COPRODUCTION AND SOCIAL CARE

Catherine Needham
Health Services Management Centre,
University of Birmingham

c.needham.1@bham.ac.uk

UNIVERSITY OF BIRMINGHAM

The coproductive scale

- Description: compliance with legal and social norms, description of the status quo
- Recognition: recognising the input that service users already make and creating new channels to harness its impact
- Transformation: a relocation of power and control, supporting users to deploy expertise and manage services.

Evaluating coproduction in social care

- Social Care Institute for Excellence has commissioned two evidence reviews of coproduction and social care (Needham and Carr, 2009; Needham, forthcoming)

- Case studies have included:
  - Time bank projects (e.g. in south London and Glasgow)
  - Key Ring project
  - Villa Family (France)
  - Local Area Coordination (Western Australia)
  - Peer support in mental health services

Benefits

- Value for money
- Accessible to a diverse range of service users
- New sources of expertise
- Health benefits for participants
- Practical skills (e.g. DIY)
- Building social capital and involving broader community
- Emphasis on outcomes based around broad quality of life factors

Limitations

- Need to recognise that some users need more support to co-produce
- May develop ‘bonding’ social capital rather than ‘bridging’ social capital.
- May clash with existing regimes of regulation and risk management
- May be based on short-term, insecure funding
- Requires support from and for staff
- Need to avoid co-productive approaches that are designed simply to cut costs or create ‘responsible’ users.

How coproduction can save money

- **Spending it on the right things** in the first place (e.g. personal budgets)

- **Understanding better what is valued** and how outcomes are achieved (e.g. experts by experience)
- **Accessing, utilising and the assets of service users** which may be freely given (e.g. peer advocacy)
- **Adding to the assets of service users** and reducing welfare dependence (e.g. time banks)
- **Reducing formal staff contributions** (e.g. better using community assets)

- **Improving service quality** (e.g. user-led evaluation)
- **Improving long-term health and well-being** (e.g. Expert Patient Programme)

But…

- **It can also cost money…**
  - Training for staff, users and other participants
  - Generating new demands
- **Cost-savings may be ‘soft’ rather than cashable**
  - Reduction in loneliness and isolation
  - Enhanced trust, social capital, reciprocity
- **The ‘business case’ can be very difficult to evidence**

Evidencing the cost savings

- Social Return on Investment (SROI)
- Cost/benefit analysis
- **BUT both are lengthy and expensive**

➢ Is there a coproductive approach to develop 'good enough' research that builds an evidence base?

➢ Organisations like In Control built the early financial case for personal budgets on a few transformative case studies and individual testimonies

COPRODUCTION AND SOCIAL CARE

Catherine Needham
Health Services Management Centre,
University of Birmingham

c.needham.1@bham.ac.uk

UNIVERSITY OF BIRMINGHAM