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# Cover Page

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**Title:** The dynamics of co-production in the context of social care personalization: A Scottish case study

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# Main Text

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## **1. Introduction**

This paper presents an analysis of the role of co-production for personalisation in the context of two recent Scottish policy initiatives, Reshaping Care for Older People (RCOP) and Self-Directed Support (SDS). The paper commences with an exploration of the conceptual framework, building on Osborne et al.'s (2016) co-production matrix, and then introduces the policy context of personalisation and the specific Scottish context of the empirical study. To address our research objective, the paper presents two exploratory case studies that consider the role co-production plays for social policy outcomes and classifies their use of co-production according to the Osborne et al. (2016) model. In discussing our findings, we pay particular attention to the implications of our evidence for both effective social policy and suggest four propositions for public service reform.

## 2. Conceptual Framework

At its highest common denominator, co-production denotes the involvement of citizens in the delivery of “public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours” (NESTA, 2011), or in more abstract terms, “all relationships between citizens and professionals which make reciprocal use of each other’s strengths” (Bovaird and Loeffler, 2010). It is, however, by no means a concept with uncontested meaning. Co-production is currently seen globally both as a core element both of civil society and of public service reform (Alford, 2015). *Inter alia*, it is argued to improve the quality and performance of public service delivery (Governance International, 2011), to encourage active citizenship and communities and support civil society (Bovaird et al., 2016), to enhance democratic engagement and social integration (Strokosch and Osborne, 2016), and to lever resources into service delivery (NESTA, 2011) – though not necessarily all at the same time (Boyle & Harris, 2009). In Scotland, it is a

significant element of the social and health-care reform agenda initiated by the Christie Commission (2011) (see also Audit Scotland, 2014; Ferguson, 2015).

The co-production concept evolved first in the US (Parks et al., 1981) and has developed subsequently around the world (e.g. Brudney & England, 1983; Bovaird, 2007; Needham, 2007; Alford, 2009; Osborne & Strokosch, 2013; Radnor et al., 2014; Brandsen, 2015). However, its conceptualisation is by no means homogenous and there are on-going debates about its definition and about the contingencies of its enactment and impact (Verschuere et al., 2012; Voorberg et al., 2015).

Recent work (Alford, 2015) has moved this debate on and provided a more cohesive conceptualisation of co-production. This approach integrates the traditional public administration perspective of co-production as a voluntary process that 'adds-on' to statutory provision (Pestoff, 2006), with that of service management theory (and its application to public services) that conceptualises

co-production as an intrinsic, and often involuntary, element of any service delivery encounter (Osborne et al., 2013, 2015). Alford (2015) explores co-production both in terms of the extent to which it is a voluntarily/involuntary or conscious/unconscious process and in terms of its location within both the individual service experience and the broader service delivery system. He also locates it within a context of the co-creation of value for citizens through their enactment (Osborne et al., 2016).

For the purpose of this paper, we follow Osborne et al. (2016), who conceptualise four processes of co-production. These are (1) 'pure' *co-production* of the individual service and its outcomes, (2) the *co-construction* of the 'lived experience' of service users as a result of using a public service (both of these former processes being often unconscious and involuntary), (3) the *co-design* and management of individual service packages, and (4) the *co-innovation* of new forms of service delivery for the future (both of these latter processes always being conscious and voluntary). Crucially, it also articulates

that co-production is not a normative good. It is as likely to have adverse effects (sometimes termed 'co-destruction' (Echeverri and Skålen, 2011)) as positive ones, dependent upon how it is managed (Figure I).

		Locus of co-production		
		<i>Individual service</i>	<i>Service system</i>	
Nature of co-production	<i>Involuntary and/or unconscious</i>	I: Co-production	III: Co-construction	<i>Towards the co-creation (or co-destruction) of value</i>
	<i>Voluntary And/or conscious</i>	II: Co-design	IV: Co-innovation	

Figure 1: Conceptualising co-production (Source: Osborne et al., 2016).

This conceptual model is adopted as it captures not only the individual and collective dimensions of co-production (Bovaird et al., 2016) but also the

intrinsic and deliberate aspects of co-production in any service context, which can be managed well to create value but also conversely managed badly, resulting in an overall co-destruction of value (Echeverri and Skålen, 2011).

### **3. Policy Background**

#### *3.1 Personalisation in Social Policy: Scotland and Beyond*

Social and health-care services are in a time of radical change across the world (King's Fund, 2014). This is due to a number of pressures - including demographic changes (Office of National Statistics, 2015), and increasing demand for services due to more complex multimorbidities (McPhail, 2016). Models of social care service delivery are also evolving with the integration of social and healthcare (Scottish Government, 2018; Social Care Institute for Excellence, 2017), a focus on prevention (Government Office for Science, 2015), and partnership approaches to support that are based around the concept of co-production (Christie, 2011).



One such approach that has been popularised across Europe and beyond is personalisation (Needham, 2011; Needham and Glasby, 2014; Needham, 2016; Leadbeater, 2016), sometimes also referred to as cash-for-care (Pearson and Ridley, 2017; Carey et al., 2017). While personalisation undisputedly is part of the marketization of social care and its challenges (Holloway, 2007; Pearson and Ridley, 2017), its underlying rationale is the co-productive involvement of service users in the design, commissioning and delivery of the social care services they receive (e.g. Bracci and Llewellyn, 2012). This includes an increased choice about the content and provision of services (Grand, 2007), which is often addressed through the allocation of personal budgets to individuals who meet specific eligibility criteria, (e.g. Duffy et al., 2010; Roulstone. 2013). It can, however, also extend beyond the allocation of budgets, including an individualised and flexible schedule of social care (Duffy, 2007).

As leading social policy scholars have identifies, personalisation is a double-

edged sword (Ferguson, 2007; Needham, 2016) that can have the potential for service user empowerment (Needham and Glasby, 2014) but also expose them to greater risks (Ferguson, 2007; Needham and Glasby, 2014; Ismail, 2017; Pearson and Ridley, 2017). This is the result of competing motivations for introducing personalisation policies, where ideals of the independent living movement in disability activism (Campbell and Oliver, 1996; Morris, 1993; Oliver and Sapey, 2006) clash with austerity-driven savings motives (Pearson and Ridley, 2017). To add further complexity to personalisation as a policy, individual implementation factors, such as the role of service delivery staff (Mason et al., 2014), have been found to influence overall outcomes from personalisation.

In the Scottish context, there are two notable policies that follow this personalisation approach: Self-Directed Support (SDS), which aims to enhance the autonomy of service users regarding their care (Audit Scotland, 2017: p.11; Social Care (Self-Directed Support) (Scotland) Act 2013); and the Reshaping Care for Older People (RCOP) initiative (Scottish Government, 2012), which

sought to empower older people and their carers, actively involve them in decisions about their own care provisions, and move resources from acute to preventative care in communities (ibid). RCOP was supported by the £230 million Change Fund for Older People (Scottish Government, 2012) whereas the former benefited from additional central government funding for local councils (Audit Scotland, 2014). RCOP and SDS were chosen as examples of incentive-driven policy change (RCOP and the Change Fund) and legislative-driven policy change (SDS).

While Scotland is reportedly slow at incorporating market elements into social care (Pearson and Ridley, 2017), Self-Directed Support (SDS) in particular was one of the Scottish Government flagship policies that heralded a new approach to social care in Scotland. Thus, Audit Scotland highlights in its latest evaluation of SDS that it is "based on the human rights principles of fairness, respect, equality, dignity and autonomy for all. This means that people should be equal partners with relevant professionals in determining their social care needs and

controlling how their needs are met," (Audit Scotland, 2014: 5) (2). Similarly to personalised care options in England and Wales, SDS provides service users with four options to fund and commission their own care package, ranging from full local authority provision of services to direct payments to others (Social Care (Self-Directed Support) (Scotland) Act 2013).

*Figure 2: Self-Directed Support and its four options (Source: Audit Scotland, 2017).*

Of particular interest for a co-production analysis is Section 1(3) of the Social Care (Self-Directed Support) (Scotland) Act 2013 (henceforth referred to as 'the Act'), which states that service users "must be provided with any assistance that is reasonably required to enable the person — (a) to express any views the person may have about the options for self-directed support, and (b) to make an informed choice when choosing an option for self-directed support."

The Act thus argues strongly in favour of maximum individual user-driven decision-making that, in-practice, amount to co-production and co-design in Osborne et al.'s (2016) co-production model. Collective co-production activities (Bovaird et al., 2015) at systems level, i.e. co-construction and co-innovation in the Osborne et al. (2016) model, are not directly referred to. The paper will hence pay particular attention to instances of collective co-production, where inputs are collectively provided and outcomes collectively enjoyed (Bovaird et al., 2015: 4).

Both RCOP and SDS aim to widen adult service users' options in choosing their own care provision and increasing their autonomy based on personal outcomes (Audit Scotland, 2014); yet, there is great variation in how successful the approach has proved in practice (Audit Scotland 2017 (Change Fund), Self-Directed Support Scotland, 2016; The Alliance, 2017; Audit Scotland, 2017). This paper suggests that co-production and how it is managed is a key factor in the success (or lack thereof) of these policies and analyses the drivers and barriers

for and to success. Pearson et al. (2017) also identified this strategic role of co-production in the particular context of SDS; however, their study does not differentiate between different forms of co-production and thus does not focus on the underlying challenges for different co-production categories. This is the current research gap that our paper seeks to address theoretically and empirically.

Beyond its critical relevance for social policy design and implementation, focusing on RCOP and SDS in the context of our two case studies on the care of older people is of particular interest for scholars and practitioners in the fields of co-production and personalisation for two reasons: First, Scotland's approach to personalisation is following similar patterns to earlier approaches in England and Wales, meaning that findings from Scotland will be of relevance across the UK jurisdictions and beyond. Secondly, the service experience of older people does not only represent the core adult service user experience but also allows us to capture the experiences of vulnerable service users whose

capacity may make it difficult for them to actively participate in standard service interactions or who require support through carers (Brown, 2010; Lymbery & Postle, 2010). Evidence also suggests that age is a driver to co-production, with older people more likely to get involved in individual co-production but not collective co-production (Bovaird et al., 2015).

### **3. Analysis**

#### ***3.1 Research Objective and Research Questions***

This paper seeks to explore the role of co-production for the implementation of personalisation policies in adult social care, seeking to address a research gap of relevance for co-production theory on individual versus collective co-production as well as our understanding of the implementation of personalisation in social policy reform. This leads us to the following four research questions:

*RQ1: What forms of co-production, following Osborne et al. (2016), have been practised in the context of RCOP and SDS?*

*RQ2: What were the drivers and barriers to co-production?*

*RQ3: How did the type of co-production relate to outcomes?*

*RQ4: How can current co-production theory and practice inform social policy and legislative reform on personalisation?*

### ***3.2 Methodology***

The research was conducted as part of a wider European research programme<sup>1</sup> that focused upon co-production and social innovation. It adopted a mixed-method qualitative approach involving two in-depth case studies in Scotland.

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<sup>1</sup> The paper is based upon research carried out as part of the European Commission's XXXX research programme (EC Reference XXXXXX). Responsibility for its content lies with the authors alone.



Each case was identified through expert interviews with key national and local stakeholders and policy-makers and a thorough desk-based document analysis.

Ten interviews were conducted for case study 1 and 9 for case study 2, amount to 19 semi-structured face-to-face interviews (1) with key informants – including service users, care staff, advocacy groups, and carers (for further information on individual interviews, please see appendix).

<b>Interviewee</b>	<b>Position</b>	<b>Organisation</b>	<b>Specific Role</b>
<b>1.1</b>	Chief Executive	Third Sector Interface	Negotiated leading role for TSI and negotiated budget and governance
<b>1.2</b>	Manager	Third Sector Interface	Facilitated consortium structure and acted as linchpin for partner organisations
<b>1.3</b>	Community Development Worker	Advocacy Group (charity)	Use existing network among older people in locality to make sure their voices are heard; member of locality consortium
<b>1.4</b>	Programme Manager	Council (Social Work)	Overall lead for RCOP in council area, working in collaboration with

			TSI to ensure working of consortium
1.5	Senior Social Care Manager	Council (Social Work)	Manages all care services across council and became part of consortium which oversaw shared funds
1.6	Development Officer	Campaigning Organisation	Represent carers in RCOP activities and make sure that projects, events, and investment include them
1.7	Senior Manager	NHS	Member of consortium; representing RCOP programme within NHS and facilitating relationships with Third Sector
1.8	Officer	Community Organisation	Locality lead, liaising between thematic leads, own locality and consortium to conduct gap analysis of services and support grassroots applications for funding
1.9	Manager	Charity	Locality lead, liaising between thematic leads, own locality and consortium to conduct gap analysis of services and

			support grassroots applications for funding
<b>1.10</b>	Manager	Charity	Locality lead, liaising between thematic leads, own locality and consortium to conduct gap analysis of services and support grassroots applications for funding

Table 1: Case Study Site 1 Interviewees

<b>Interviewee</b>	<b>Position</b>	<b>Organisation</b>	<b>Specific role</b>
<b>2.1</b>	Programme Manager	Council (Social Work)	Overall programme lead for RCOP and in charge of budget as well as organising liaison between council, NHS and Third Sector
<b>2.2</b>	Social Worker/Dementia Champion	Council (Social Work)	Dedicated role to support co-productive approach to RCOP initiatives/ Frontline service delivery; contribution to co-production strategy; liaising with Third Sector; conducted gap analysis

2.3	Social Worker/Dementia Champion	Council (Social Work)	Frontline service delivery; contribution to co-production strategy; liaising with Third Sector; conducted gap analysis
2.4	Service User	n/a	Co-creating and taking part in events and activities
2.5	Carer	n/a	Co-creating and taking part in events and activities; acting as consultative advisor for social work plans
2.6	Dementia Advisor	National Charity	Organise local activities for people with dementia; liaise with council and NHS to ensure people are heard and respected. Involved in gap analysis
2.7	Manager	Advocacy organisation	Offer advice and representation services to people with dementia; represent their interest and facilitate service user involvement in RCOP planning
2.8	Community representative	n/a	Supporting local community projects since retirement; acting as consultant

			on council panels, in particular for RCOP
2.9	Manager	Advocacy group	Representing carers in RCOP activities and make sure that projects, events, and investment include them

Table 2: Case Study Site 2 Interviewees

To address the research objective, interview protocols focused on the individual positions and perceptions of the involved actors as well as the organisational and legislative coordination mechanisms employed, identifying relevant drivers and barriers for successful co-production and seeking to record the outcomes of services that were a product of co-production.

Interviews lasted between 20 and 80 minutes and were recorded and then transcribed. Data analysis was conducted according to the Gioia methodology (Gioia et al., 2012), following first an inductive, then an abductive approach of interviewee-led first order concepts, an analysis resulting in second order

themes, and finally aggregate dimensions. Coding was undertaken in NVivo with verification through two coders.

### ***3.3 Two Case Studies***

The cases were located within two local authorities in the 'Central Belt' of Scotland, capturing both rural and suburban areas in commuting distance to Scotland's two major metropolitan centres. This allowed us to capture representative experiences applicable across Scotland and the wider UK.

Case I focused on a co-production approach as part of the Scottish Government's 2011 initiative, 'Reshaping Care for Older People' (RCOP) and benefited from dedicated funding – the Change Fund – for the purpose of creating more open communities for older people, including vulnerable services users suffering from learning disabilities and dementia (COSLA, NHS and Scottish Government, 2013). The project was coordinated by the local Third Sector Interface and had a remit to ensure that service users were involved

throughout. The project was targeted at elderly people, with varying degrees of capacity (for instance, through dementia).

Case II was led by a local authority social care dementia care unit was seeking closer collaboration with other social and health-care actors across the public and Third sectors and a shift in focus on outcomes and service user voices.

Whilst it already had an expressed orientation towards co-production, actively using the terminology, the unit required significant further investment that was again supplied through the Change Fund to embed these connections and service user focus.

Further information on the two case study initiatives and the types of projects resulting from them is presented in Table X.

<b>Case Study</b>	<b>Overall Initiative</b>	<b>Types of Projects</b>
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<p><b>Case Study Site 1</b></p>	<p>Third Sector-led cross-sector consortium with six localities and 10 thematic strands</p>	<ul style="list-style-type: none"> <li>• Community-driven projects, often requiring less than £300 (afternoon activities, bingo groups, craft groups)</li> <li>• 10 themes: <ul style="list-style-type: none"> <li>○ Befriending</li> <li>○ Community food initiatives</li> <li>○ Community transport</li> <li>○ Volunteer development programme</li> <li>○ Advocacy strategy</li> <li>○ Carers and support</li> <li>○ Dementia</li> <li>○ Palliative care</li> <li>○ Learning and education</li> <li>○ Health and wellbeing</li> <li>○ Digital Inclusion</li> <li>○ Physical Activity</li> </ul> </li> <li>• Household/property support</li> <li>• Information hotline for elderly and their carers</li> </ul>
<p><b>Case Study Site 2</b></p>	<p>Council-led social care department dementia consortium</p>	<ul style="list-style-type: none"> <li>• Socialising opportunities for people with dementia (cafés, dances, etc.)</li> <li>• Improving infrastructure for people with dementia (e.g. transport)</li> <li>• Inter-generational exchanges (e.g. radio programme, dances)</li> <li>• "Gap analysis" of services</li> </ul>

Table 3: Case study co-production projects and types following Osborne et al. (2016)

### 3.4 Data Analysis



The interview data are visually displayed in Table X following Corley and Gioia's (2004) data structure model and will be discussed in the following sub-sections.

INSERT FIGURE X HERE

*Figure 3: Gioia methodology coding process according to Corley and Gioia (2004) and (Gioia et al., 2012).*

### First Order Concepts

Transcripts were uploaded to NVivo in their entirety and coded following the Gioia methodology (Gioia and Corley, 2012). This yielded 52 first order concepts, with the highest number of references focused on impact and outcomes (77 individual mentions from 18 interviewees), relations with statutory providers (46 individual mentions from 14 interviewees), the origins of the co-production approach (45 individual mentions from 15 interviewees), the understanding of co-production (43 individual mentions from 13 interviewees), resources, such as funding and staff (42 individual mentions from 16 interviewees), and the

commitment from service users required to co-produce (39 individual mentions from 16 interviewees).

### Second Order Themes

Using insights from the literature in section 2, first order concepts were grouped into second order themes, with a total of X themes verified by two coders. Particular consideration was given to how first-order concepts related to the research questions and the co-production framework identified through the literature.

### Aggregate Dimensions

Finally, the second-order themes were aggregated into 3 dimensions, namely co-production implementation, context and potential. Co-Production implementation denotes practical themes of managing co-production, including the different actors involved (individual and organisational). It also relates to

prior motivations that affect the overall introduction of co-production as the approach of choice for RCOP and SDS.

The co-production context stands for internal and external factors that set the operating environment for managing co-production in the context of the RCOP/SDS case study sites. Co-production potential, finally, represents data relating to outcomes, the service user experience as well as overall attitudes towards co-production practice, which operate as a third dimension next to implementation management and the context.

#### **4. Findings**

In this section, we will discuss the specific findings arising from the interview data analysed according to the aforementioned Gioia methodology in relation to the first three research questions, while the fourth research question will be addressed in the discussion.

- (i) RQ1: What forms of co-production, following Osborne et al. (2016), have been practised in the context of RCOP and SDS?

The interview data, supported by internal documentation on governance structures, indicate a discrepancy between the endeavoured co-production approach envisaged for both case studies and its implementation. This was apparent throughout all three dimensions, but in particular as part of the co-production potential dimension and the 'attitudes towards co-production'. Most actors felt that they 'were already doing co-production before we knew it was co-production' since 'it just made sense to us' (manager, advocacy group, case study II). Among frontline social work staff, however, there was some enduring scepticism. Some considered co-production to be 'a flavour of the day' (social worker in dementia care) - popular with the Scottish Government, but not fundamentally different from what they had been doing before:

*'I hadn't heard the term before, it was a new term for me. But I've been in social work for nearly thirty years and I'm used to terms coming up and my field is being 'reinvented' every few years and, you know, different words can be used for different things.'*

(Social worker and Dementia Champion, Case Study II).

Significantly, though, many social workers found it hard to differentiate co-production from consultation and often conflated the two. They argued that any service would have to take into account user input and feedback and that this had been part of their practice for many years. They failed to differentiate between 'asking' service users for their opinions (consultation) and users having direct control over the design and delivery of their services, in partnership with professional staff (co-design, in terms of Figure I above) – and showed little awareness of the such partnership and interaction as an inherent part of the service delivery process (co-production in Figure I).

Those leading the co-production initiatives were aware of this particular tension and highlighted training and communication efforts to resolve the differences between conscious co-production and consultation/participation for care staff (though again with little cognizance of unconscious co-production) at the level of co-production implementation. A Third Sector Interface manager (Case study 1) recalled:

*'(...) we started to put it in a more concrete fashion what we were doing in terms of co-production [sic]. I think that was really important, because prior to that, people thought that the words co-production and [consultation] could be interchanged. I feel very strongly that it is obviously not the case, it cannot be.'*

The majority of what was described as collective co-production was in fact what Pestoff (2012) classified as co-governance and co-management between public sector organisations and private organisations (mostly from the Third Sector), with additional service users consultation, in particular in case study 2, and the

intrinsic co-production entailed in any service (Osborne et al., 2016). This seems to confirm findings from Bovaird et al. (2015) about the challenges of in particular collective co-production (co-construction and co-innovation in the Osborne et al. (2016) model). Co-governance and co-management are hence added to our co-production matrix. Their predominance across the case studies is problematic if a co-productive is meant to drive personalisation to address structural inequalities and increase service user empowerment rather than just better informed 'consumer' service users (Needham, 2016).

Lindsay et al. (2013) suggest that metrics may have a role to play in explaining the preponderance of co-governance and co-management as official measurement (in the public sector and by funders) tends to capture these initiatives more easily compared to forms of individual and collective co-production in the Osborne et al. (2016) model.

Co-production and co-construction were present in both case studies, again by virtue of being intrinsically linked to the use of any service (Osborne et al., 2016). They entailed, for instance, the attendance of dementia cafes, tea dances for the elderly or movie viewings, which were initiated and organised by either statutory or Third Sector organisations. Case study 1 showed evidence of co-design, in particular through the locality structure that was part of its governance approach (co-production implementation dimension). This was not apparent in case study 2. There was no mention of co-innovation in both case studies.

<b>Case study</b>	<b>Type of Co-Production</b>	<b>Examples</b>
<b>Case Study 1</b>	<i>Co-Governance</i>	<i>Consortium to decide on spending</i>
	<i>Co-Management</i>	<i>Gap Analysis of existing services in localities</i>
	Co-Production	<ul style="list-style-type: none"> <li>• Attendance at events (dances, tea parties, café drop-ins, etc.)</li> <li>• Use of services (e.g. transport)</li> </ul>



	Co-Design	<ul style="list-style-type: none"> <li>• Older People's Partnership Board</li> <li>• Local projects through localities (e.g. bingo supply for neighbourhood group)</li> </ul>
	Co-Construction	Consortium members and service user involvement through locality structure as part of governance
<b>Case Study 2</b>	<i>Co-Management</i>	<ul style="list-style-type: none"> <li>• <i>Forum for joint delivery of RCOP</i></li> <li>• <i>Gap Analysis of existing services across localities</i></li> </ul>
	Co-Production	<ul style="list-style-type: none"> <li>• Attendance at events (dances, tea parties, café drop-ins, etc.)</li> <li>• Use of services (e.g. transport)</li> </ul>
	Co-Construction	Scottish Dementia Working Group chaired by service users

Table 4: Types of Co-Production following Osborne et al. (2106) and Pestoff (2012, in italics).

(ii) RQ2: What were the drivers and barriers for co-production?

Following the Gioia methodology analysis, the content behind each first-order concept was revisited as to assign a role as driver or barrier to co-production where this was possible, with some concepts fulfilling both roles (e.g. resources)

while others were not discussed as either (e.g. replication of co-production).

The type of co-production described was also matched at aggregate dimension level, allowing us to present drivers and barriers not just in relation to individual themes but also in their relation to specific forms of co-production. Results are displayed in Table X.

Aggregate Dimension	Type of Co-Production Mentioned	2 <sup>nd</sup> Order Theme	Drivers	Barriers
Co-Production Implementation	<ul style="list-style-type: none"> <li>• Co-Governance</li> <li>• Co-Management</li> </ul>	Managing Co-Production	<ul style="list-style-type: none"> <li>• Accountability</li> <li>• Transparency</li> <li>• Governance</li> <li>• Partnership work</li> <li>• Personal role in co-production</li> <li>• Individual relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Personal Role in co-production</li> <li>• Sustainability of co-production project</li> </ul>
		Actors in Co-Production	<ul style="list-style-type: none"> <li>• <b>Statutory Providers</b></li> <li>• Voluntary sector</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Statutory providers</b></li> </ul>
		Motivations for Co-Production	<ul style="list-style-type: none"> <li>• Need to co-produce</li> <li>• Origins of Co-production approach</li> </ul>	
		Environmental Factors	<ul style="list-style-type: none"> <li>• Community</li> </ul>	<ul style="list-style-type: none"> <li>• Austerity</li> <li>• Privatisation</li> </ul>

<b>Co-Production Context</b>	<ul style="list-style-type: none"> <li>• Co-Governance</li> <li>• Co-Management</li> <li>• Co-construction</li> </ul>	affecting Co-Production	<ul style="list-style-type: none"> <li>• Renegotiation of Social Contract</li> </ul>	
		Organisational Factors affecting Co-Production	<ul style="list-style-type: none"> <li>• Learning Capacity</li> <li>• Culture Change</li> <li>• Individual Leadership</li> <li>• Information Flow</li> <li>• <b>Leap of Faith</b></li> <li>• Resources</li> <li>• Trust</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Resources</b></li> <li>• Risk of Co-Production</li> </ul>
		Legislative Factors affecting Co-Production	<ul style="list-style-type: none"> <li>• Legislation (incl. SDS)</li> <li>• Reshaping Care for Older People</li> </ul>	<ul style="list-style-type: none"> <li>• Eligibility of Services</li> </ul>
<b>Co-Production Potential</b>	<ul style="list-style-type: none"> <li>• Co-Production</li> <li>• Co-Design</li> </ul>	Service User Experience	<ul style="list-style-type: none"> <li>• <b>Carers</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Carers</b></li> <li>• <b>Service User Contribution to Co-Production</b></li> <li>• <b>Lack of Service User Representation</b></li> <li>• Support Needed to Co-Produce</li> </ul>
		Outcomes	<ul style="list-style-type: none"> <li>• Measurement of Outcomes</li> </ul>	
		Attitudes towards Co-Production	<ul style="list-style-type: none"> <li>• Doing Co-Production without Calling it so</li> </ul>	<ul style="list-style-type: none"> <li>• Frustration</li> <li>• Jargon</li> </ul>

			<ul style="list-style-type: none"> <li>• Conceptualisation of Co-Production</li> </ul>	<ul style="list-style-type: none"> <li>• Scepticism towards Co-Production</li> <li>• Conceptualisation of Co-Production</li> </ul>
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*Table 5: Drivers and barriers to co-production, following Osborne et al. (2016) and Pestoff (2012). Those drivers and barriers discussed in more detail below are highlighted in bold.*

The results of the analysis support previous findings that both case study sites were predominantly engaging in co-governance and co-management among the public and Third Sector rather than following either of the active forms of co-production identified by Osborne et al. (2016). Most variables mentioned for the co-production potential dimension related to co-production and co-design but were also framed in the context of barriers, whereas co-production implementation and environment, relating mostly to co-governance and co-management (Pestoff, 2012) were discussed in the light of drivers of co-production.

We now present a more detailed discussion for those drivers and barriers that are of particular interest due to one or more of three indicators: the number of sources mentioning the concept as either driver or barrier, the number of individual references across both case study sites, and a new light shed on the academic literature.

### Leap of faith

Respondents identified the need for what a Third Sector Interface Chief Executive called a 'leap of faith', to open up the decision-making processes beyond the existing organisational actors. This required the existing (professional) actors to allow more time and resources to facilitate such open decision-making processes, so that users and carers could become fully engaged. Moreover, it also required a commitment to surrendering decision-making and budgetary power by statutory managers – not always something that they did easily. While this leap of faith related to culture change, interviewees described it as a separate variable that presented a necessary

condition for culture change in the first place. We hence suggest that future research adopt a closer focus on the initial leap of faith and its contingencies.

### Resources

Dedicated funding was identified, unsurprisingly, as one of the most crucial success factors. 'Everything needs to be funded, whether it's funded through at charitable organisation or the government [level]' said one social worker, 'there's got to be money behind it'.

The Change Fund was praised by all for its support. However, it was unclear how the projects would be funded once this scheme ended. A recent study by Audit Scotland suggested that the Change Fund/RCOP achieved only limited impact, mostly due to a lack of sustainable funding (Audit Scotland, 2016). A social worker feared a lack of on-going commitment to co-production and argued that '[y]ou cannot throw a bit of money at something and then walk

away. And I'm just worried, maybe we've thrown a wee bit of money at this and we may walk away.'

Third Sector staff in particular referred to the saving in financial resources that resulted from co-production in their localities. One programme manager stated: "I think through the partnership, we have done the work much cheaper than anybody else could have done it. I think it has been a huge financial benefit for the partnership to invest at a preventive level."

However, there was also a negative connotation to resources as a variable. First of all, there was marked scepticism about the willingness of government to "put their money where their mouth is". A social worker stated that "if governments were serious about local authorities looking at different ways of working (...). We need the resources to do that."

Service managers also articulated a conflict between funding innovative projects like these two cases, and hiring more staff. They found it hard to resolve this conflict as little comparable success data was available for the co-production projects. Health bodies, with a more clinical mind-set, were especially prone to such concerns and this could be a source of tension between them, local government, and third sector partners

Others commented on resources as not only denoting financial resources but also time and engagement as a barrier to co-production. A service user involved in several boards described this as follows:

*"I don't think there was necessarily a lack of financial resources. I think, the biggest resource was time and different appointment times to get together and to really talk at some length and some depth about what they were doing and how they could benefit from what the other groups were doing. Many professionals didn't have enough time."*



## Measuring Outcomes

Almost all respondents, but especially those involved at a strategic level, commented on the crucial importance of monitoring the processes of co-production in order to evidence its success:

*'Metrics are everywhere, everything is measured... It is a fairly formal system of reporting and performance management that ties us to the investment and the outcomes of the investment that is associated with the reshaping agenda. Systematic reporting. We are at the initial stage of reporting outcomes, but we are reporting activity, we are reporting process, we are reporting the building of infrastructure'. (Local government senior manager).*

However, this was again seen as an ambiguous variable as measurement did not seem to capture the actual co-production impact while it was also putting a burden on staff and participants:

*"You cannot totally measure, you can keep people at hospitals and hospitals have been measured, there is admission to hospitals and how many leave.*

*You bring other teams in and you make people more powerful; they can know that they can impact this. They are a lot less stressed and they are achieving their outcomes, not other peoples." (Third Sector Manager)*

*"Sometimes you've seen a person smile at you but I don't know, that person can't tell me if they're feeling less lonely. Is she smiling because she enjoys the activity? Or is she smiling because she is recognising my face? (...) So that's where I would say it's very difficult and sometimes we're actually missing a lot of good work that's happening through co-productive processes. But how*

*would you get that through, I don't know. And how would we evidence it.*

*Through photographs, right enough?" (Advocacy group manager)*

*"And I think because we are constantly being assessed and monitored and...*

*You know, that's quite hard for people to think well, you know, but we need to insure that there's ideally results, the metrics." (Social Worker)*

### Role of Statutory Providers

Statutory providers were seen as a crucial group of stakeholders as they were often in charge of the most substantial and regular sources of funding. Beyond the 'leap of faith' discussed above, interviewees commented about the change in attitudes that were necessary to foster overall culture change. Thus, statutory partners were a necessary condition for successful co-production but often also a barrier.

*"Initially there was a strong reluctance from the partners to consider the devolved budget situation. There was a fear. There was a lack of confidence that resources could be managed appropriately, that accountability could be assumed and demonstrated. And that, essentially, partners felt that they were simply throwing money to the third sector to prop up organisations that were suffering financial cuts elsewhere. So we had to take a very strong position in demonstrating the intent."*

(Third Sector Interface CEO)

*"I think some of them have had to change their working practise. Before they were really semi-public. You know, they were not very open to any type of involvement or consultation and I think it has been a learning curve. It has changed a lot of people in terms of how they change their practise and what they have been doing in the past and seeing that there is an actual benefit from co-production."*

(Third Sector manager)

## Carers

The carers we interviewed were rather pessimistic of their influence through co-production, particularly because of the pressures upon their own time:

*'They were saying that there was a meeting there and would I be interested in going, so I did go and they just kind of more or less told us what the [co-production] form meant and what they were looking for and everything. And at the time we thought it was quite good but I find myself going to these meetings I get a wee bit bogged down with the whole process – sometimes it just doesn't quite get through to me, what they're looking for, or what they're trying to do. And I think sometimes when you're looking after someone with dementia and you go to these*

*meetings, your brain isn't just as alert as it should be because I find myself thinking about what's going to happen tomorrow.'* (Carer)

A campaigner from a carer advocacy group highlighted the problems associated with public transport, especially in rural areas - 'if you take the bus it eats all of your time up.'

Most fundamentally, though, carers questioned the basic premise of involving dementia patients in the co-design of their own services:

*'It's quite difficult sometimes. I mean one of the co-production [events] we went to, we broke into groups, my husband, he went with one group and I went with another. But I felt that I was kept busy wondering how he was coping because he wouldn't have a clue what they were talking about or anything. [...] But I just felt, you know, that I wasn't really concentrating on what I should have been concentrating on.'* (Carer)

There is thus a real tension between the views of project managers and staff and those of carers. For the latter, co-production was generally received as 'a good idea' but definitely not practicable in reality. Most crucially, many carers did not believe that the involvement of service users (or carers) was actually affecting decision-making about service delivery in any substantive fashion. This tension remained unresolved.

#### Service User Contribution and Lack of Service User Representation

Third Sector respondents particularly remarked that it was crucial to work at ensuring 'buy-in' to the new model from service users in order to motivate them to get involved and to break down barriers to their participation. A council manager was more specific, and argued that successful co-production required 'not just [users] but [users] who can articulate what they need eloquently'.

In addition to the aforementioned confusion between consultation and co-production, many interviewees saw co-production as a top-down imposition and poorly implemented, in particular for vulnerable service users. As one social worker put it, '[t]he whole process has been too fast... to clearly listen to people with dementia in the process, I think. (...) we need to find better ways of... slowing things down'. She feared that co-production was simply a 'fashionable fad' amongst policy makers and involved little genuine engagement from service users.

Staff on the same project disagreed though, arguing that '[y]ou have to get past the idea that people with dementia cannot make decisions for themselves or don't know what they want.' (Third sector manager). A service user advocacy campaigner agreed, explaining that

*'[I]t is a challenge, because people with dementia find these kind of things scary... Not all, but a lot of people... fear for the unknown for*



*suffering dementia... It is often also the fear of speaking in front of people. So they do not volunteer for these kind of things, because they don't want to be singled out – "I have dementia".'*

The service users interviewed did not believe that their service was open to their input and or that they could ask for new services, nor that they had the power to do this as individual service users. In context, service users expressed a desire for mutual support rather than individual co-production, expressing a belief that one could advocate better for the desired services as part of a collective rather than as an isolated individual.

*'...where all these people like us can get together and exchange views about what they are going through... It has taken an awful lot of worries from me because I live on my own and living on my own means that you have to think about what is coming next to me.'* (Service user)

Project staff were aware of this scepticism from service users and did try to overcome it – either by encouraging carers to be advocates on a vulnerable adult's behalf or by employing approaches that are best described as 'informal' and 'accidental' to engage with service users – such as, for instance, through asking questions at social events in order to gather information.

(i) *RQ3: How did the type of co-production relate to outcomes?*

<b>Case Study</b>	<b>Overall Initiative</b>	<b>Reported 'Outcomes'</b>	<b>Type of Co-Production</b>	<b>Beneficiaries of Outcomes</b>
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<p><b>Case Study Site 1</b></p>	<p>Third Sector-led cross-sector consortium with six localities and ten thematic strands</p>	<p>Reported as number of people for whom impact has been recorded on the following indicators:</p> <ul style="list-style-type: none"> <li>• Reduction in isolation for older people (4,146)</li> <li>• Enabling participation and value diversity for older people (4,234)</li> <li>• Improved information, advice and education for older people (3,517)</li> <li>• Improved independence and wellbeing for older people (3,937)</li> <li>• Delayed need for complex support for older people (1,143)</li> <li>• Carer reduced isolation and loneliness (1,429)</li> </ul>	<p>Largely co-management and co-governance among public sector and Third Sector (Pestoff, 2012) but with co-production, co-design and co-construction</p>	<p>Direct benefit</p> <ul style="list-style-type: none"> <li>• Older people</li> <li>• Carers</li> </ul> <p>Externalities (recorded from interviews and documentary analysis)</p> <ul style="list-style-type: none"> <li>• Carers</li> <li>• Third Sector (capacity)</li> <li>• Wider community (future options/community building)</li> </ul>
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		<ul style="list-style-type: none"><li>• Carer improved health and wellbeing (1,268)</li><li>• Carer linked to direct carer support services (1,233)</li></ul> <p>(all data from case study site publication)</p>		
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<p><b>Case Study Site 2</b></p>	<p>Council-led social care department dementia consortium</p>	<ul style="list-style-type: none"> <li>• Reported (unspecified) reduction in unplanned bed-days for people over 65</li> <li>• 63% reduction in bed-days resulting from delayed discharge</li> <li>• 22% increase in weekly home care hours provided</li> <li>• 12% increase in total number of older people receiving home care</li> <li>• Rising (but unspecified) number of referrals to Community Rehabilitation Team.</li> <li>• More home visits by district nurses (unspecified)</li> </ul>	<p>Mostly co-management among public sector and Third Sector (Pestoff, 2012) with co-production and co-construction</p>	<p>Direct benefit</p> <ul style="list-style-type: none"> <li>• People with dementia in defined locations (case homes, localities, etc.)</li> </ul> <p>Externalities (recorded from interviews and documentary analysis)</p> <ul style="list-style-type: none"> <li>• Carers</li> <li>• Third Sector (capacity)</li> </ul>
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*Table 6: Findings on outcomes and co-production types for each case study, building on outcome classifications from Bovaird et al. (2016) and Loeffler and Bovaird (2010). Outcomes were evaluated and reported by case study sites and have not been verified independently.*

The main issue in linking co-production types to outcomes was the actual measurement and reporting of outcomes. While reports in both case study sites took into account all five years of the project (2011-2015), interpreting outcomes proves difficult for two reasons. In case study site 1, the main indicator used was individual contacts/referrals. The accompanying qualitative data presents a positive but also highly localised view that makes it hard to evaluate the overall legacy of the co-production initiatives in both case study sites.

Case study site 2 used measurements at service level that showed reductions, but these cannot in their entirety be traced to any individual policy or project and may have other underlying drivers. Moreover, it says little about actual personal outcomes.

This evaluation is echoed by Audit Scotland, who found little systemic change in their overall audit of Reshaping Care for Older People (RCOP, Audit Scotland, 2016) and highly variable outcomes in their report on Self-Directed Support (Audit Scotland, 2017). Their audit report suggests that

*"[t]here is little evidence of progress in moving money to community-based services and NHS boards and councils need clear plans setting out how this will happen in practice. To implement RCOP successfully, partners need to make better use of data, focus on reducing unnecessary variation and monitor and spread successful projects."* (Audit Scotland, 2016)

A key factor in the ambiguous outcome role of the Scottish Government and its evidencing strategy. There was no impact reporting framework in place and the national performance framework (3) did not show a sufficient focus on outcomes to evidence meaningful change (Audit Scotland, 2016). While individual qualitative data suggests supports anecdotal evidence that



meaningful positive outcomes have been achieved, there is not enough robust data to confirm this conclusion.

What can be suggested is a tentative finding that a focus on co-management and co-governance (with co-production and co-construction latent in the background), as prevalent in case study site 2, may lead to a reporting focus on service data, while active co-creation in case study site 1 may encourage a focus on reporting outcomes on a more individual basis.

## **5. Implications for Practice and Future Research**

Our data seems to confirm Bovaird et al. (2016) in so far as there are more reports of individual rather than collective co-production, at least in terms of conscious and voluntary co-production which we refer to as co-creation. Collective action proceeded mostly through Third Sector organisations. While this confirms the strong evidence across the literature regarding the central role of the Third Sector for co-production (Martin, [2011](#); Brandsen and Pestoff, [2006](#);

Pestoff et al., 2012; Ewart and Evers, 2012; Bochel et al., [2007](#); Pestoff, [2012](#)), it also paints a rather less positive picture about the forms of co-production actually practiced.

Thus, we find a predominance of co-governance and co-management among the initiatives reported as part of the co-production efforts relating to RCOP and SDS. This echoes Pestoff (2012) as service user involvement was not fully clear in the interview material and often sounded more like a collaboration among organizations involved in the provision of public services. Our findings complement Andreassen (2018), who identifies different forms of citizen involvement from advisory panels of service users to panels from the general public, finding problematic issues with the professionalization of co-production participants. While this was not the case in our two case study sites, the evidence suggests that a lack of such professionalization was a key barrier in moving from co-governance and co-management to active forms of co-production.

There was some evidence that the interaction with service delivery staff enhanced recipients' co-production capabilities, in line with Mason et al.'s (2014) findings on the relationship between service delivery staff and patients. It highlights the role of individual leadership that emerged from the interview data as well.

Based on the preceding discussion and our research findings, we address the final research question RQ4 through four propositions for practice.

*RQ4: How can current co-production theory and practice inform social policy and legislative reform on personalisation?*

Proposition 1: Policy-makers and those involved in implementation need to differentiate between the individual co-production dimensions to maximise value creation

This is important because the forms of engagement will differ across types and locus. For instance, voluntary co-design of individual services can be facilitated through individual contact among the care team and service users, whilst the creation of facilitative forums, such as experience groups including user groups (and carers), can guide co-innovation at the service system level.

Proposition 2: Metrics and evaluation need to capture more than just the structures of co-governance and co-management

This finding echoes Lindsay et al. (2013) and the Audit Scotland (2016) conclusions on RCOP, which show that data itself leads to evidence-based decision making. A meaningful system of comparable metrics needs to support organisations in their frontline activities rather than act as an additional administrative burden. Our data suggests that part of this evaluation strategy needs to be a more realistic timeframe that allows for outcomes to be tracked over time. The current focus on quantitative, population-level data does not seem fit for this purpose. While qualitative forms of impact recording provide

a more powerful insight into actual outcomes, they are also difficult to evaluate at policy-level. This paper sadly cannot offer a panacea for this problem, however, it indicates that efforts have to be part of a system-wide effort rather than one driven by individual organisations on a local level.

Proposition 3: Effecting successful cultural change in social and health-care services, based around co-production, will require engagement with the wider community

Current co-production theory between service user and professional alone highlights that co-production is far from dyadic: it requires an approach that includes a wider variety of stakeholders. This is particularly relevant when it comes to negotiating self-directed decision-making on services by vulnerable users and which decisions involve potential risks to themselves, service staff and the wider community. Instead of risk management that seeks to minimise all such risks irrespective of the expected benefit, co-production theory strongly supports a negotiated risk discourse that includes service users, professionals,

carers and the wider public. This may also help to prevent the “blame game” effect (Hood, 2002; Brown & Osborne, 2013; Flemig, 2015) that a media predominantly focused on failed social policy innovation can trigger. This governance structure needs to be taken into account in policy design rather than just as a point of implementation, which resulted in highly variable outcomes for both RCOP and SDS.

Proposition 4: Policy-makers and practitioners alike need to move beyond co-production implementation and focus more on co-production potential in order to move beyond co-governance and co-management

Of course, implementation is a key factor in successful co-production. However, there seems to be a disconnect between the way we conceptually use co-production to foster personalisation and how we operationalise co-production.

While the former focuses on individual outcomes, the latter puts structures over substance, as we found in our two case studies (at least in terms of recorded measurement). Our analysis suggests that a focus on co-production potential,

i.e. the service user experience (bottom-up and not top-down), outcomes and attitudes towards co-production, deserve equal attention throughout the process. User-centricity is already the focus of much recent service design, especially regarding digital services (e.g. the Scottish Government's Scottish Approach to Service Design). A shift to outcomes is part of a wider legislative change as recommended by the Christie Commission (2011). Yet, little attention is paid to existing attitudes towards co-production, especially a lack of clarity on what co-production means and how to communicate this transparently, without the use of jargon. We believe that, in line with our first proposition, this is the greatest contribution that current co-production theory can contribute to improving personalisation policies through co-production.

## Notes

(1) 20 interviews were originally collected (ten for each case study site), yet one interviewee withdrew their contribution shortly after the interview for personal reasons.

(2) Further legislation following this new approach are the Community Empowerment (Scotland) Act 2014, and the Public Bodies (Joint Working) (Scotland) Act 2014 (introducing the integration of health and social care), all based on a human rights approach and what is informally called the "Scottish Approach" (Ferguson, 2015) inspired by the Christie Commission (2011) findings.

(3) The National Performance Framework and its associated National Outcomes are currently being revised by the Scottish Government.



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