The benefits and challenges of the co-production of health and social care services in a rural context

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Introduction

On October 11th 2011, the Rural Policy Centre and the Scottish Government Joint Improvement Team co-organised a ‘Rural Scotland in Focus’ workshop entitled “The benefits and challenges of the coproduction of health and social care services in a rural context”. This workshop followed on from the Rural Scotland in Focus Roundtable Debate on “The Future Role of Civil Society in Promoting and Sustaining Health and Wellbeing in Scotland's Rural Communities” which was held in November 2010. Participants at the November Debate felt that there was consensus around the main themes that came through from the discussions, but, given the complex, multi-sectoral and potentially sensitive nature of the issues involved, further discussion workshops to identify specific actions would be useful. SAC therefore offered to convene further discussion workshops in 2011.

Two presentations were given at the start of the October 2011 workshop to introduce the topic and set the scene. The first was given by Gerry Power, from the Joint Improvement Team, and summarised the context for coproduction in Scotland. Kay Barclay, Senior Researcher with the Scottish Government, gave a researcher’s perspective on the importance of robust research for evidence based policy-making. Group discussions then focused on: 1) the state of the evidence on the coproduction of health and social care services and, 2) where do we go from here in terms of improving the evidence base, why do we need to do this and who should take responsibility for improving it? Participants at the workshop included a diverse range of stakeholders. In addition to representatives of the Joint Improvement Team and SAC, health boards, third sector organisations, community development organisations and research institutes were also represented.

This Briefing reports the key issues discussed by participants and their ideas on how the barriers to increasing coproduction can be broken down. The final section draws on some follow-up discussions between representatives of SAC and the JIT to identify some next steps to be taken forward by researchers, policy-makers and communities and the third sector, on the basis of discussions at the workshop.

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2 More information on this Debate can be found at: http://www.sac.ac.uk/ruralpolicycentre/news/pastevents/healthandwellbeing/.
3 These are summarised in the Event Report which is available online at: http://www.sac.ac.uk/ruralpolicycentre/news/pastevents/healthandwellbeing/.
Key issues raised in the group discussions

- **State of the evidence and the challenges of collating the evidence**
  - It is difficult to quantify the benefits of coproduction (both social and economic) and evidence-gathering often requires a long timescale; qualitative research can send a strong message and is powerful but policymakers often want quantitative evidence.
  - There are challenges with collecting data at the local level and making it available, not least with respect to cost and anonymity concerns.
  - The reasons for collecting evidence for different stakeholders need to be made clearer (i.e. is research undertaken to establish the value or impact of coproduction to funders, the Scottish Government or health professionals), in order to ensure a balanced and impartial evidence base on the barriers to, and benefits and challenges of, coproduction.
  - The academic literature on coproduction is highly theorised; the evidence of its impact is effectively ‘competing with’ evidence from well-funded randomised drug trials.
  - Particular forms of research and evidence may be more appropriate and powerful for some audiences but may be less so for others (e.g. communities and clinicians).

- **Barriers to increasing coproduction**
  - Language: we need to ensure that the term coproduction is widely understood by all stakeholders in the same way. Coproduction as a way of delivering services has existed for many years, particularly in remote and rural communities; however, its application in this context, particularly in the UK, is relatively new.
  - Attitudes: health professionals may demonstrate a reluctance to re-think their ways of working or the ways in which they collate and value different kinds of evidence.
  - Capacity: some communities might not possess the required capacity, willingness, knowledge or understanding to coproduce services (but what kind of capacity is needed?); people who do not wish to become involved in coproduction should not be forced to engage in it.
  - Evidence: a lack of evidence on the barriers to, and ‘downsides’ of coproduction as well as the benefits.
  - Timescales: the Scottish Government wants coproduction to happen quickly but parts of the third sector and some communities need time to develop the necessary skills and capacity.

- **What is different about coproduction in a rural context?**
  - Many rural areas have a strong tradition of informal and formal support so the coproduction approach has ‘always been used’ here; these locations may therefore be more amenable to trying out new coproduction-based approaches; neighbours supporting neighbours is ‘quintessential coproduction’.
  - At the same time, the characteristics of rural areas, such as distance and population dispersal, create additional costs in terms of service provision and supporting communities to build capacity.
  - Rural populations are ageing faster than urban population so rural areas potentially represent locations in which innovative coproduction approaches can be tested; the ageing population provides a driver for innovative approaches to change the way in which the NHS works.
  - It is also important to recognise that rural is not homogenous, between accessible and remote areas, between villages and small towns, etc.
How can we break down the barriers to increased coproduction?

Participants at the workshop identified a range of barriers to increasing coproduction. The following list highlights the barriers identified and suggests possible approaches to breaking down these barriers.

**Improving the evidence base**

- **Better evidence at the local level**: more systematic data collection is required about what is already happening at the local level (including activities that may not be termed coproduction) to establish an accurate baseline for future developments.
- **Who is responsible for evidence collection**: clarity is also required about who is responsible for collecting and collating the evidence; an organisation may be required to play a role in facilitating and coordinating the dissemination of evidence (through a network such as the National Rural Network, for example).
- **Best practice approaches**: Sharing ideas on best practice is important as communities can learn from one another regarding what works and what doesn’t. Taking an action-research approach may be useful.
- **Reconceptualising 'valid evidence'**: there is a need for health professionals to recognise the value of qualitative evidence around the 'softer' benefits of coproduction (such as interpersonal contact and the potential increase in mental wellbeing inherent in this) as well as the quantitative assessment of financial savings in terms of reduced unplanned admissions.
- **Better approaches to evaluation**: the UK may be able to learn from the experiences of other countries with regard to undertaking evaluations; evaluation needs to be built into projects (and indeed funding proposals) from the start so that ‘the journey’ is fully understood.

**Changing the system**

- **Changes required within the NHS system**: the NHS system needs to be more flexible and less bureaucratic; consideration needs to be given to encouraging and rewarding those who are willing to try new approaches to service provision. A 'leap of faith' may need to be taken by a small number of health professionals to encourage the system to change to match the current political will. This may require ‘leaders’ and ‘some brave commissioning decisions’.
- **Take advantage of current opportunities**: the ageing population trend and public sector budget cuts, while bringing challenges, also represent opportunities for new approaches such as coproduction to be introduced.
- **Working across ‘silos’**: Stronger cooperative relationships between stakeholders will help to enhance coproduction and to ensure that organisations and individuals work cross-sectorally and across ‘silos’ (including health, housing, transport, etc); the Change Fund should help encourage such cross-sectoral approaches.
- **Facilitating dialogue**: the Scottish Government has an important role to play in facilitating dialogue to ensure that all stakeholders understand what the desired outcomes of initiatives which seek to support coproduction are, and what roles different organisations are expected to play in this.

**Tackling unhelpful language and attitudes**

- **Changes in attitudes and expectations**: expectations around what the health service can and should deliver need to change amongst policy-makers, health professionals and communities. All stakeholders need to demonstrate a greater openness to new approaches.
- **Identifying key principles**: a set of key principles about approaches to coproduction may be more appropriate and useful than a one-size-fits-all policy. Again, action-research approaches may be useful in improving understanding of how the principles work in different contexts if similar research models are adopted.
- **Clarity over language and use of terms**: work is required to ensure that all stakeholders understand the term coproduction. A broader notion of ‘service’ may need to be adopted such that aspects of informal care provided between individuals (sometimes involving smaller
voluntary organisations) are encompassed in coproduction thus providing a broader sense of what are appropriate interventions. It may be necessary to accept that certain health and social care services may be more amenable to a coproduction approach than others, although the need for a holistic approach to be taken to health and wellbeing should not be forgotten.

Where do we go from here?

- **Researchers**: new datasets are now available (e.g. SPARRA⁴) to explore individual and community level health indicators and improve the evidence base particularly around preventative/anticipatory care approaches. In addition to the valuable contribution that qualitative research can play in examining the opportunities and challenges of coproduction, social researchers have a role to play in analysing these new datasets and helping to create a holistic picture of health and wellbeing at local level.

- **Policy-makers**: place-based approaches are required to health and social care, such that these issues are not looked at in isolation but as part of a wider, holistic, long-term approach to improving the health and wellbeing of local communities; where this approach has happened successfully in rural locations, it may be possible to draw lessons for other locations.

- **Communities and the third sector**: it is important to recognise that, although the third sector has a significant role to play in improving health and wellbeing, we need to recognise that there are also potential challenges of capacity for these stakeholders to engage in service coproduction (and the associated evidencing of this) which may vary geographically.

Attendees at the October 11th workshop on “The benefits and challenges of the coproduction of health and social care services in a rural context”


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