnerships as they will not have clear lines of access for support. There needs to be a 'national lever' for drawing agencies together in order to avoid duplication between agencies to clarify lines of responsibility.

There is a need to join-up initiatives and legislation at a Scottish Government level but this does not always happen (e.g. the legislation underpinning integration and community empowerment).

National collaboration

The cluttering of national agencies, which often work at cross-purposes, was a key theme from the national interviews. This is consistent with the systemic challenges highlighted within the local interviews. For example, N02, when asked about this finding from the local interviews, said ‘yes, 100% ... I’d be quite happy to call it a cluttered landscape at the moment’. The interviewee did not say that there was a problem with the number of agencies, rather it is more of a question of them working in ‘harmony’:

It’s not just about organisational behaviours either. It’s a lot to do with how they’re commissioned to do bits of work and all that that we are, whatever, by osmosis you get this kinda cluttered landscape. And I think that that’s, it’s actually something that we’re quite mindful of at the moment ... When it comes to who actually does this work, who actually goes out and supports health and social care partnerships to improve, ... it felt quite difficult to identify even as national agencies who, who should and who can go out and provide that support. And I think it feels frustrating that there isn’t that kinda one, one lever to pull at a national level to, to essentially support something that we’re all bought into. Yeah and the fact that maybe the improvement agencies could collaborate a bit better although that’s putting probably too fine a point on it. (N02)

The point about having a cluttered landscape ‘by osmosis’ and not having national levers for ensuring collaboration between national agencies is perhaps an explanation as to why those in local HSCPs are sometimes unsure about where to access specific forms of support on, e.g. co-production, evaluation or improvement approaches. More broadly, the

interviewee felt that a potential solution to the national cluttered landscape and the need for more effective co-production is to undertake empowerment properly and where there is scope, for national agencies to be more responsive and empowered than they currently are:

I think there’s a need for more empowerment of local systems actually so we’ve got local accountability mechanisms built into the fabric of our public services through the council. Through, now through the health and social care partnership or IJB through the community planning partnership. And, and I think that they’re there because we, because we all recognise that, that local empowerment is the best way to tailor services to the needs of our particular community. And I think that what sometimes is a barrier to that is actually the...behaviour of and the restrictions of national agencies to, to really be empowered and flexible at a local level to adapt to, to adapt the resources, target the resources to local need and to kind of, and maybe for central authorities, let’s call them, to, to let go a little bit of their, their own requirements for reporting on national indicators because they might not, not always be wholly relevant to what needs to be done for a local community. (N02)

N04 had a sense that there were a number of national agencies operating across similar domains and that there was not always a strong degree of consistency:

There is a whole plethora of other national organisations who are also working on that. So we have the Care Inspectorate who have an improvement arm. We have SSSC, social care arm who are now taking on an improvement approach.

We have NHS Education for Scotland who are, who should need to be, have some responsibility for that ... We, we've got a kind of, a major improvement programme ... I wouldn't say there's a ... particularly consistent approach to how that is done and how well that's being done. (N04)

Conflicting agendas

Moreover, the matter of conflicting agendas at a national level, is a theme throughout this report – also recognised by N03. The argument is made that a lack of cross-departmental strategic dialogue and leadership around legislation and initiatives has contributed to a state of confusion for HSCP areas:

I think there's also a bit of confusion when sometimes you look at the policy agendas coming out of the Scottish Government, so how they, so each department, they do a bit of legislation, for example, will have their own expectations around how things work, but they route it all through this kind of community planning agenda. So what do we mean by that? And I think that's the difficulty, and I think that's when you talk to the chief officers, they'll say well, I'm getting asked to do this by community planning, I'm getting asked to do this around health and social care, by the way, I've got community justice sitting over here and I've got public health forum just about to come through the door as well, who all want their outcomes delivered ... But you will speak to people in Government and they will admit yeah, we do need to speak to each other more around developing policy.

I also think there's something really interesting about the dynamic at government level about this. So we talk a lot in our reports about joined up government, or lack of, when we don't see it, and I think there

is an issue with stuff around the Community Empowerment Act and how it fits with other policies and legislation. And again you could argue that that's very much true of integration, you know, the fact that policies will come out. And I know people who are steeped in integration will look at them and say, well, that's just totally ignored the fact that we've got integration now, so there are definite parallels between the two. (N03)

The issue of co-production, however, will be fundamentally challenged by governmental silos which aid and abet a lack of integration and the cross-fertilisation of policy knowledge. This, according to the interviewee, undermines the agility and organisational readiness for co-production to have the best chance of success, and highlights that silo-working is not just a concern for HSCPs, as it runs all the way up to Scottish Government level:

And the government bit's really fascinating because equally you've got people kind of in their silos and, you know, dedicated to whatever the policy might be they're looking after, and you see the struggle in trying to make those connections, and our ask is always how does the policy connect up with practice changing essentially, how is it filtering all the way through, and it's just amazing the kind of road blocks that happen along the way, I think, and I think the integration of health and social care is really showing some of that, and the chief officers are at the front of it all... So if you've got almost this complexity to deal with and being seen as the solution to fixing the health and social care problem, and you've got systems that are not on board with it, I mean, is it even possible, you might ask. (N03)

SYSTEMIC CHALLENGES: CAPACITIES AND CULTURES

Sub-themes

There are capacity challenges at a national level in terms for dedicated Scottish Government support for integration.

The pace of integration is being undermined by deep-rooted cultural, behavioural and practical factors which will continue to impact on the organisational readiness for co-production to be sustained.

National political leaders need to have honest conversations about the extant model of health and social care to highlight how co-production plays an important part but the funding model is out of step with capacity.

National capacity to support co-production and integration

One of the key themes to arise from the local interviews was the capacity challenges for implementing and sustaining co-production and co-creation; this key area was also stressed within the national interviews.

Interviewee N01 stated that *'one of the myths that perpetuates in here is that there are dozens of people working in integration and there aren't'* (N01); which reflects the capacity challenges also faced by national organisations to support the integration agenda. Interviewee N02, also acknowledged that although budgetary constraints represent a barrier to co-production, there is also an issue with the

not having the infrastructure or capacity to enable policy planning and evaluation and that it might be a question of investment – *'there's something to be said for the extent to which councils in the health board are actually funding more than just like the salary of the chief officer in IJB [Integrated Joint Board] meetings'*.

N01 also compared, rather candidly, the integration agenda to Winston Churchill's famous saying about democracy (i.e. that democracy is the worst form of government, except for all the others) and they noted that *'But I think it's a little bit like what Churchill said about democracy, you know. It doesn't work but it's better than the alternatives'*. This interviewee also reflected that *'one of the great things about working on integration is none of it is rocket science, absolutely none of it. ...You observe the local population getting terribly exercised at the idea that something might change in that hospital, even though they don't access it. Even though it's decrepit'*. N01, takes this reflection further and suggests that involving people is just part of the solution, acknowledging that there are other everyday systemic challenges that face Chief Officers and partnership managers in health and social care areas to deliver integration.

Cultural Influences

At a systems level, N03 reported that in terms of challenges and their composition, they are not all the same and *'there's a whole legacy behind every little stone you lift up'*. This means that *'it's very difficult to start to change in any meaningful way'*. In many respects, moves to empower communities and embed co-production in a sustainable manner, cannot be divorced from the deep-rooted cultures, behaviours and practices that uniquely exist within organisations. Interviewee N04 focuses a great deal on capacity and cultural challenges. And

highlights the findings from the Audit Scotland 2018, progress report which discusses how the degree of reticence amongst senior individuals in the public sector who did not want integration to happen because integration is about a shift in the power balance. This indicates that an explanatory factor for at least some of the inertia and lack of progress with regards to integration is as a consequence of vested interests and a fundamental opposition to integration as a policy idea:

It's massive, it's huge. And I think there are similarities to integration actually in that we talk a little bit in the report, and certainly about presenting about the reports, we've doing a lot about some organisations thought this would just go away if they ignored it. They didn't want it to happen, they didn't agree with it, and they lobbied very, very hard cause we do know, we hear a lot about the conversations that go on behind the scenes, and a lot of pressure from very senior folk for this not to happen, because it is about a power shift, integration is absolutely about that. (N03)

The culture of blame avoidance, suspicion of national auditing, and relational concerns was also raised by the interviewee, who expressed some bemusement at the conflicting behaviours seen within HSCP areas. On one hand, senior managers are actively promoting transparency, however often what's demonstrated in practice, are defensive behaviours:

The culture ... to me was quite shocking, quite shocking. In organisations that on one hand would talk about openness and engaging the public and transparency. And I know from my work in here that it's not as open and transparent as we would like. And then seeing their reaction to inspections where we

had chief execs turning up to feedback in meetings where it was way below their pay-grade, sitting very close to inspectors, questioning judgements on very junior inspection teams, disagreeing with things that they had found, not wanting to hear the story at all. ..So the strength of what we do, I think, is we come in and say to these people actually that's not very healthy, and because of the independence we can say that publicly, we can talk about those things.... To be able to talk to chief officers and for them to tell you honestly what the problems are, and that kind of takes a long time to build up, but it's something that we kind of instil in folk here. (N03)

Interviewee N05 reinforced similar messages, to emerge from the other national and local interviews, particularly that integration needs to be supported nationally and the leadership is vitally important. This interviewee provided an insightful example of a time when there was a realisation that the statutory and third sector needed to co-produce with each other:

I do have a lot of sympathy for colleagues within the statutory sector, trying to actually deliver on this. But there is a, there is a, a mindset. And I've seen it, I've seen it work because I've seen my own views change. Again the...the example I used is when we were reorganising psychiatric services in Lothian. And we had to close down an old psychiatric unit and transfer acute mental health services out of the, out of the county and to the city centre. And how are we going to then provide a community service which would support that. And for a long time the clinicians and myself as the general manager thought, 'well if we're moving beds we need some form of'...it sounds bad, some sort of halfway house with beds in it. So if somebody has a crisis we can put them in there until

the main service opens at nine o'clock in the morning... That's the way we thought in terms of institutions, institutional care. And we had, it took a while but with, with users of services, carers services and very effective advocates of the service, it soon became apparent that, you know, that is not what, what people who use the service wanted. What they wanted was somebody they could speak to on a seven day, twenty four hour basis if they had a crisis. Not, not a bed, you know. But it took a lot of persuading that, in fact, as a statutory service we weren't equipped to provide that. The people who were equipped to provide that were the third sector. (N05)

The cultural differences between the statutory and third sectors around co-production were expressed clearly; highlighting cultural restrictions within statutory organisations that may prevent effective co-productive efforts:

And although you might have the third sector person on the strategic planning table, do you have them at the local mental health planning group. Do you have them at the, at a service level, you know, where are the changes taking place right down the line because there are, one of the complaints we have is that, you know, as a third sector and if I sit at the strategic planning group. But there are changes that take place at service level and we don't get to hear of them until they've happened. So it needs to permeate right through the organisation. They need, people need to be given permission and not to be fearful of taking those decisions. And it's not just about being fearful about, you know, higher management. It's about being fearful about, you know, what, what does society think about that. And, you know, there's risks involved in it. And what happens if it goes wrong and who's gonnae get blamed. You know, statutory sector managers are risk averse. (N05)

The interview concluded with the point that co-production is one method for improving the health and social care system but has to be seen in the context of the fact that the system is 'buckling'. There is a lack of willingness at national government level to have 'honest conversations' about the current system, which lacks the resource and capacity to meet demand:

You're either gonna have to sort of do more yourself in terms of self-management or you're gonna have to pay more or you're gonna have to do something, you know, in terms of, you know, supporting the third sector more or transferring services to the third sector. So you won't be going to the health service and social care. You know, you'll, you'll have to rely on a third sector organisation. You know, the, the mind-set in it does need to, to change. And you either do more yourself or you do more with organisations or the alternative is we pay more national insurance or we pay a health tax or we, we fund it out of our own pockets. And it might be a combination of all of those. So co-production is just one tick in the toolbox about doing more together, about having discussions with the professional about, you know, what can I do more for myself at that level. Co-production in terms a' co-creation is about how do organisations who are cash strapped do more with third sector organisations to try and see if they can get more bang for their buck. And it's about government having an honest conversation with organisations and with society about, you know, you know, 'listen, there simply isn't enough money to do that. You can see things aren't working so we need to have a conversation about how we do things differently'. And co-production is one a' the methods, not the only one but one a' the methods in which you might actually start to fix some a' that. (N05)

SUMMARY OF FINDINGS

Both the HSCP area interviews and the national interviewees generally recognise the positive impacts, and attach value to, co-production as a means of supporting service improvements. In relation to the terminologies used, both the literature review and interviews supported that there is more awareness of the term ‘co-production’, as opposed to ‘co-creation’.

Evidencing the effectiveness of co-production and co-creation, is significantly challenged by the nature of public service reform in Scotland. A policy disparity has arisen around empowerment and accountability. The ‘empowerment heavy’ approach to reform, has left HSCP areas, and their leaders, struggling to navigate through often conflicting policy agendas and unclear policy narratives for change (e.g. co-creation, co-production, improvement, localism, and empowerment).

The accountability for implementing these policies and delivering outcomes, rests with the Chief Officers and the HSCPs. However in the current financial climate, there is evidence of defensive and risk averse cultures, hindering the transformation progress.

There is also a lack of capacity and capability within the system to lead and evaluate co-production and promote the outcomes of co-production, to support policy ambitions.

One of the key barriers to sustaining co-production and co-creation, highlighted in both local and national interviews, was the cluttered landscape of national improvement agencies in Scotland. This is problematic for national agencies themselves in that it is difficult for them to understand their impacts and contributions to national-level outcomes. Compounded by an empowerment heavy model where their level of influence and control is inextricably lessened due to the composition of the policy system in Scotland.

This cluttering is also challenging for local areas as it creates confusion as to where to access information and support – particularly with regards to co-production, improvement, methodology guidance and evaluation.

The findings did not suggest there were too many agencies, rather, there was a need to align the work of these agencies and have this alignment reflected in the policy and governance levers to support cross-fertilisation and consistent policy messaging and support.

Within the current social, policy and political context, there are a number of acute capacity challenges to sustaining co-production and co-creation in health and social care. These capacity challenges, have implications for national public service leadership and have essentially produced capacity gaps on both sides – i.e. at *meso*

and *macro* levels. The cumulative result of this is that *meso-macro* relations between national areas and HSCP areas has been strained due to multiple policy agendas and the challenges regarding the pace of change demanded at a national level.

The fact that integration was one of SNP Government's flagship policy initiatives is an overriding political driver for its continuation. Yet there remains fundamental institutional and cultural issues that need to be addressed locally within HSCP areas. In this respect, it could be deduced that policy expectations about the public sector in Scotland being 'institutionally fit' to adopt integration co-productively were, and remain, problematic.

If Scottish Government seek to encourage co-production and co-creation then it would be advisable to provide more national guidance to HSCP areas on the practical application of the terms, and to build in capacity and capability to support HSCPs. This is a key source of concern by those in HSCP areas who are tasked with leading co-production as part of the integration agenda, which, interestingly, is also generally recognised by national agencies/organisations.

CONCLUSIONS

This qualitative research report has summarised the findings of interviews with participants tasked with undertaking co-productive and co-creative work across Scotland in order to progress health and social care integration and includes the insights of key national agency participants. What is clear from this research

is that there is general value attached to the idea of undertaking co-productive work (even if the language was unfamiliar to interviewees or if they used different terms to describe such processes). However, this research suggests that if Scottish Government wants to promote co-production and co-creation as key mechanisms of change; then operational guidance, training and support should be provided to HSCP areas on the practical application of the terms.

A general theme from the research, emphasises the skill-sets and leadership qualities required to undertake and promote co-production. This requires space for experimentation and risk-taking. The scope for delivering co-production also needs to be seen in the context of nature of governance relations facilitated by the Scottish Government, which is to adopt a somewhat empowerment-heavy model, with the result being that the system has perhaps become (overly) complex and one where Chief Officers of health and social care areas are challenged, with some impossibly so, by the scale of the tasks they face. A national official recalled that when they took up their job nearly one decade ago their line manager said that *'the biggest difficulty you're going to have is that in order for this to work, you're gonna have to see a manifestation of leadership in the public sector which is co-dependent. Which has people sharing power'*. This remains as acute an issue now as it was a decade ago.

There are useful examples of local co-productive practice through specific service changes but there is a need for such approaches to be manifest and sustained at a higher level

within the system. A clearer sense of national direction is seen as desirable by HSCP areas.

There are also questions about how HSCPs can demonstrate their contributions towards national-level outcomes within a complex system. How can co-production be evaluated? What are the national-level expectations? The MSG⁶ report, for example, notes that *'every Health Board, Local Authority and IJB will evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress using the support on offer'*. According to this research, *'the support on offer'* needs to be carefully thought through by Scottish Government given the consistent view from local interviewees and amongst the national interviewees, is that there is a cluttered national landscape of agencies which needs to be disentangled to identify all offers and discuss how national support can dovetail, rather than duplicate – to develop the skills and capacity required to embed a co-productive approach within local and partnership service planning. The MSG⁶ report also calls for HSCPs to have *'tough conversations'* to make integration work but there is a strong argument to be made, based on the evidence provided in Part 2 of this report, that tough conversations need to equally take place at a national level in order to reduce inefficiencies and provide clear and consistent support to HSCP areas. Evaluating integration by drawing on a range of evidence forms on a routine basis will become ever more important for HSCP areas.

Not all HSCPs are at the same stage in their evaluative thinking and, again, this comes down to outcomes-based leadership. A key challenge here are the differences in data collected in

relation to outcomes from an NHS and social care perspective, reflecting the cultural differences of the organisations involved in delivering integration. A further evaluative complication is the role co-production plays in supporting the design and delivery of services with a preventative focus. Shifting the focus of service delivery to preventative activities, is an important feature of integration as well as other public sector reform efforts (such as community empowerment). However, this is not straightforward and even more challenging to evidence the impact of prevention. This requires patience, creative space and longevity to see the results of such work; especially, bearing in mind that health and social care integration is in its formative stages of implementation. The politics of the situation is such, however, that national government will want to be able to report on the success of one of its flagship public sector reform initiatives. Therefore, the expectations that local evidence is gathered to demonstrate the impact of the work of HSCPs to deliver national outcomes are high. If performance, scrutiny and evaluation, are likely to become increasingly important as pressure grows to evidence impact, then agile leadership to ensure that meaningful and sustained co-production is promoted and implemented across the system will be of acute importance for enhancing the quality of health and social care integration in Scotland in the coming months and years.

Finally, this research suggests that the term co-production is recognised far more than co-creation both in the literature (demonstrated in Part 1 of this report) and in the interviews with stakeholders (demonstrated in Part 2 of this report). Therefore, this research recommends that

it would be helpful for both national policy actors and for those tasked with leading and managing integration within HSCP areas if the term 'co-creation' was withdrawn from policy narratives entirely and, instead, the focus became about **'meaningful and sustained co-production'** in an effort to start to address the confusion that exists around governance reform terminologies.

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APPENDIX

Semi-structured interview guide: How co-creation is understood, implemented and sustained by managers/planners as part of improvement programme delivery within the health and social care context in Scotland.

INTRODUCTION

The Scottish Government promotes integration and partnership-working, as major drivers for change under the national outcomes policy framework, as central to improvements in the public sector (Scottish Government, 2017; Scottish Government, 2018a). As part of this, co-creation and co-production have become recognised by public and third sector bodies in Scotland as important, given the general view that co-creation and co-production can lead to the achievement of positive outcomes for citizens, more effectively than more traditional methods of designing and delivering goods, services and facilities (Evaluation Support Scotland, 2017; Alliance Scotland, 2018; Healthcare Improvement Scotland, 2018; Scottish Co-production Network, 2018).

Little is known about how co-creation and co-production is understood, implemented, and sustained within Scotland's health and social care services. Given the normative centrality of co-creation and co-production for improving public services, it is timely to ask how co-creation and co-production can be sustained based on the

occupational experiences of those tasked with enacting co-creation and co-production.

The study will provide lessons about how service managers/planners (who work across partnership boundaries) plan, deliver, and evaluate co-creation and co-production, as part of the efforts to deliver long-term sustainable public sector reforms within complex systems.

BEFORE INTERVIEW

- Ensure participant information sheet has been read
- Ensure consent form has been signed
- Ensure participant is comfortable and is ready to begin

WARM UP QUESTIONS

- How did you get involved in health and social care integration?
- What is your role and how long have you been in this position?
- Can you describe this approach to health and social care integration in this area?

CO-CREATION / CO-PRODUCTION – CONCEPTS-IN-USE

Based on your experiences and role, we are interested in your understandings of the ideas of co-creation and co-production. [These group of questions can be used to probe understandings of either one or both of the terms, to elicit knowledge about the terms, as well as their use-in-action, that is, how they are articulated in daily sayings and doings and whether there is conceptual clarity of the terms as distinctive, or overlapping/switching/blurring of terms. Need to be attuned then to which word has traction for the remainder of the interview, especially if the notion of co-creation is less familiar, which is a possibility.]

- What does the term ‘**Co-creation**’ mean to you? What are the key characteristics of ‘co-creation’ from your perspective?
- What does the term ‘**Co-production**’ mean to you? What are the key characteristics of ‘co-production’ from your perspective?
- How do you understand the differences / similarities of these ideas?
- What or where is your key reference points(s) when it comes to informing your approach to leading partnership changes within your areas? (e.g. a specific policy document, experiential learning, literature, an initiative).
- From your perspective how well promoted are the ways to allow you to take a co-creative approach in your role?
- What support is available to you to support co-production/co-creation?
- (if appropriate) How do you/have you engaged with this support to date?

CO-CREATION / CO-PRODUCTION – APPLICATION FOR IMPROVEMENT

We are interested in your familiarity with the increasing connections being made with the ideas associated with improvement methods and how co-creation and co-production can be embedded in this work. [These questions will need to consider participant’s awareness of improvement methods and then their familiarity with the uptake of co-creation and co-production into the discourses associated with improvement methods. Paying attention to how these are articulated in terms of inter-organisational relations will be very important here as this is a critical dimension effecting action. After establishing levels of awareness, questions will possibly then be able to discern how these ideas are linked-in-action]

- To what extent are improvement methods are embedded in your work?
- Do you see the links between co-creation and/or co-production and improvement, when it comes to ‘leading’ such activities from a higher level in the system?
- What do you think are the kinds of impacts, or changes to services, that co-creation and co-production have facilitated through integration? And can you give examples?

1. CO-CREATION / CO- PRODUCTION – ASSESSING CONTRIBUTION

In your role, as a manager, or planner, in your context, we would like to develop an understanding of how you assess improvement efforts that involve co-creation and co-production. [At this point we are seeking rich descriptions of

the doings of these participants, in terms of their day to day work and the ways in which they make judgements about what changes are a result of deploying what they understand as co-creation and co-production in planning, implementation, service redesign and evaluative/review activities. How do they capture their efforts? We should utilise practical examples as prompts if required.]

- Do you know if co-production/co-creation approaches are making a difference to your (improvement) work? Do you evaluate this in any way and if so, how?
- Do you think that the impact of co-creation can be evaluated at a partnership or national level? If not, why not? If so, how, in your opinion, can this be best undertaken?
- If others were to ask you, how would you evidence the effectiveness of co-creation and co-production in integration?
- Can sustainability be achieved in co-creative practices within public sector reform and if so, how?
- What contextual conditions do you think facilitate co-creation or co-production in your improvement efforts in health and social care?
- What contextual conditions do you think constrain co-creation or co-production in your improvement efforts in health and social care?
- [if not unearthed fully answers to the above questions] If we widen this out, how do national social, policy and political dimensions shape the sustainability of your efforts?
- As a senior individual in this context could you please tell us how it feels personally when it comes to operating in such a complex context?

WARM-DOWN

- Do you have any final comments regarding what we have talked about today?
- Do you have any questions about how we will use your input?

Thank the participant for their time, and confirm they are happy to proceed as outlined in the consent form and participant information sheet.

2. CO-CREATION / CO-PRODUCTION – ENABLERS AND CONSTRAINTS

We are conscious that the work associated with integration is complex, multi-layered and that planned objectives are influenced by many factors which will effect local outcomes. [These questions are intended to get a sense of the local, the situational and space for maneuvering in relation to enacting improvement activities that incorporate co-creation and co-production. They are also useful for acknowledging that what they do on a day to day basis is complex, hard, takes time and that their efforts are contorted by the mix of matters that makes up their contexts].

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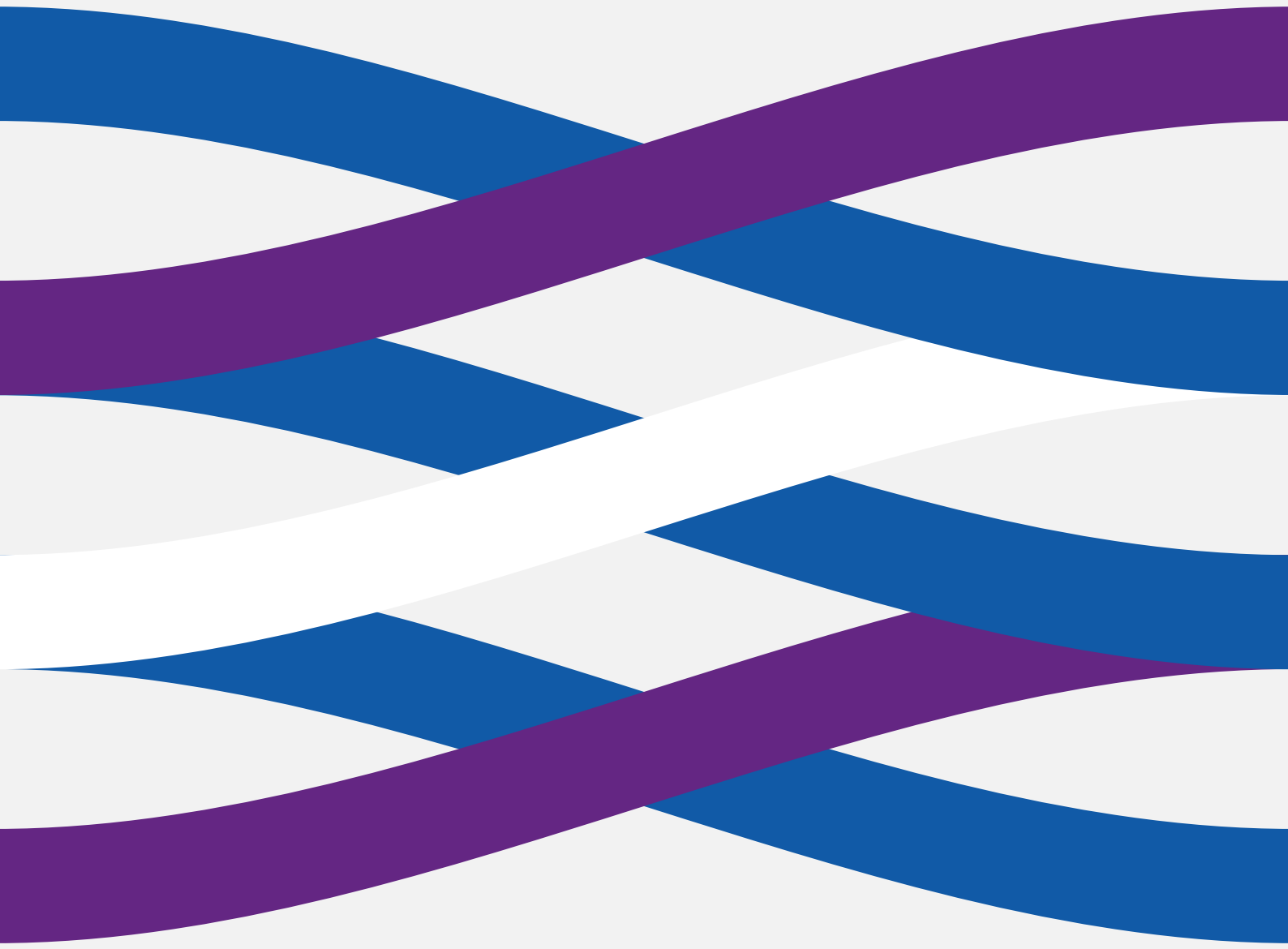
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