Coproduction from Theory to Practice: Wandsworth Community Empowerment Network

An Evaluation Report

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With an Introduction from Councllor James Maddan Wandsworth Council, Foreword from Alice Evans, The Lankelly Chase Foundation and an Afterword from Malik Gul, Wandsworth Community Empowerment Network.

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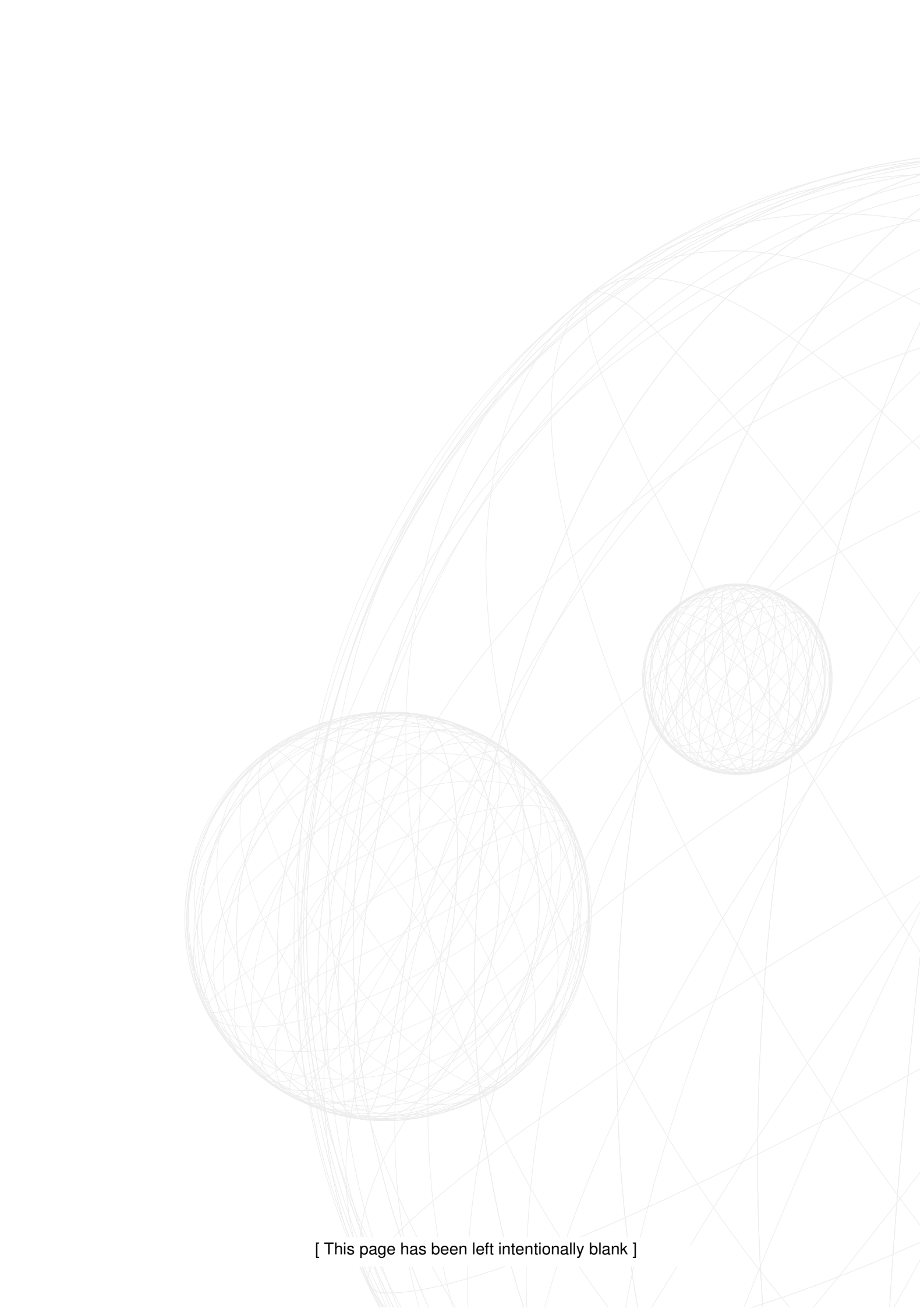

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Introduction

I am pleased to introduce this evaluation and report on the work of the Wandsworth Community Empowerment Network. Originally formed in 2001 to be part of the Boroughs Neighbourhood Renewal Plans, they have continued to build their network of relationships and ideas, and have developed their work from engagement and involvement in public services, to coproducing them. From developing a theory on Coproduction, to putting it into practice.

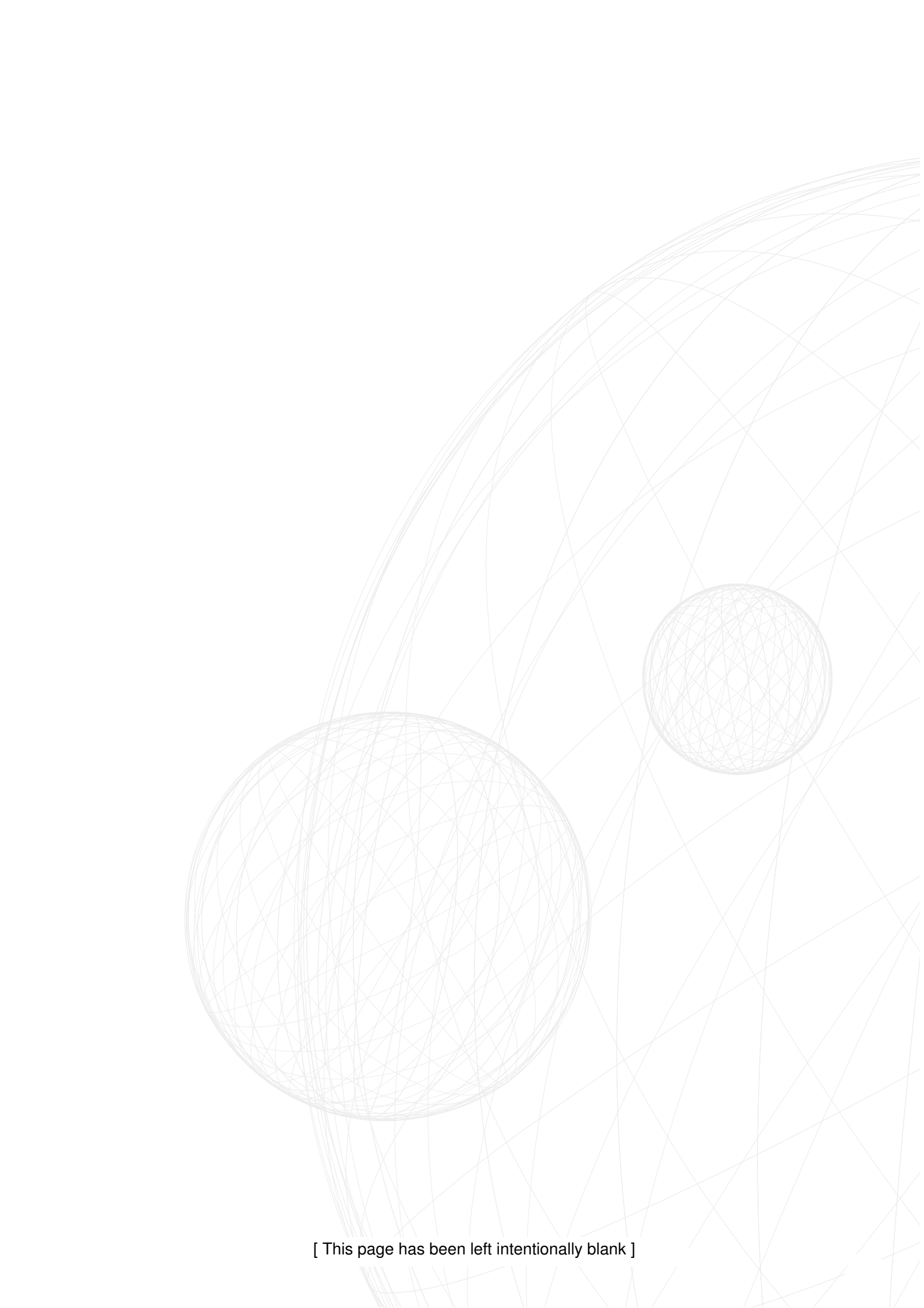
As they started to bring together their many conversations and relationships into a shared space, they invited me to Chair what became the Wandsworth Coproduction Reference Group. Over the past few years leaders from across our public agencies and diverse communities have come together to get to know each other and gain a shared understanding on our collective health and social care challenges. And how by working together we may be able to address them in better and smarter ways.

Towards the end of last year, the Lankelly Chase Foundation, along with support from the public agency members of the Reference Group, commissioned an evaluation of the Network, to seek to understand the processes that have emerged from the series of coproduction projects that have been developed – from the BME Mental Health Forum to Family Therapy and from IAPT to Self Management of Long Term Conditions - and to present a series of recommendations around what the next steps for Wandsworth Coproduction should be. This Report is a culmination of that work.

In the Foreword to the Report, Alice Evans Director of System Change at Lankelly Chase sketches out a context within which this work is developing. Dr Rochelle Burgess and Natasha Choudary, the researchers, present their evaluation and findings, which have identified a new phase that engages with issues of power, position and resources prior to the emergence of mutually beneficial coproduced initiatives. The presence of this phase differentiates this work from other models and is a new contribution to the literature on Coproduction. The Report concludes with an Afterword from Malik Gul, Director of Wandsworth Community Empowerment Network, which suggests the possible future of this work in Wandsworth, and beyond.

I hope you find this Report a useful and interesting read. We are living through changing and challenging times which requires the many to contribute ideas and suggestions, their effort and capabilities, to reimagine and build the relationships and services that we all need to survive and thrive. We invite you to join us.

Councillor James Maddan
Cabinet Member Adult Care and Health
Wandsworth Council



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Foreword

It's increasingly accepted that addressing our most entrenched problems requires asking of ourselves what can we achieve together that cannot be accomplished on our own We know that public services and those funded by them are under enormous and unrelenting pressure to deliver within a context of huge budget cuts, increasing demand and constant structural change. Doing what is done now but harder, faster and on less money just isn't an option. Nor is cutting provision to the bone, lifting thresholds of access and rationing services. This simply suggests people wait until their situation gets really bad before giving support – and we know that this does not work for either the individual or the person supporting them.

The wider context requires us to be audacious in our thoughts and actions, to tread new paths and to form new and unlikely alliances. To do this requires bravery, skill and an ability to bridge the divides of service lines, institutional structures and to reach out to others.

Wandsworth Community Empowerment Network and the statutory services around them are doing just that. Through careful relationship and network building Malik and colleagues are at a point where Mosques, Churches, Temples, the NHS mental health trust and Clinical Commissioning Group are sitting together talking about what's required in their local community. Where Imams and Pastors are trained in delivering therapeutically informed support, working in a dementia friendly way and where their skills are valued and recognised across the board. Through taking this approach people who have been deemed "hard to reach" are being engaged – thereby challenging the notion that they were ever hard to reach but instead highlights that statutory provision have been devising services in ways that meant that they, not people, were hard to reach.

What is clear from all of the work we fund at Lankelly Chase is that the stories we tell ourselves about 'others' get in the way of collective action. It is easy to blame the other side, whether it's commissioners, the voluntary sector, individuals or communities. We need the humility to reflect on our roles and responsibilities and to be prepared to be wrong – accepting that if it was obvious what was wrong, we would already be changing it. These types of skills require us to invest in learning with each other, seek perspectives from people who view and experience the system differently, collectively create the solutions as well as share the risks. This is exactly what's happening in Wandsworth.

What's emerged is a system in which honest, open, trusting dialogue is essential, a system that recognises everyone is part of it and so everyone must have their voice heard and a system that is constantly learning and adapting. It is a place where co-production of support is genuinely happening. And as we collectively move to the next phase it requires us to work out how financial, quality assurance and monitoring encourages rather than blocks this way of working.

What this will continue to ask of each of us is an acceptance that there is a different way of being, that we can bend and flex our approaches – because as the past few years have shown us when we are prepared to act in this way something truly exciting and powerful emerges. This work hasn't happened overnight. It's required commitment and focus over many years, but I hope it shows that investing in dialogue reaps rewards far beyond initial expectations.

What excites me about what's happening in Wandsworth is it's showing that through dialogue and co-production from the ashes a phoenix is slowly emerging – and my desire is that for co-production to become the norm there is a recognition that we have to invest in ground zero first.

Alice Evans
Director, Systems Change
The Lankelly Chase Foundation

Executive Summary

The following evaluation report presents findings from a multi-site ethnography of the Wandsworth Community Empowerment Network (WCEN). Development of a theoretical model highlighted that the WCEN approach was theoretically innovative through its development of a preparatory stage prior to coproduction activities. This initial phase is cognisant of the importance of shifting power relationships, developing trust within and across groups in the network, and committing to engaging in these supportive processes over time. This key phase led to a series of specific outcomes for both communities and statutory partners, who worked collectively to coproduce health services in Wandsworth.

Findings highlighted that the WCEN model resulted in significant shifts at four key levels: identities, ideas, practices and individuals. Evidence demonstrated that identities of communities have shifted, because of a process of empowerment, which shaped the way communities participated in ventures with one another and with statutory agencies. Statutory agencies views of communities shifted, viewing them as meaningful partners, autonomous actors, with important assets to contribute to mutual engagements. This fed into shifts in the conceptualisation of coproduction. The nature of practices of engagements between statutory and community groups shifted. These changes included the development of safe-spaces, which shifted engagement between statutory agencies and communities within environments for mutual learning and a tangible space to redress imbalances of power.

Barriers to systems change included risk adversity within statutory agencies, primarily around financial risk. However, some evidence suggested that risk adversity might be linked to issues of shifting power to communities. Other barriers included professional values such as a view of the individualisation of health and views of coproduction, that only value nominal participation from communities. Findings also suggested that redistribution of financial resources would help to solidify small systems change currently achieved within the WCEN network.

Risks to the future development of the network linked to dangers around scaling-up work before capacity had been built, the need to foster community resilience to shifts in wider political priorities and reforms. The risk of losing organisational identity was also noted as formalisation of the network could affect the qualities of passion and commitments that underpin current engagements. Lastly, concerns were raised around the likelihood of coproduction being positioned solely as a cost-savings activity, which would therefore limit its ability to result in meaningful changes within communities that could lead to a reduction of inequalities.

The report concludes with recommendations in three key areas to sustain progress and to build on current strengths in systematic ways. First, there is a need to streamline focus in programmatic areas, in order to avoid burn out of already over-committed, albeit passionate individuals. Secondly, WCEN should work towards distributing leadership across the network. This would even out capacity in community sites that are less developed, and bolster the capacity of well-established sites for the delivery of services. This is critical in supporting future expansion in relation to new coproduction projects. Thirdly, the report suggests WCEN should commit resources to develop mechanisms of accountability within the network. Specifically, efforts should be made to establish a framework of monitoring and evaluation of health improvements and patient outcomes linked to coproduced interventions. The formal health economy in the United Kingdom (UK) is currently facing a series of challenges in maintaining high quality service delivery amidst a climate of restructuring and cost savings.

Statutory bodies including the NHS, Public Health England, and related social care organisations have been called on to reconceptualise models of care in response to increasing levels of austerity and mounting burdens on the health sector. The NHS five year forward view (NHS, 2015) articulates the need for more integrated approaches to treatment, situating community engagement at the heart of a process to tackling health inequalities. In doing so, it conceptualises the 'community' as a critical resource and 'partner' in reducing strains on the health sector, increasing availability of locally relevant care and access to prevention services (NHS, 2015).

This positive view of patient and community involvement has a long legacy within the NHS, albeit under slightly different formulations. Arguments for patient centred care, patient engagement and increased patient ownership, are all united by the premise that individuals should be supported in taking a more active role in their treatment and achievement of well-being (Laverack, 2007). Ideas of patient involvement are taken a step further under the remit of community participation and empowerment discourses, which are driven by arguments espousing the importance of attention to wider dimensions of community life, including access to power, recognition and resources in empowering people to take ownership in their lives (Laverack, 2013, Rifkin, 2012). Within both perspectives, working with communities are viewed as a means to widen the parameters of care, to engage with social determinants of health and to positively change the shape of contemporary health services in the UK (Public Health England, 2015).

Coproduction of health care services stands at the intersection of these two fields. As argued by Batalden and colleagues (2015) Coproduction approaches highlight the value of partnerships at multiple levels that is in line with a more complex view of service user-provider relationship to include more complex dynamics of partnerships, power and resources. Co-commissioning, co-design, co-delivery (which includes co-managing and co-performing), in addition to co-assessment and evaluation of services are positioned as the pillars of coproduction approaches (Loeffler, Powere, Bovaird, Hine-Hughes, 2013). It is hoped that through increasing the presence of multi-level partnerships embodied by coproduction, increased attention to the lived experiences of patients, families, and health professionals can be achieved. Beyond this, coproduction discourages the oversimplification of partnerships that are often associated with 'patient engagement' and 'patient centred' approaches (Bovaird, 2007). It also creates a platform to acknowledge the importance of addressing power dynamics and social realities between groups engaged in coproduction, alongside efforts to promote change for individuals, systems, and wider communities. Despite growing evidence of the value of coproduction approaches within public policy settings, (Batalden et al., 2015) there remains a need to evaluate the everyday realities of achieving coproduced services, and the impact this has on the wider health care landscape.

Introduction

The formal health economy in the United Kingdom (UK) is currently facing a series of challenges in maintaining high quality service delivery amidst a climate of restructuring and cost savings. Statutory bodies including the NHS, Public Health England, and related social care organisations have been called on to reconceptualise models of care in response to increasing levels of austerity and mounting burdens on the health sector. The NHS five year forward view (NHS, 2015) articulates the need for more integrated approaches to treatment, situating community engagement at the heart of a process to tackling health inequalities. In doing so, it conceptualises the 'community' as a critical resource and 'partner' in reducing strains on the health sector, increasing availability of locally relevant care and access to prevention services (NHS, 2015).

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Since 2001, WCEN has built a programme of coproduction programmes that draw on investments and engagements with a wide range of actors within the health economy – including statutory bodies, and voluntary and community-based organisations. In principle, the WCEN coproduction model seeks to tackle socio-cultural inequalities through a process of engaging communities as experts and leaders in their own rights alongside statutory partners, as part of a process of using communities as platforms for the delivery of locally relevant services. Given the paucity of evidence on the lived realities of coproduced services (ref), the overarching aim of the evaluation was to develop an understanding of the WECN coproduction network. By examining the process of "coproduction", the evaluation sought to understand the network's ability to provide alternative mechanisms for service design and delivery in communities, in line with the following aims:

1. To explore the dynamics of the WCEN coproduction approach and factors that enable or hinder the model's success

2. To identify aspects of change taking place as a result of coproduction at the different levels of systems, communities and individuals in Wandsworth

3. To identify mechanisms through which the coproduction model contributes to system concerns or challenges (e.g. clinical governance, safeguarding and risk) within the wider health system

The following report presents findings from an evaluation study over two months, using a range of methods that target the multiple layers of action and relationships related to the achievement of coproduction.

Methodology

The evaluation study was guided by a multi-site ethnography in order to bring to the fore the complexities of systems, practices and contexts that drive coproduction in practice. Given that multi-site ethnographies typically involve a blend of qualitative and quantitative approaches and support investigations of complex engagements with place and space (Marcus, 1999) the approach was well suited to an exploration of WCEN and its various network partners. Data was collected across three phases, over a four-month period from October 2015 to January 2016 (see appendix 1). Each phase is detailed below.

Phase 1: Participatory Learning Appraisal (PLA) Workshop with Community Network Members

The first phase of data collection was designed to identify and explore the relationships that drive success in the coproduction network, with an emphasis on the connections between network members and statutory services. The initial phase also attempted to identify how issues of power, control and identity were experienced within the network, with a view to explore how this may affect organisational culture, values and internally shared aims. It was hoped that the first phase would inform data collection in subsequent phases.

Methods:

A one-day participatory learning appraisal (PLA) workshop was conducted, including members of the WCEN network who were involved in the delivery of health programmes, or participated in other network activities. A PLA approach aligns with the wider ethos of the network, through its positioning of people as experts in their own worlds. The workshop involved a 1.5-hour focus group discussion with 20 members of the WCEN network, representing a range of community based and faith based organisations in Wandsworth. Following the focus group, participants completed 3 hours of PLA activities in order to identify factors that support or limit the success of the network. Three activities were conducted:

Organisational mapping – to visualise and understand participants' impressions of the network, and relationships within the network to larger more powerful bodies (i.e. NHS Trusts, Clinical Commissioning Groups (CCGs).
Power Venn Diagrams – to understand how participants view the power relationships inside and outside the network, to help clarify its structure.
Pairwise Ranking – to enable members to identify those aspects of the network they think have the most impact on the delivery and access of services within wider communities and to reflect on the success of the network.

Phase 2: Site case studies

Case studies of organisation sites were developed in order to gain in-depth understandings of how network organisations operate as individual entities and how the processes of coproduction had an impact on engagement with target communities. Four sites were selected in an effort to explore the range of organisations included in the WCEN network. The selected sites included organisations that worked with faith-based groups in minority and majority populations, cultural groups, and multiple disadvantaged groups. Each site was identified as having direct experience with coproduction processes at some level of action.

Methods:

Daylong observations and semi-structured interviews (see appendix 2 for interview schedule) at four member organisations that were delivering, or had previously delivered, coproduced health programmes in community settings:

- NTA (n= 3 interviews, 1 observation)
- ELAYS (n= 1 interview, 1 observation)
- Holy Trinity Church, Roehampton (n = 1 interview)
- Mushkil Aassan (n = 2 interviews, 1 observation)

In addition to observations and interviews, an individual outcomes survey was distributed to community members who participated in coproduced services at each site (Total n = 26). The survey explored community member's attitudes and experiences of coproduced services, where applicable, across sites. The survey adapted the following health and wellbeing measures:

- Quality indicators for primary care mental health services
- New Economic Foundation (NEF) Short form well-being survey
- Patient Activation Measure (PAM)
- MOS Social Support Survey

Finally, in order to explore how each organisation integrated with the wider network and assess processes guiding the network as a whole, an additional four observations of member organisation activities were conducted:

- Coproduction reference group meeting (two hours)
- Healing our Broken Village conference (eight hours)
- BME mental health forum (two hours)
- Wandsworth Advice network meeting (initial partnership meeting with WCEN) (two hours)

Phase 3: Participatory Learning Appraisal with Statutory Services

A one-day PLA workshop was conducted with statutory partners within WCEN. The aim of these workshops was to generate an understanding of how statutory partners saw ideas and concepts related to coproduction, community engagement and the work of WCEN. Following a 1.5-hour focus group discussion with 18 participants representing statutory partners across sectors within the health economy, participants completed two hours of PLA activities. Activities were as follows:

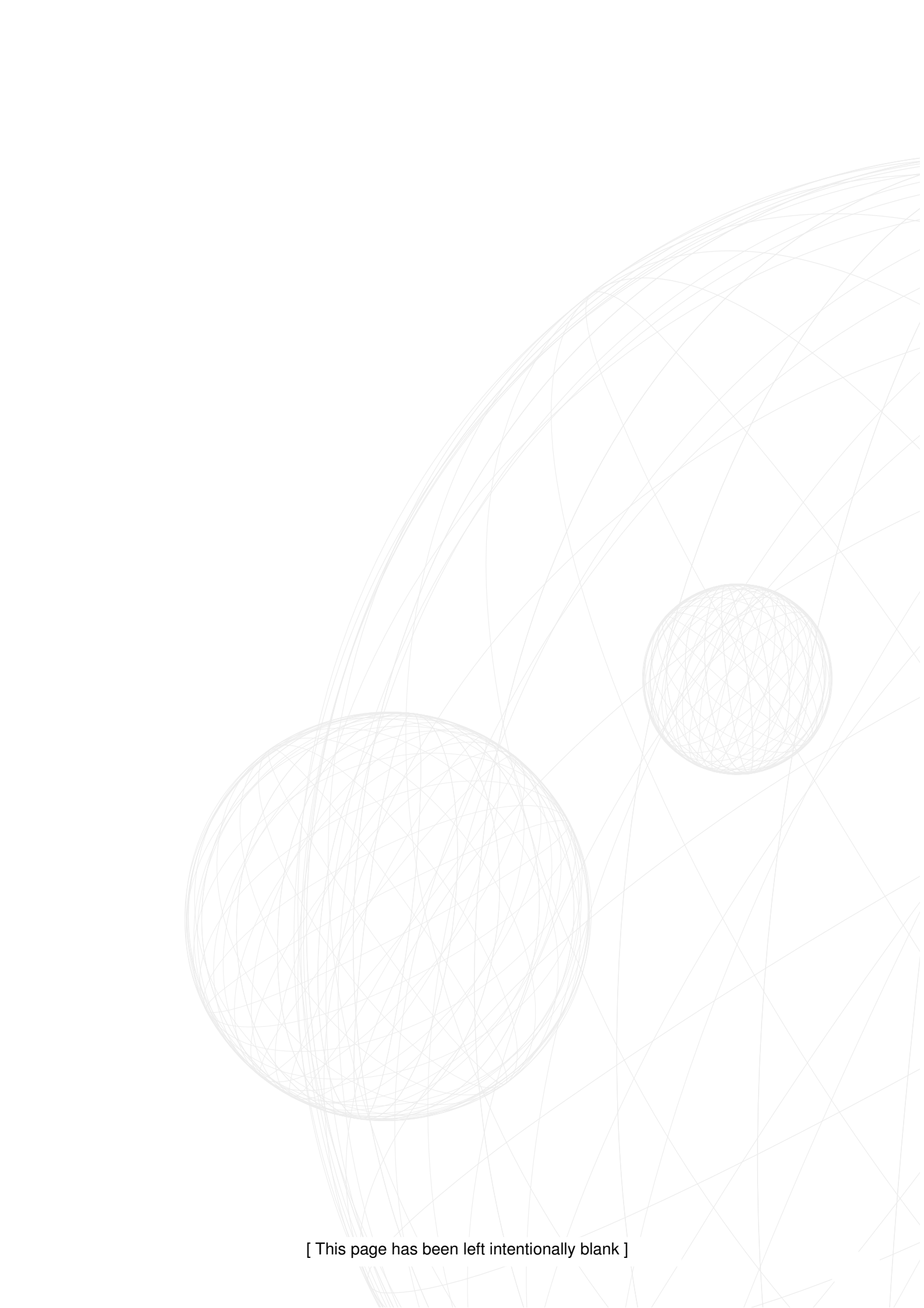
Organisational mapping – This activity visualised and explored statutory partners' impressions of community health services and how communities are positioned within the wider health economy.

Coproduction vignettes – Small group discussions of vignettes of coproduction were facilitated. Each vignette presented an example of WCEN coproduction activities. Participants were advised to identify the benefits, challenges, opportunities and constraints to employing coproduced services within the context of how they used the practice.

In the weeks following the workshop, eight semi-structured interviews were conducted with key individuals in various statutory agencies who have been involved with coproduction work with WCEN over the past eight years. The interview schedule is presented in appendix 3.

Data Analysis

All interviews, focus groups, and feedback sessions following PLA activities were recorded and transcribed verbatim by an external transcription company. Data was analysed using a thematic analysis, blending inductive and deductive approaches to the data (Braun & Clarke, 2006). An initial cluster of global themes were identified based on primary concerns driving the objectives of each phase of research, in order to guide initial readings of transcripts. Transcripts were read independently by each researcher, who developed a series of data driven codes to explain processes linked to each global theme (i.e. identification of organisational and basic themes for each pre-defined global theme). Following initial readings of the data, an analysis meeting between the researchers resulted in the adaptation of the coding framework around emerging findings from this. This resulted in three overarching global themes as follows: coproduction as a process; processes of change; and conceptualisations of the network's future. The remaining report is organised around these three global concepts.



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Coproduction from Theory to Practice

Defining Coproduction

Despite its heritage in the well-established field of patient participation, coproduction remains a relatively new and largely under-researched field of study (Batalden et al., 2015). Much of the current appeal of coproduction is linked to a desire for multi-disciplinary approaches to treatment and care that prioritises patient engagement, (NHS, 2014). However, its increasing popularity in current discourse is linked to its ability to provide a direct response to many of the economic and resource challenges facing overburdened health sectors (Bovaird, Va Ryzin, Loeffler & Parrado, 2015).

A recent review of coproduction identified 64 peer-reviewed articles on the topic, many of which were theoretical in nature (Palumbo, 2016). Durose and colleagues (2014) note a weakness of the current evidence supporting coproduction, linked primarily to the concept's definitional breadth, a position supported by Bovaird and colleagues (2015) who also highlight the amorphous nature of the concept in both theory and practice. For example, while the seminal work of Brudney and England (1983) identify three broad levels of coproduction at the levels of individuals, groups and collectives, Palumbo (2016) maintains that within the confines of health care, only the individual level of coproduction has been prioritised. Loeffler and colleagues (2013) extend this individual patient engagement perspective across four levels of involvement in service improvement: co-commissioning, co-design, co-delivery and co-assessment. However, even within these broadened areas, a narrow focus on individualistic engagement remains with an emphasis on relationships between providers and users within a process of enhancing value of health services for citizens. This is demonstrated by a recent study considering coproduction and the self-management of COPD, which included discussions of co-design, co-delivery and co-assessment. These were anchored to the notion of developing expert patients and carers through training in biomedical perspectives of care (Cramm & Nieboer, 2016).

Research by Bovaird and colleagues (2015) suggests that intersections of individual and collective processes are common within each type of coproduction. This position informs a definition of coproduction as a series of inputs and benefits that are either collective or individual in nature. Individual inputs include contributions made by individual volunteers or users, versus collective inputs, which include contributions made by groups of individuals or collectives. Individual benefits would include the results gained from participation in coproduced patient-client or self-management groups, which may lead to improved health. Collective benefits can also be linked to the wider society. In this iteration, coproduction involves engagement by groups who may not suffer from a condition themselves, but participate in improving services for others in the general population. While the authors acknowledge that not all forms of coproduction fit into their proposed matrix, their position enables a more complex view of the potential forms of engagement that can occur between professionals and citizens who seek to make better use of the other's resources in order to improve service outcomes (Bovaird et al., 2015).

Bovaird's model (2012; 2015), acknowledges inputs from individuals, communities, and statutory sectors in order to achieve coproduction at various levels of service design. Figure 1 highlights that within their proposed model; these groups ultimately remain individual entities, who produce inputs at both collective and individual levels with a shared target of improving services. This model is well acknowledged within grey literature reporting on coproduction in the UK and has been applied in numerous settings (New Economic Foundation, 2013).

To date, psychosocial factors such as power, position and culture that have been identified as key drivers for outcomes of partnerships and participation in health contexts, (Burgess, 2015; Becher & Wieling 2015) have been largely overlooked within coproduction literature. In his recent review, Paulombo (2015) highlights that the different and often opposing perspectives held by patients and providers present one of the largest barriers to successful coproduction, as it hinders the establishment of a shared vision. This, alongside unequal access to information about the outputs or issues around coproduced services, has been suggested to contribute to a lack of willingness for patients to commit to coproduction processes. On the side of practitioners, risks associated with promoting increased patient engagement were viewed as limiting practitioner buy-ins to the process (Sharma, Conduit & Hill, 2014). Such arguments suggest that while coproduction may theoretically create a platform to challenge the limited engagement with patient realities that characterise most health systems, in practice this is not always achieved, particularly in the absence of attention to issues of power, participation, and empowerment (Palumbo 2015; Campbell & Cornish 2010).

Defining Coproduction in Practice: The WCEN way

The coproduction approach used by WCEN seeks to tackle socio-cultural factors that frame a poor uptake of services in marginalised communities, through a process of engaging with communities as experts and leaders in their own rights and viewing communities as platforms for the delivery of locally relevant services. WCEN exists as a main hub that works to connect and support various organisations working at the coalface of communities, dealing with issues of health, empowerment, and social development. At the core of WCEN's ethos is a vision of improvement for entire communities, in particular, the need to advocate for increased attention to groups that are overlooked or labelled 'hard to reach' by statutory sectors. Data collected from the evaluation study highlights that WCEN's various member organisations are anchored by a shared belief in the importance of such work. Groups articulated a shared vision of the 'promised land' – where populations who have experienced exclusion and histories of multiple disadvantage in ways that directly influence well-being – could be recognised, valued, and repositioned in society.

> *I think the outcome of this work, in terms of a common goal … I want to go back to the idea of equality, because that's a word that's over-used and most governments talk about equality and unfairness and massive injustice and yet we don't tackle them, we quite often feel unable to do that and I think one of the things that the network and coproduction has offered to us has been the opportunity to have a mechanism by which we can start to find some way, to find a voice, to find actions that we can take from our different positions … but all of us working with groups who don't usually have access and who experience a lot of inequalities, don't have access or opportunities, don't have access to services, don't have access to benefits … that's one of the things that I think that all of us, wherever we are, whatever group we're working on, we're wanting to open up access, we're wanting to create inclusion. – Network organisations focus group, Female participant 1*

On the surface, WCEN thus emerges as a form of collective coproduction in line with Bovaird and colleagues' (2015) framework, where a unified collective produces inputs into the coproduction process, with benefits targeting the wider community, as well as the individuals who contribute to the process. However, beyond this similarity, findings from the evaluation indicate that the WCEN model differentiates itself from other theoretical models in two critical ways: first, through an acknowledgement of power and difference between partners; and second through the establishment of a shared vision of the aims of coproduction held by communities and statutory sectors.

These two differences ultimately contribute to a coproduction model where statutory and community partners operate from within a shared platform as one network, in contrast to other models (see figure 1 below).

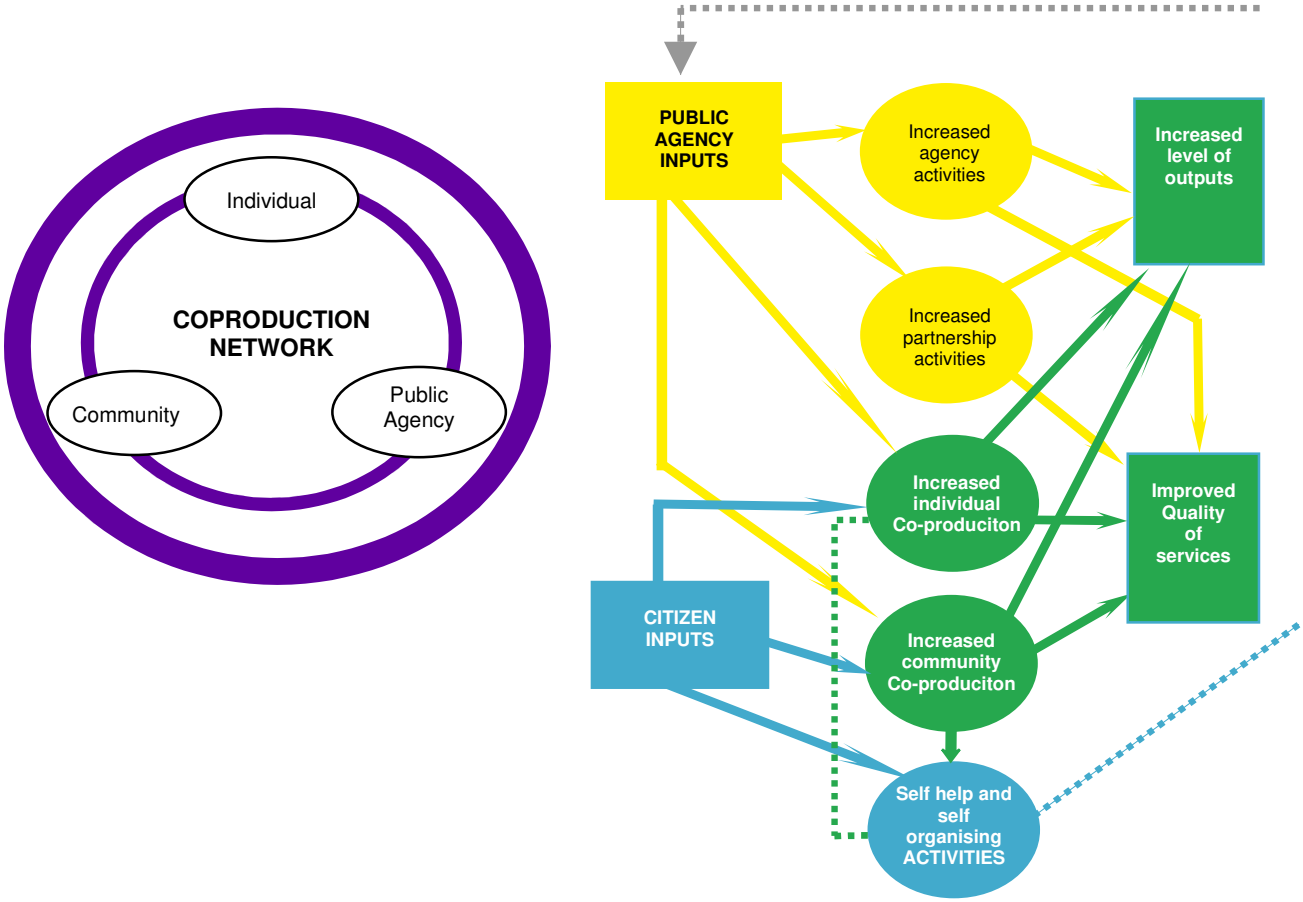


Figure 1: WCEN vs. Bovaird & Loeffler 2012 coproduction model (individual citizens, communities and statutory agents in shared space vs. citizens and agencies as independent agents to a shared goal)

Within WCEN, there was evidence of overt recognition of power asymmetries between groups who are typically involved in the coproduction process. The WCEN director's acknowledgement of this inequality ultimately shaped and informed a process of engagement that was tailored to statutory and community organisations in different ways, in line with the types of power that each group held. In particular, there is an acknowledgement of the fact that the two groups are not created equal in terms of resources and understandings that those who hold positions of authority linked to positions of power or specialisation often dominate group spaces in terms of contributing ideas (Mischler, 1984). Notes from observations of network meetings involving both community and statutory partners highlight explicit practices of inclusion to ensure equal participation in spaces where community members may be less likely to contribute to the development of ideas. For example, in sessions such as the BME mental health forum or coproduction reference group meetings, direct contributions were invited from community participants if they were not contributing equally. A history of such practices were confirmed in accounts from community organisations network members during interviews and focus group discussions. For example:

> *…. I sit on a couple of different boards now and as a result of sitting on those boards, I'm able to take my knowledge in to these spaces and all of that has grown out of the work that Malik and WCEN did in terms of setting up those relationships… so I've sort of followed really in his footsteps, as he has encountered and established relationships he created spaces for us to do that. – Community organisations interview, Female*

Mechanisms for engaging statutory partners also indicates an acknowledgment of power differentials not only between communities and the formal sector, but also within statutory bodies themselves. Engagement with statutory partners with high levels of strategic power highlight an understanding of how positional power influences mechanisms of change within systems (Burgess, 2015). Specific efforts are made to illicit participation from high-ranking officials, including chief executives of statutory agencies within Wandsworth, such as the NHS, mental health trust and local government. Targeting these specific individuals enabled important 'buy in' into the coproduction process by statutory agencies. Once leading decision makers were on board, participation from members at the coalface of service design and delivery were facilitated and recognition from other powerful statutory bodies often followed.

> *I think the most important contribution is being able to be seen there and supporting [coproduction] and if I can say, as a chief exec, I'll do it and then bring some of it back into the organisation, I think that that's a big thing because if I'm saying it, you get others saying oh, we'll accept it….if I wasn't supporting it I think it would be just seen as this little bit on the side…. I think [my contribution] is raising that profile and with our board around the work that we do with that so there's obviously the money that we need but I think it's a lot broader than that and it's being seen, willing to listen to what people are saying, around what services are, how we change some of those – statutory organisations interview - male*

Secondly, the WCEN model creates opportunities to establish a shared vision of the aims and objectives of coproduction on both sides of the process, rather than assume a shared vision or outcome is automatically visible to both sides of the equation from the outset. This is enabled by the director's ability to work as a broker between the two sides of the coproduction coin, at times long before different partners meet in person. During these engagements, the director moves between communities and statutory sector, mediating and translating ideas between the two groups, in order to lay the foundations for a shared vision. Evidence of this was noted during BME mental health forum meetings, where the director worked to translate complicated service delivery jargon used during the presentation of new IAPT goals into more practical tangible terms to ensure understanding among community organisation actors also in attendance.

Such communicative acts are enabled by the application of different languages, each tailored to highlight notions of 'sameness' between the director, and his audience. This process is the embodiment of linking social capital, a form of partnership that has been shown as vital to the promotion of effective health partnerships in low resource communities (Cornish, Campbell, Shukla & Banerji, 2012). The result of this brokerage is the development of a shared view of coproduction and views on the value of the network, though articulated in slightly different ways across groups:

> *I see [coproduction] as almost harnessing the enthusiasm in the community and do I want to say community-led? Yes, I think I probably do. It's recognising what they do in the community and say well, hang on a minute, we can sort of fit that with our goals and then come together - Statutory partner focus group, participant Male 5*

> *Coproduction is developing a relationship between the community and the statutory bodies, so you coproduce things rather than it being dictated from above – community network focus group, Male participant 1.*

> *… (with) coproduction I think is something interesting there has to be some giving away of power, but there also has to be something about accepting power and accepting responsibility – statutory partner focus group, participant Male 1*

I think a turning point came when we realised that those people, the people with the power, they've got needs too, they've got expenses, they've got quality targets, they've got all kinds of things .....and they [statutory bodies] are failing, run out of ideas, but we've got some solutions, we've got some ideas, so I think, for me, that was a turning point ..... and we stopped asking for things, saying we need it so therefore you should give it to us, because that actually didn't work .....but saying we can help you do what you're supposed to be doing …- community network focus group, female participant 1

These two issues point to the most important distinguishing feature of the WCEN model of coproduction – a preparatory phase of engagement that works to establish a shared space for action around coproduced services. Depicted in figure 2 as stage 0, this preparatory stage engages and psychologically prepares partners to participate in a process of coproduction, that is founded in more mutually beneficial engagements for both partners and enables shifts within the health sector that extend beyond the empowerment of individual patients. The model is described in further detail in the subsequent section.

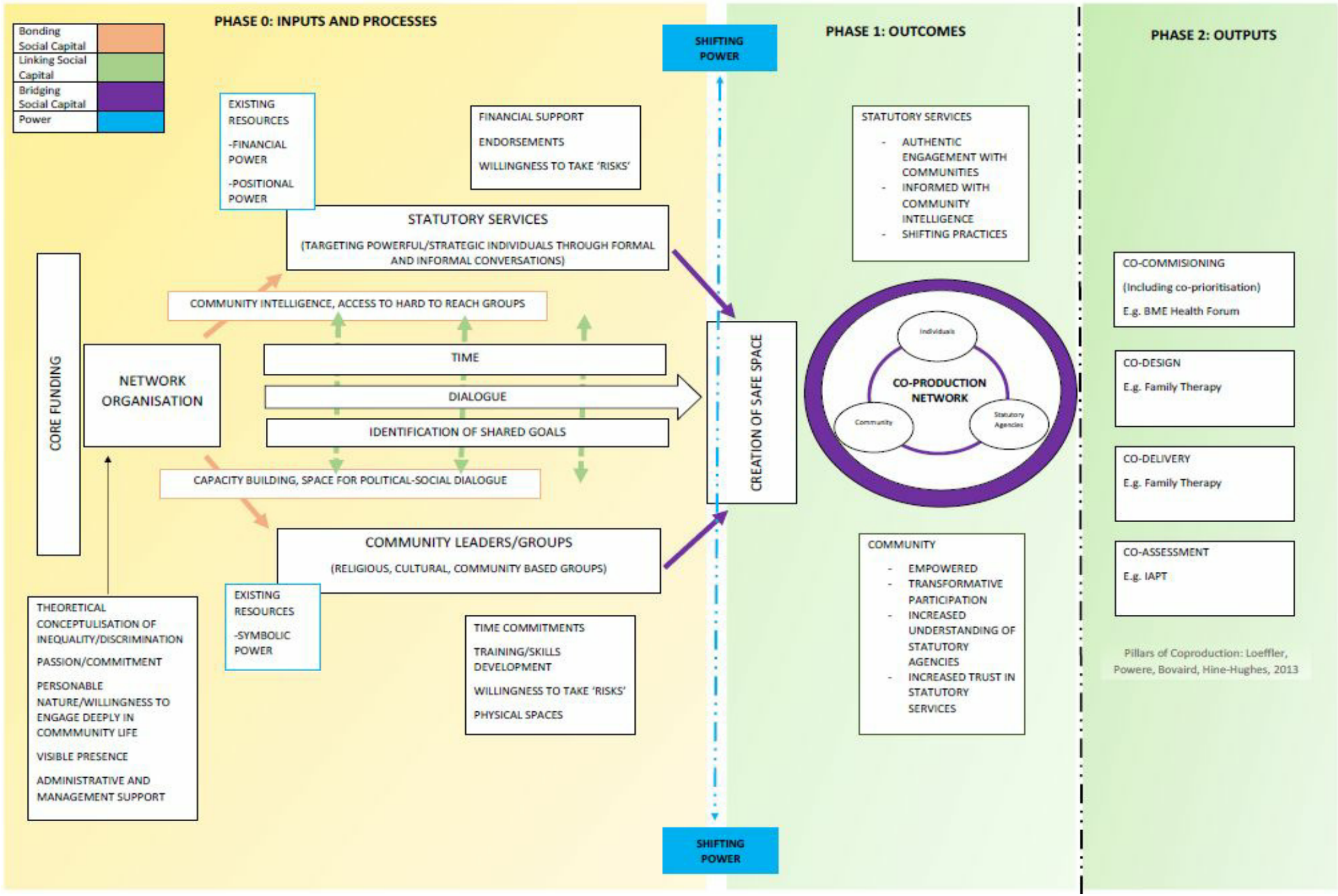
CASE STUDY OF COPRODUCTION: FAMILY THERAPY

Through the Black Mental Health Conference, held in partnership with the New Testament Assembly Church, a group of local faith leaders started to have discussions on how they could respond to the mental health needs that existed within their communities; BME communities are grossly over represented in mental health services both at a community and in-patient stage.

Working alongside the SWLSTG Family Therapy service, a series of conversations began on acknowledging and valuing skills applied by community leaders- as pastors, friends, advocates, confidantes, listeners, enablers- and how these could be enhanced to provide early intervention and prevention support for people who may have mental health needs.
A bespoke Black Pastors Network for Family Care was formed, which included 11 local leaders undertaking an accredited training course in Systemic Family Therapy. Most went onto complete a two year course and are now qualified as Family Practioners. As a group they have completed over 700 hours of clinical work, and are now working towards providing support and therapy through 'family clinics'. Based within their own community sites.

A clinical governance framework is now being co created around this work. A Muslim Network for Family Therapy has been developed to follow a similar pathway.

Figure 2


Bonding Social Capital
Linking Social Capital
Bridging Social Capital
Power
PHASE 0: INPUTS AND PROCESSES
PHASE 1: OUTCOMES
PHASE 2: OUTPUTS
SHIFTING POWER
EXISTING RESOURCES
-FINANCIAL POWER
-POSITIONAL POWER
FINANCIAL SUPPORT
ENDORSEMENTS
WILLINGNESS TO TAKE 'RISKS'
STATUTORY SERVICES
(TARGETING POWERFUL/STRATEGIC INDIVIDUALS THROUGH FORMAL AND INFORMAL CONVERSATIONS)
CORE FUNDING
NETWORK ORGANISATION
COMMUNITY INTELLIGENCE, ACCESS TO HARD TO REACH GROUPS
TIME
DIALOGUE
IDENTIFICATION OF SHARED GOALS
CAPACITY BUILDING, SPACE FOR POLITICAL-SOCIAL DIALOGUE
COMMUNITY LEADERS/GROUPS
(RELIGIOUS, CULTURAL, COMMUNITY BASED GROUPS)
CREATION OF SAFE SPACE
THEORETICAL CONCEPTULISATION OF INEQUALITY/DISCRIMINATION
PASSION/COMMITMENT
PERSONABLE NATURE/WILLINGNESS TO ENGAGE DEEPLY IN COMMMUNITY LIFE
VISIBLE PRESENCE
ADMINISTRATIVE AND MANAGEMENT SUPPORT
EXISTING RESOURCES
-SYMBOLIC POWER
TIME COMMITMENTS
TRAINING/SKILLS DEVELOPMENT
WILLINGNESS TO TAKE 'RISKS'
PHYSICAL SPACES
SHIFTING POWER
STATUTORY SERVICES
- AUTHENTIC ENGAGEMENT WITH COMMUNITIES
- INFORMED WITH COMMUNITY INTELLIGENCE
- SHIFTING PRACTICES
Individuals
CO-PRODUCTION NETWORK
Community
Statutory Agencies
COMMUNITY
- EMPOWERED
- TRANSFORMATIVE PARTICIPATION
- INCREASED UNDERSTANDING OF STATUTORY AGENCIES
- INCREASED TRUST IN STATUTORY SERVICES
CO-COMMISIONING
(Including co-prioritisation)
E.g. BME Health Forum
CO-DESIGN
E.g. Family Therapy
CO-DELIVERY
E.g. Family Therapy
CO-ASSESSMENT
E.g. IAPT
Pillars of Coproduction: Loeffler, Powere, Bovaird, Hine-Hughes, 2013

Theoretical Framework: Rethinking social change through coproduction

Figure 2 above presents a theoretical model of the WCEN approach to coproduction. The model highlights the 'lived reality' of coproduction, which is achieved across three phases. Phase 0, or the preparatory stage defined in the previous section, is driven by a series of psychosocial resources in particular, bonding, linking and bridging forms of social capital. With these resources, strong foundational relationships within groups and across sectors were developed, resulting in the creation of a new-shared space: a collective where both statutory bodies and community groups identify as members. The presence of this phase differentiates WCEN from other models of coproduction, as it explicitly recognises and engages with issues of power, position and resources and their potential influence on the ability for professionals and communities to engage in mutually beneficial forms of participation.

As alluded to earlier, the coproduction process is initiated through initial engagements lead by the WCEN director. Within a series of targeted engagements at both statutory and community levels, the director utilises bonding social capital in order to establish trust and a common vision with each side of the coproduction coin. Bonding social capital is defined as close-knit ties within communities that help to facilitate access to key structural and symbolic resources (Putnam, 2000). Development of trust is critical in order to bring both groups of actors into a shared space for the purposes of coproduction; a process similar to inter-organisational work where the importance of trust is well established (Vanneste, 2016).

In the community context, bonds are achieved through ongoing physical presence in communities – which are significant displays of a willingness to engage that helps to foster trust. As noted by one community member about a previous staff member of WCEN:

> *He comes to NTA loads, he's always at services and so on, but he integrates himself really well. And he also had, K.... in the early days Ks role was really significant she and there were lots of times where, as he would describe it, she would be just going along, being paid to go along and have tea,*

Once strong bonds were established with statutory partners, ongoing commitments were ensured through establishing financial ties to the work of the network and its organisations. Much needed economic resources by way of small pots of funding that bypassed more complicated mechanisms of monitoring were contributed by statutory partners. Utilising funding of this nature also allowed for a certain flexibility for how funds could be spent – in particular the development of ventures that were not supported by the right types of 'evidence'.

It is important to highlight the presence of time and dialogue as a key component of phase 0 of the model. This process occurred over a number of years, enabled solely by the existence of core funding from a third party agency that was not linked to the statutory bodies. Overtime, links were built between statutory bodies and communities through strategic 'conversations', which highlighted mutual gains to be achieved through the parties' eventual engagement with each other. Woolcock (1998) identifies this as a process of linking social capital where brokers move between communities in order to facilitate the transfer of resources to new spaces. The process of building links across groups has also been linked to the development of inter-organisational trust – where trust with one individual can develop trust in an affiliate organisation linked to that key individual (Vanneste, 2016). This is symbolised by a quote from a focus group discussion with community organisation members on the importance of trust within and across the network.

> *If [the WCEN director] had asked us to come together five years ago like this, would we have been interested, maybe not.... but relationship is where it all starts and trust, once you have a relationship you get to know one another, you get to know what that person's intentions are, are they trying to make a difference in a positive way, or are they trying to make a difference in a destructive way and do they have a hidden agenda, talking about the status quo and people who are co-ordinated or running groups from whichever age it's from, so first of all we had to build this trust amongst ourselves – and it started with trusting*

Brokerage also involved a process of linking resources contributed by both groups of actors towards a new-shared goal – the creation of a new shared and safe space for the development of new ideas, understanding and recognition. The ability to establish a new space through resource contributions from both sides is enabled through Putnam's (2000) notion of bridging social capital, where ties are built beyond one's own community to another for the purposes of accessing resources to achieve a particular goal. In this model, bridging social capital enabled community network member's access to funding contributions in order to support events being run at the community level, such as certain healing our broken village conferences held over the past 8 years. Furthermore, these statutory sector contributions embodied a willingness for more powerful groups to not only recognise local views, but to make steps to respond to them, which is often absent from health partnerships between partners of unequal power and resources (Vaughan, 2011).

Crucially to the process, bridges were also facilitated in a bottom-up direction, where statutory agencies were given opportunities to draw on local expertise and cultural capital held by community leaders. While this provided statutory bodies with much needed intelligence about 'hard to reach' groups, it also re-affirmed the power held within communities themselves, establishing the foundations for empowerment of members from typically excluded groups of society.

Ultimately, the exchange of resources between groups vis-a-vis contributions to developing safe spaces also represents a transfer of power. As resources move from one group to another, power is positioned not as something exclusively held by one group over another, but rather as a process of relating, and a resource that is available to multiple actors, for multiple purposes (Foucault, 2008). More importantly, power becomes embodied in non-tangible entities, such as key relationships within target communities and the ability to speak 'local languages', highlighting an acknowledgement of more complex notions of power which has been highlighted as critical for health partnerships (Burgess, 2015). This process of power and resource exchange is depicted in the model as the bridge between the preparatory phase 0 and phase 1, the latter of which locates processes of coproduction.

It is important to note that once these safe spaces are established, they remain key aspects of a coproduction process – the BME mental health forum, annual conferences and knowledge exchange meetings and the coproduction reference group remain platforms where groups of actors can more readily engage and participate in coproduction at various levels.

The model identifies a series of key outcomes for both statutory bodies and communities as a result of phase one. Statutory bodies achieve more authentic engagement with target communities, engage in practices that are driven by community intelligence and begin to shift practices within the health sector as a whole, particularly around how they engage with communities. On the side of communities, individuals within community organisations become more empowered, through engagement in transformative forms of participation. They also have increased trust and understandings of statutory bodies, which feeds into their ability to act as bridges between their wider community networks and formal health sectors and services. Detailed examples of all of these outputs are provided in the next section of the report. The establishment of phase 2 resulted in coproduction activities in four key dimensions in line with previous models. In areas of co-commissioning, in particular the issue of prioritisation was established through the development of the coproduction reference group, and BME mental health forum. These two bodies represent formalised processes where community organisations who were previously absent, now drive and support agendas around health service development and prioritisation. Co-design of services is embodied within two cases of activity in the WCEN network – the establishment of the family therapy network for faith leaders within Wandsworth and the development of a bespoke IAPT service at the Shree Ganapathy Temple (see box 1 and 2 for summaries). Co-delivery of services, which is articulated as partnerships in the delivery of care, is also embodied in these cases. One primary gap in the model is an absence of models of co-assessment, an issue that is addressed further in section six of the report.

As suggested earlier, the mapping of stage 0 within the WCEN approach highlights a new contribution to the literature on coproduction. The importance of attention to this phase and the theoretical processes that underpin its operation is supported by calls to reconceptualise ideas of participation and social change in relation to promoting health (Cornish, Montenegro, van Reisen, Zaka & Sevitt, 2014). Ultimately, coproduction faces critiques over its inability to produce measureable outcomes and a reliable evidence base. However, we suggest that such arguments are linked to the tendency to overlook or minimise the small wins embodied within smaller shifts in understanding and practices that can contribute to wide scale change later. By valuing change solely in terms of discrete health behaviour changes (such as the outputs linked to individual level coproduction within health services), it is easy to label programmes as 'failed' and overlook important processes. As such, it is critical to widen definitions on what counts as meaningful change in spaces of health promotion.

This argument is supported by Catherine Campbell's (2014) recent reconceptualization of social change for health, which highlights the importance of acknowledgements of power in driving and valuing change. Within mainstream community health improvement approaches, ideas of power are linked to materialist views that position power as a zero-sum force used to allow one group to dominate over the other. However, in doing so, community mobilisation efforts can be deemed satisfactory as long as they appear to transfer power – often in one direction, from top-down. Examples of this are seen in the one directional transfers of knowledge that typify community-based interventions, such as the training of community health volunteers as peer-educators. More critical positions on materialist power may extend such efforts to include the acknowledgement of the need to transfer political and economic power (Freire, 1973) as well. However, the processes related to this achievement are slow and often are rarely achieved within the space of a single intervention.

CASE STUDY OF COPRODUCTION: IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

SWLSTG were keen to provide "Talking Therapies" in locations that were more local to communities, with a focus on groups who have previously not been able to access this support. BME communities in particular are underrepresented in these services.

A series of conversations were developed with service and community representatives working together to deconstruct the language, methods and tropes that are associated with mental health and the stigma and taboo around presenting for therapies; whilst reconstructing an approach and practice that was sensitive to faith, racial and cultural needs.

This led to the recognition that local people who are acknowledged and trusted as having leadership roles are often better placed, because of their resonance and connection, to invite others from within their own communities into conversation and relationship; acting as enablers and facilitators into the service.

A series of Talking Therapy workshops located in community sites were established, in Churches, a Drop-In Centre for Single Mothers and Parents, a South Asian Care Organisation which attracted over 50 "hard-to-reach" women to attend the introductory session – all co-facilitated by local leaders, who also had direct input into the design and delivery of the workshop content, ensuring that cultural nuance and references were included to make the offer more connective and appropriate to need.

This approach is being developed, adapted and extended to other communities and groups, including accredited training programmes for co facilitators (e.g. in assessment and triage)

However, Campbell (2014) suggests that when social constructionist positions on power are applied to understanding community mobilisation for health, opportunities to identify and build on changes are regained. For example, Michel Foucault's (1988) views of power as more complex, fragmented and diffused through relationships and systems in society suggests that groups who are traditionally seen as lacking in power actually have power available at their disposal. Within the proposed model, this is highlighted in the bottom-up transfer of power from communities to statutory partners in the process of establishing safe social spaces. Under the umbrella of this alternative perspective on power, the small changes created by a process of developing relationships emerge as crucial to a process of wider systems change and social change. The subsequent chapter in this report highlights how this critical phase trickles down into discrete changes in three areas: identities, ideas and practices.

Processes of Change

Data from each of the four research phases highlighted that across the model, change occurred at four key levels: identities, ideas, practices and at an individual level. Crucially, changes within phase zero set the foundations for meaningful changes in phase 1 and 2. It is also important to note, that the divisions in these levels is for the purposes of clarity in reporting – in reality, many of these shifts occurred in tandem, feeding into and informing each other in ways that could not always be divorced from the other. These shifts are presented as if they were the 'outcomes' of phase 0.

Shifting Identities

The community groups involved in WCEN demonstrated a shift in their self-perception. This shift allowed them to participate in more meaningful ways within the context of their organizations and wider networks activities. The notion of participation is interlinked closely with ideas of empowerment and in some instances; participation is identified as empowerment or as an outcome of feeling empowered (White, 1986). For the purpose of reporting, participation is viewed as an outcome of being empowered. The ability to participate, as a result of feeling empowered, was linked to crucial aspects of phase 0, namely, capacity building, identification and recognition of community assets and a space for political and social dialogue. The data reveals that community groups were able to participate on a number of platforms in ways which align with transformative participation and had shifted away from nominal or instrumental participation (White, 1996)

Reoccurring themes from interviews and focus group discussions signified that community groups felt they were more confident and able to engage with statutory agencies, inform and contribute to discussions on how health (health-related) services should be organized and delivered and lastly, to challenge wider social injustices. The community groups' ability to participate with statutory agencies included being more confident to engage, knowing who to engage with and how, also feeling that their participation could make a difference.

In the accounts presented, it was evident that network members had started to be more active in their engagement with statutory agencies in a number of ways. For example, in one interview it was revealed that, as a result of the networks interest in addressing health inequalities, they had now become involved in a number of strategic boards and meetings, which allowed them to input into decision making around mental health care services. Later in the interview, it was also revealed that participation had shifted from merely being present at meetings to being able to participate in ways that meant they could express their views, as well as question and challenge decisions, and in turn make a difference through their participation.

> *'Certainly for me, when I started, I knew very little about mental health. I remember the first time when I got co-opted onto what was at that time the mental health partnership board, it was just new in terms of not only the material as it were, the content, but the whole process, how they worked, what their protocols were etc. and thankfully this woman, who was a partner (unclear) and she gave me a whole lot of insights into what sorts of things I should expect and what terms meant, what abbreviations meant and all of those sorts of things and that was very very helpful. I now feel that I appear at a number of meetings with key decision makers and work with them on different things and that definitely has been a shift that's come out of the relationship' – community organisations interview - female*

> *'… there was a time when people would just be spoken at and they'd sit back and now people are questioning, they're digging and they're delving and so on, so I do agree that it definitely has changed' – Community organisations interview - female*

The confidence to participate in different ways and in varying forms of engagement is further illustrated by an interview with a Somali Community Leader, he expressed that his community was often described as excluded or hard-to-reach by statutory agencies and as such when they were approached, it was to participate in nominal ways with health service interventions and other decision-making activities. However, being a part of the network gave the group a greater sense of legitimation and knowledge in how to build relations with statutory agencies. This has empowered the group to participate in meaningful dialogue and decision-making, which occurred on terms, set by the community groups. It was expressed that the group now feels confident to approach statutory agencies with issues that arise in the community rather than waiting to be approached or have an agenda imposed upon them.

> *'Definitely, it works much better when it comes from inside because it's something that we need, we demand and the community is actually asking for it.... We discuss what we want and then we go to the public health or whatever, police or anything and then we deliver and they support us, as long as we meet their thing…' – Community organizations interview- male*

The interview also revealed that the group felt that when participation was not valued, but merely there to serve an alternative agenda, they would refrain from participating at all. The latter demonstrates transformative participation further, whereby dominant power structures are challenged.

The shifts in modes of engagement with the statutory agencies was also attributed to being a part of the network as it gave them opportunities to participate in ways they have not been able to do prior. Therefore, it may be suggested that being involved in a wider network compared to operating in silos increases confidence and physical opportunities to take action in alternative ways. This is illustrated in one of the interviews below, which highlights the increase in modes of engagement as a result of being a part of the network.

> *'Also linking us with lots of bigger networks as professionally with all these other Muslim networks, New Testament Assembly, different organizations, the mental health, all that is something that actually we have only been able to access and build relationships with through the network; otherwise we would be completely in isolation from the rest of the society, from the rest of the organization meeting together, so it wouldn't be working, trust with the Somali, young people, nobody, we wouldn't be able to link up, but we attend meetings, different meetings, faith meetings, mental health meetings, police meetings and things like that, through the network .....'.- Community organizations interview- male*

Political consciousness in itself may be considered a form of transformative participation. Throughout the fieldwork a number of key political issues arose that impacted the everyday lives of the communities the groups represent. For example in the focus group, the implications of the Prevent Agenda on the Muslim community was discussed at length, specifically the risks this poses to individuals reporting to mental health services, through fear of being targeted as an extremist. Another example was provided in an interview, which highlighted the impacts on young girls and their families from the punitive and traumatic practices which have arisen from enforcing statutory reporting for Female Genital Mutilation (FGM).

A final example was observed at a conference held by the network, whereby one member of the network stood up and asked the senior leaders of the mental health trust, why the senior leader's team does not reflect the diverse population it serves. These examples were a few amongst many, and the nature of these discussions throughout the process of collecting data indicate strongly that the community group do not feel powerless in their current situations and instead they participate, by raising issues and considering options that challenge the existing patterns of dominance.

The values of the network were also crucial in shifting identities. Having a sense of solidarity was identified as key in feeling as though their participation would make a difference. Community groups expressed a sense of collectivity and solidarity and this gave them a greater sense of empowerment to participate in challenging social injustices. The network provided them safe spaces (as community groups alone and with statutory agencies) to identify collective views on matters of injustice and consequently raise and legitimize their political consciousness. The space to recognize that some social injustices affect multiple community groups gave them a sense of inclusion, as opposed to the discourse usually associated to them; exclusion, hard-to-reach and/or marginalized. It was expressed that the network is like a machine, which the statutory agencies cannot ignore.

> *'it has actually proven that, a big machine you know, they're harder to turn back, but they're being poked and at least they feel something has happened in order to stop that poking on that side so I think yes, organizations, the network is a big, is the biggest tool, because a big machine, you can't, one individual can't do anything to it, but a big organization will, network, will actually make them realize, the change has to come in place, yes. – Community organizations- male*

A sense of equality, collectivity and inclusion are all criteria for meaningful participation. So far, it has been highlighted that the shift in identities has transformed the ways in which community groups participate with statutory agencies. However, this shift was also apparent amongst the community groups themselves – in one interview, it was expressed that relations and benefits are now two-way between the Director of the Network and the community groups. There was a clear shift between what would be expected in phase 0, whereby the lead of the network organization would be primarily 'inputting' to the organizations, to one where the community groups themselves unlock their own assets and capabilities to develop relationships which are reciprocal.

> *'So the relationship now with WCEN is slightly shifted to what it was initially, where Malik was the introducer, he was the door-opener, he was the one who was banging on those doors and causing them to be opened, now we work in a way where we're both a strength to each other, when whatever doors we open gives him access and whatever doors he opens gives us access as well.' -Community organization interview – female.*

This section has highlighted the ways in which the identity of the community has shifted and this has been evident through examples of transformative participation. The following section will discuss how ideas amongst statutory agencies have shifted.

Shifting Ideas

Coproduction has the potential to be the mechanism for systemic change; however, ideas, values and ideologies can hinder this process. This hindrance can come from any or all of the stakeholders, yet its detrimental impact is far worse if the stakeholders with the greatest forms of power (statutory agencies) uphold or project negative views of coproduction or its related processes.

A recurrent theme in the data pertained to how fundamental ideas had shifted amongst statutory agencies mainly surfaced in two ways. Firstly, in relation to how the statutory agencies viewed the community and secondly, in the ways they conceptualize coproduction. Both shifts indicate that statutory agencies working with, or as a part of WCEN, had shifted to having ideas that enable and support coproduction behaviors.

Previous government agendas and policies have often required statutory agencies to engage with the community, however at times this has been carried out in tokenistic ways, usually only requiring nominal or instrumental participation from community members. The relationship between the statutory agencies and community groups in the context of WCEN has historically been characterized by viewing the community as targets or 'objects' as opposed to assets; as a result, engagement with communities has included tick-box exercises or consultative forums. In the interviews and focus group with the statutory agencies, it was evident that some key stakeholders had shifted the ways in which they viewed the community, its assets and the possibilities and benefits of engagement and involvement.

A shift in ideas was evident in relation to the valuing of communities views and how these can best inform the way services are designed and delivered, as opposed to decisions being made by professionals for them.

> *'…I mean I've had meetings with the Somali women's association and a lot of the issues that I talked about with the Somalis came up there and understanding of, that they are, what they want, what they need, whether it's people at the temple or the mosque or wherever… - statutory agencies interview- male*

A member of the Public Health team, who identified that it was not beneficial to 'push' an agenda onto a community but instead to develop relations of trust and 'vibrancy' in order to identify and reach shared goals, echoed this view.

Generally, there was recognition that the community have assets that the statutory services do not, it was expressed that the community have various forms of knowledge and skills that are crucial for health care decision-making:

> *'That's why it's really important that we work with community groups so that you can break down the barriers, because the community group knows the people that they work with.' - Statutory agencies interview- female*

Reframing the community in this way allows the community to be considered as active as opposed to passive recipients of imposed decisions and agendas.

There was a common view amongst interviewees that working with community has multiple benefits. In one interview, with a strategic manager, it was expressed that engaging with the community enabled them to think differently about service design and delivery.

> *'so the network's really important in helping us think differently and also how we then change and deliver our services differently, so different types of people still get the same benefits, it's that recognition, you can't do it the same way for everybody, yes, so I think that's where it's really really powerful and helpful, yes.' - Statutory agencies interview- female*

A senior manager from the statutory agencies also discussed the benefits of working with the community and how they can deliver aspects of health care that the statutory agencies do not have the skills or social-capital to do.

> *'I think they've done more than we could ever do as a statutory agency, because they're able to talk and just, you see people giving, you go into the church there and there's people standing saying this is good for your mental health, people listen. If I say it well, yeah you would say that because you're from that lot over there, so I think that's a really big thing.' - Statutory agencies interview- male*

The shift in how they view the community also led to changes in how the statutory agencies thought about shaping and designing services. For example, in one interview it was expressed that whilst raising awareness of illnesses are important this should be carried out in a way that individuals can gain meaningful benefits from, for example, programs that offer employment opportunities.

> *'I'm thinking about a career pathway, so I'm thinking you say have a summer fair and I don't know, Mrs Brown turns up and buys a cup of tea, gets talking to the woman behind the counter, volunteers to run the tea shop next time and then she realises that the tea shop's being part-funded by a local community organisation, she gets involved with that community organisation, she realises that one of the key things that they deal with is domestic violence, so she gets more interested in their work, then she goes to a promotional event or a public sort of training event around domestic violence, she's more interested in that and then she goes on this particular training around domestic violence awareness and how to look out for it in the community, then she gets involved in more general health and wellbeing things and she trains up and becomes a community champion, we currently offer the community champion course, two-day health and wellbeing training course, so all the time she's getting, she's from the local community and she's getting more involved in the local community in a more and more professional manner, so she does a two-day training course, then she becomes a health trainer and suddenly she's got a job, the health trainer's sort of a Grade 2 - 3, Grade 4 NHS scale, so it's not the best paid job in the world, but it's a stepping stone. She could, from the health trainers then you've suddenly got experience, you've got a qualification and you can go other places, the Mental Health Trust have a programme, so I see community development as not only getting people involved more in their own community, there are real opportunities there for career progression.' - Statutory agencies interview- male*

This quote reflects a shift in the ideas around how inequalities may be tackled. Part of this shift may be attributed to the nature of engagement the statutory agencies now have with the communities, they are viewed as assets and not as passive targets.

This is further illustrated in an interview where it is made evident that whilst collecting health outcomes data is important, it is actually engaging with the community regarding psychosocial issues and concerns that was considered helpful;

> *'to be able to talk to them and to understand what their fears and worries are, to a great extent that helps.' - Statutory agencies interview- male*

Drawing on these two quotes, a reframing of the community impels statutory agencies to consider other frameworks, which can inform their decisions, such as one that considers the social determinants of health. This shifts the community from individuals who are responsible for their own choices to communities that are part of a wider system. This therefore implies systemic change is required for health to improve.

The community groups themselves also noted this shift in ideas about communities. In one interview, it was expressed that current modes of engagement had a sense of newness:

'I remember the chair coming with his key officials and it was a really new thing for them to sit down in a room and just have a conversation with the community, where the community was able to talk and you felt the newness, you felt that we were making, we were now moving to a very different level' – Community organizations interview- female.

CASE STUDY OF COPRODUCTION: SELF MANAGEMENT OF LONG TERM CONDITIONS

Long Term Health Conditions- from diabetes to rheumatism and arthritis to cardiovascular diseases- have the most debilitating affect on the quality of peoples lives, as well as draw the greatest cost from healthcare resources. Early intervention and prevention is the key to reducing these burdens.

Local people often congregate around places of community association. Within these places – faith centres, social and recreation groups, clubs and societies- group culture and behaviours are often reinforced; and where the greatest opportunity often exists to affect change and influence choice.

Working with Wandsworth CCG a series of conversations were developed with local community leaders within their associational spaces – the Hindu Society, Shree Ghanapthy Temple, Association of Somali Women and Children, Sikh Khalsa Centre – to share and exchange knowledge and information on how to prevent and self-manage health conditions and the challenges and barriers that affect this. A series of coproduced workshops were designed privileging the role of community leader as enabler and facilitator, which ensured support and buy–in to self management of health workshops.

They are planning for local leaders to be accredited in Expert Patient tutor training to support groups to self organise within their own social networks extending the opportunities for self help and care.

This discussion on shifting ideas about how statutory agencies view the community is closely related to the conceptualization of coproduction.

The conceptualization of coproduction was expressed in alternative ways to some of the, either over-simplified ideas about coproduction or coproduction being locked at an individual level (patient-professional e.g. patient-doctor relationship). The data revealed that many of the key stakeholders from statutory agencies either situated their conceptualization of coproduction in a more critical framework, which has a transformative agenda considering socio-cultural inequalities and/or, coproduction as having multiple-dimensions and possibilities of it occurring at various levels. The Chief Executive of the Mental Health Trust, who described his ideas around coproduction in Wandsworth, best illustrated this:

'I think our view of coproduction is a lot more aligned than some of the others, so I get for some people, coproduction is all about writing policies together, to me that's, we used to have a, we do still have a big active service user network and we had this group called Surge and this was all about well, we want to write policies together and to me that's the bottom of the kind of thing, the thing really is about how do we get us working around the same goals and also move services out of statutory, to do things in a partnership with community and I think that's what we share, we share that belief that that can be done, together rather than separately and at a more strategic and a more bigger network than some of the smaller things that others think that coproduction is all about.' - Community organizations interview- male.

The ideas around the community as an asset alongside the conceptualisation of coproduction as multi-faceted and interlinking, is best illustrated by the figures below which provides a contrasting view given by the statutory agencies in a PLA workshop. In the workshop, participants were asked to map health services taking into consideration the notions of power, communication and partnership working. It is evident that in the first example, figure 3, communities are considered as part of a wider network, implying shared power and resources as opposed to being placed in the centre (see figure 4). This may indicate that the individual is responsible for their own health and they have the power and resources to make use of the services 'provided' for them. The latter supports individualised conceptualisations of health, distracting from the dynamics of power and societal inequality at play.

Figure 3: Mapping Communities

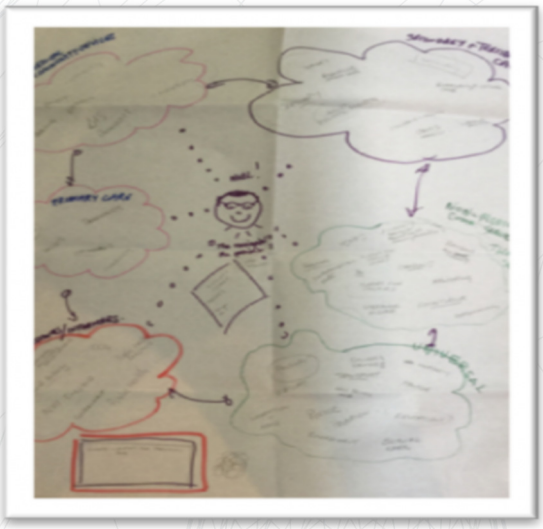


Figure 4: Mapping Communities

Having highlighted the shifts in ideas about who the community are and what coproduction involves, the following section will address how a shift in identities and ideas has led to a shift in practices

Shifting Practices

> *'Can I just say, I think part of the challenge that we have is that we're working with systems within systems within systems and it's difficult to break into the layers of systems, but in the six years that I have been involved in this work, I have seen things happen and changes albeit little steps and in steps…but I know that, say for example in our church, we just held our seventh mental health conference and I remember the very first one that we did, we were sat and we were being talked at by people from the agencies, the seventh one was very different, the sixth one was very different.' - Network organisations focus group – female participant*

The above quote highlights the significance of some of the shifts in practices; systems change requires persistence, consistency and in-depth work, all of which take substantial time and energy from all involved. However, the evidence reveals that some of the efforts put in phase 0 and 1 of the model have started to materialize into practices, which reflect systemic change. In this next section, we will discuss shifts in practice; this will look at the creation of safe spaces and specific examples of coproducing activity.

Practices for engagement, in particular the creation of safe spaces, were an important aspect of change created by the network. Issues of power could be tangibly addressed in ways that continued processes of empowerment for marginalized groups and maintained shifts in ideas about who communities are. An alternative approach to conceptualizing this 'safe space' is the establishment of learning cultures, where individuals can engage with varied others, share understandings and learn from each other (Abercrombie et al, 2015).

In WCEN, these safe spaces took three shapes. Conferences , Coproduction Reference Group (CRG), and the BME mental health forum. Each one will be discussed below, where shifts in practices overlap they will only be discussed in one of the examples, but it should be noted that evidence suggested practices in one safe space were also duplicated in another.

Conferences

WCEN organizes conferences 3 - 4 times a year and they have emerged into a fundamental aspect of the work. The conferences are open events, which combine academic and practice-based presentations and discussions of issues relating to social injustice. Observations of one of the conferences, 'Healing Our Broken Village: Systemic Factors Affecting Black Mental Health', provided a concrete example of how dynamics between the statutory agencies and communities have shifted and consequently have led to a shift in practices, which are dictated by dynamics of power. For example, the agenda of the conference was bottom –up, issues that arose from the community dictated the nature of the conference. This is a significant contrast to the alternative events offered to the community around mental well-being where the agenda is largely set by the statutory agencies and focuses on raising awareness of mental-ill health.

> *'yes and it was just fascinating, it was like and it was a very very full room as well and we had people from so many different institutional backgrounds that had come along and that felt like a shift, it was like a feeling and I think in some ways Our Broken Village this year mirrored that again, where we were putting the things that we wanted to have on the agenda and setting it in that way' – Community organisation interview – female*

The focus on systemic determinants of mental health at the conference demonstrates the community group's political and critical consciousness of factors affecting their communities and an aspiration to address these issues head on with key decision-makers. The above demonstrates a shift in power through the practices that occur, the agenda is not dictated and there is a platform to ensure critical issues are discussed with the statutory agencies.

The conferences provide a new structure for statutory agencies and communities to engage; the new structure relocates power to the communities. The conferences allow for issues, which determine health to be openly discussed. The conference provided a safe space for critical issues to be discussed without discrimination or implication for community groups or individuals. The nature of conversations indicated very strongly a shift in power imbalances. There were open discussions between senior leaders and individuals during question and answer sessions around issues of racism and allocation/lack of allocation of financial resources – the conferences enable this to happen. Fundamentally, the conferences provide a platform for the public agencies to be held to account; however, it was observed that this did not have a confrontational or defensive approach by either party. Instead, a sense of solidarity was observed. This sense of solidarity can be attributed to the in-depth work that has been carried out in other phases of the model to develop common agendas and strong relations.

It was noted that the conferences offer a platform for learning for the statutory agencies. In a video summarizing the learning from the day, a Medical Director highlighted the importance of how fractured families (because of the trans-Atlantic slave trade) can affect one's health and wellbeing – this type of knowledge, in this setting is a unique platform for collaboration and learning.

The space in which the conference was held also demonstrated significance in a shift of practices; the conference was held in a church in Tooting (N.T.A); use of this space means that statutory agencies come away from 'safe civic spaces' and are consequently, required to participate on the communities terms in community space. One of the speakers at the conference announced *'We have invited the public agencies to join US – it is not something they have devised'*. The offer of participation extended by community groups to statutory agencies demonstrates relationships that are built on trust, mutuality and reciprocity on one hand but on another, it sends a message to the statutory agencies that the power rests with the communities, of whom they need to engage with. Significantly, the direction of the offer of participation demonstrates a shift in the power dynamics between the two groups.

Furthermore, this embeds the notion that the community has assets, not only in terms of social capital but also in terms of physical spaces. This becomes important for coproducing behavior as identifying community spaces for service delivery is realized via physical experience for statutory agencies.

Attendance at the conference from statutory agencies was remarkable, senior leaders, alongside other representatives, were present. Many of them stayed for the entire day, followed by *'the sharing of food and fellowship'*. The presence at both the conference and the informal dinner facilitated the breaking down of barriers between the statutory agencies, communities and individuals. Furthermore, the presence of senior leaders endorses coproduction as an acceptable practice within the institutions they represent, also demonstrating their commitment and support towards a more critical conceptualization of health.

The conferences were a fundamental aspect of collective coproduction as opposed to individualized coproduction. Collective coproduction focuses on community cohesion, improved horizontal (community) and vertical (statutory agencies/community groups) relationships, increased trust and mutually beneficial relationships through systemic change (Bovaird and Loeffler, 2009).

The conferences are also key in the joining-together of multiple perspectives on addressing systems changes. According to Abercrombie et al, 2015) systems change can occur in a number of ways and is informed by various types of knowledge. The conferences enable multiple perspectives to come together in one space, creating a unique learning culture. For example, attendees at the conference ranged from elected members, academics, community workers, commissioners, service-users, faith leaders and so on. All of these individuals came together to stimulate discussions around systems change. This multiple-perspective approach allows for dynamic thinking which facilitates discussions around the possibilities of change to the 'complicated dynamics of social problems'.

The conferences provide a concrete example of where this systemic change has occurred as power structures, routines, relationships and resources are reconfigured in one safe space to enable or facilitate coproducing behaviors. This practice demonstrates shift in cultural and structural practices. This quote taken from an interview with a community group member exemplifies these shifts:

> *'Well, just going back to when we, say for example when we did the first Healing Our Broken Village conference, or the first few in fact, they were invited and we sat and listened, they were the ones in control, because the way that I guess at that time we didn't have enough clout to actually have the ability to control things, whereas now it's turned right around, so that they come and they listen to us and they take away some of the learnings and then work with us to implement changes and so on, so for me I guess I've seen that myself in the complete shift and with the new chair of the trust and how he engages with us and participates in events and so on, his input has been as a result of the work that's been done over the years to cause them to no longer, I guess, fear this group of people out there who they've never had anything to do with, now it's quite different.' Community organisation interview – female*

Coproduction Reference Group (CRG)

The CRG provides further evidence of shifting practices. It brings together community leaders and senior leaders of multiple agencies. The most senior level representatives were present from the CRG, South West London and St Georges Mental Health Trust and Public Health) at the meeting observed. Significantly, the meeting is chaired by an elected member, who is also the cabinet member for adult health and care services. The CRG demonstrated a very significant systemic change as it was highlighted that there is no other platform in the borough that requires all of the statutory agencies to collaborate in this format, even more profound is that the community groups are also present. Therefore, this platform enables conversations, prioritization and decisions to be made. It is space that allows for crosscutting agendas to be identified and solutions to be designed. It was in this meeting that it was first identified that a shift to outcomes-based commissioning is currently being implemented in Wandsworth and is mostly likely to be the best model of commissioning for WCEN in their capacity building stages (March 2016 onwards). Significantly, this model of commissioning is closely aligned to coproduction as it focuses on social, environmental and economic factors relating to health. Since this discussion at the CRG, the WCEN Director informed us that they are now in advanced discussions to carry out the community research that will determine what the outcomes will be. From the CRG, WCEN is provided with unique opportunities to coproduce initiatives alongside multiple partners and collaborate in innovative ways.

BME Mental Health Forum

The third example of safe spaces, as a shifting practice, is the BME Mental Health Forum. This forum brings together professionals and community groups from the mental health arena who are responsible for shaping services. This forum is a very specific example of shifting practices which relies on aspects developed and facilitated in other safe spaces (building of trust, recognition of community assets, open-dialogue and shifting of power) to enable transformative coproduction to take place. This forum is one of WCEN's more mature networks that was developed out of concerns around the overrepresentation of BME communities in the mental health system. An observation of the network took place, which highlighted several areas of coproduction in practice. The forum was a platform for co-prioritization and co-design to take place. The members of the network reflected on the most recent 'Healing our Broken Village Conference' and drew out areas that should be used to inform the ways in which Mental Health Services should be designed. In the latter part of the forum, a commissioner from the mental health trust was present to discuss the IAPT program. This forum allowed for authentic coproduction to take place based upon principles of trust, respect, mutuality and reciprocity. The observations made were also verified in an interview with one of the community members, who stated that they were able to participate in discussions and decision making around mental health whilst at the forum:

'… there was a time with the BME forum when there were a small number of people who spoke and the whole meeting and there'd be just a very small number of people to speak and I think that in the last few years I've seen more and more where a much more wider range of people are talking, they're expressing views, they're raising questions…' Community organisation interview – female

Safe spaces: shifting practices in relation to Coproduction?

These alternative spaces provided critical platforms for establishing opportunities to develop and support further process of change within the health sector itself, creating spaces for various forms of coproduction to occur. For example, when designing the IAPT services, community groups were asked to be involved in the recruitment process. This enabled the recruitment of practitioners for the IAPT service to be from the local community. This also facilitated the process of peer-support with the IAPT service, which is an example of another form of coproduction and co-performing. Other examples of coproduction were also evident in terms of how the services, delivered by WCEN, were reassessed and negotiated. In one interview, it was expressed as an on-going dialogue between multiple stakeholders rather than one typified by the traditional commissioner-service provider relationship.

'…I think the first IAPT session was held here and then because of all of the work that's continued, the sessions have grown so it's not just CBT sessions that take place here, there's about six different groups that meet here plus the CBT sessions, but that's happened over time and it's happened with conversation and it's happened with the church being involved and it's happened with a re-look at the contract and it's never the same thing on and on and on, so .....' Community organisation interview – female

These three safe spaces have a common thread that enable them to support and facilitate coproducing behaviors. The safe spaces provide increased interaction between statutory agencies and community groups where critical issues can be discussed and draw together inter-sectoral collaboration. At times they are directly used for 'coproduction' in its simplest form and at others times they are used to build and develop an infrastructure based on a reconfiguration of power and relations to develop the opportunity for more authentic coproducing behaviors. Albeit one is not more important than the other, instead both are required to continue to develop the dynamic requirements for coproduction in practice.

CASE STUDY OF COPRODUCTION: CARDIOVASCULAR HEALTH

Risk factors for contracting cardiovascular disease(s) increases with age. The NHS Health Check programme has been devised to screen identified groups to ensure prevention and early intervention. Unfortunately, existing "marketing" tools – leaflets, posters, letters in the post ...are becoming ineffective, as news and information is increasingly accessed and influenced through other kinds of social networks and media.

Working alongside Wandsworth Public Health a programme of workshops were devised that bought together local people to have conversations on the barriers and impacts that increase the risk of cardiovascular disease and the cultural and social factors that contribute towards them. These groups developed a series of interventions- Healthy Eating and Exercise for South Asian Women, Healthy Cooking for Somali Women, Exercise for Black Men- and indentified venues and leaders to lead these programmes. This self organisation was embedded within existing networks of relationships and ties, and promoted through peer-to-peer conversations and social network groups.

Over 40 people participated in the various groups and all reported an increased understanding and awareness of risk factors associated with poor diet, lack of exercise and risk behaviours- all primary factors associated with cardiovascular disease- and with the exercise groups, a reduction in weight and adoption of healthier lifestyles.

They are planning for Healthy Lifestyle programmes to be located in more community sites, led by community leaders who become trained and accredited – as nutritionist , exercise leaders and health care assistant- so that skills remain embedded within local networks.

Shifting Individuals

In order to assess how WCEN activities had shifted individual health outcomes we distributed an survey to community members (n = 23). The survey explored community member's attitudes and experiences of co-produced services where applicable across sites. The survey adapted the following validated health and wellbeing measures:

- Quality indicators for primary care mental health services
- New Economic Foundation (short form well-being survey)
- Patient Activation Measure (PAM)
- MOS Social Support Survey

Measuring individual health outcomes was problematic in for several reasons- firstly, the lack of base line data; secondly, the poor response rate and thirdly, the difficulty in identifying suitable respondents. However, overall the process itself was useful in determining the gaps that WCEN need to address in order to sustain the work they are doing.

As these issues emerged (primarily, from data collection with the community groups in phase 1 of the research process) we decided to alter the survey to capture two aspects; attitudes towards coproduced initiatives delivered at community sites and secondly, if they had participated in any existing coproduced initiatives, how satisfied they were with the experience. Based on the survey data that we were able to use, descriptive data is presented on these two areas later in this chapter. Before moving onto that, the three problems with the collection of individual health data are addressed.

Lack of base-Line Data

It became evident that there was not any base-line data collected from the coproduced initiatives that were being delivered to date and therefore this made a comparison of pre and post coproduced interventions impossible. Collection of base-line data will be fundamental in any new initiatives in the next phase of the networks activities. A systematic approach to data collection before starting to intervene in improving health of individuals will enable WCEN to demonstrate the impact of the approach.

It was identified that data from the local Mental Health Trust is collected for the IAPT services, however due to the nature of the data it was not possible to use this to evidence any individual health outcomes shifts as an indicator of WCEN activities. However, this did highlight that it will be imperative that the measures used to assess individual health outcomes in the future are considered in-line with the data being collected by other relevant agencies. The benefits of this will be two-fold; there is greater possibility of carrying out comparative data analysis with geographical areas that are not delivering coproduced services and secondly, individuals will not be over-burdened with survey questions from a number of agencies as this could potentially break down trust and relations between service providers and individuals.

Survey Response

We expected to receive between 80-90 responses to the survey, however we only received 23 completed surveys. Of the 23 surveys, only 16 were fully completed.

The community groups themselves disseminated the survey and therefore we were not able to measure the cooperation rate. However, such data collection would be an important aspect in the future.

Expected number of response	n=85	
Response Rate	n=23	0.27
Completion Rate	n=16	0.7

Table 1: Survey response rate

The response rate was considerably poorer than expected. This meant that any statistical analysis was not possible. The low response rate raises questions about the use of surveys with some communities and if they are the best suited tool for measuring individual health outcomes. A range of measures and alternative tools will need to be considered as a part of wider task to ensure that the tools used align with the nature of WCEN activities. One recommendation identified from this process will be the use of training up researchers from the community organizations. Community researchers have two benefits, firstly they can overcome barriers such as language/translation and secondly, it is a means of providing employment opportunities, therefore building the capacity of the communities.

Identifying suitable respondents

Data collection was not a clear-cut process as collection of personal data had not always been systematically recorded and following up with individuals was not possible. It was then necessary to rely on community organizations approaching individuals who had previously been involved. This was difficult given the short time frame and was not a methodologically sound way to collect the survey data. This highlights the need to systematically collect data for individuals involved in coproduced outcomes. This will form another important aspect of the next phase of work - the possibility of collecting personal and demographic data will enhance evaluation potential for individual health outcomes.

The issues highlighted are not unique to WCEN and they are also widely written about in the coproduction literature; evaluation to date has largely focused on process and ‘soft’ outcomes. According to Leone et al (2012), evidence on the effects on health outcomes and patient satisfaction remains an area that is neglected.

Having highlighted the issues that emerged from evaluating individual health outcomes, the next section will provide a summary of the data that we were able to collect. Albeit limited, it highlights potential areas of success and future development.

Attitudes towards coproduced initiatives

The findings suggest that individuals still feel that medical professionals and social workers are an important source for addressing health concerns (47%), however 53% of the respondents would turn to community groups or their social networks (see chart 1). This demonstrates that the development of social networks and the embedding of health services in community sites play a significant role in improving individual health outcomes. An interesting finding is the importance of friends as a source of health information, this may be reflective of the nature of marginalized communities' social networks. Evidence reports that communities from marginalized communities may not have family members in their close network (due to fractured family structures as part of wider migration). Therefore, networks of friends play a key role in the dissemination of information and navigating services.

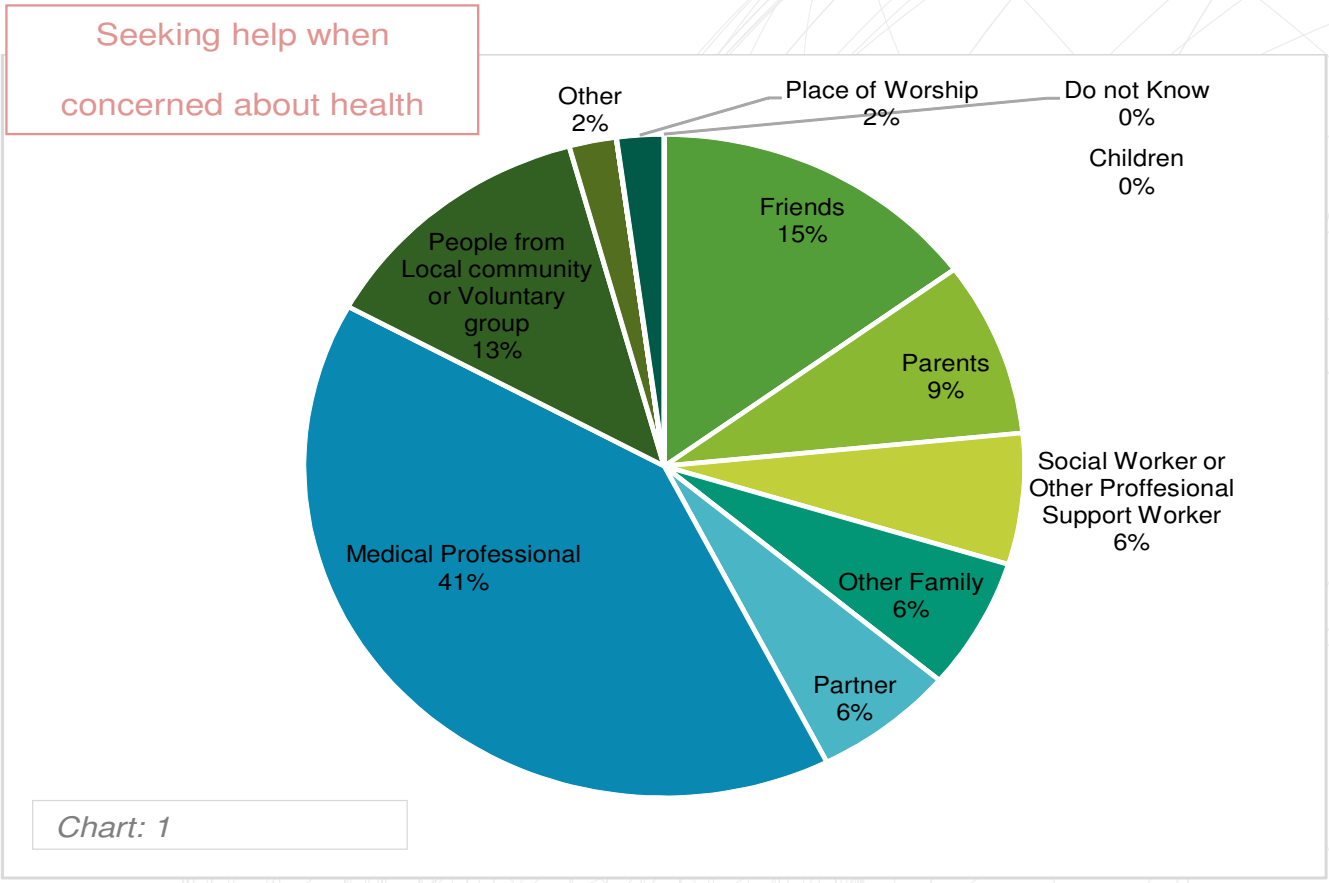
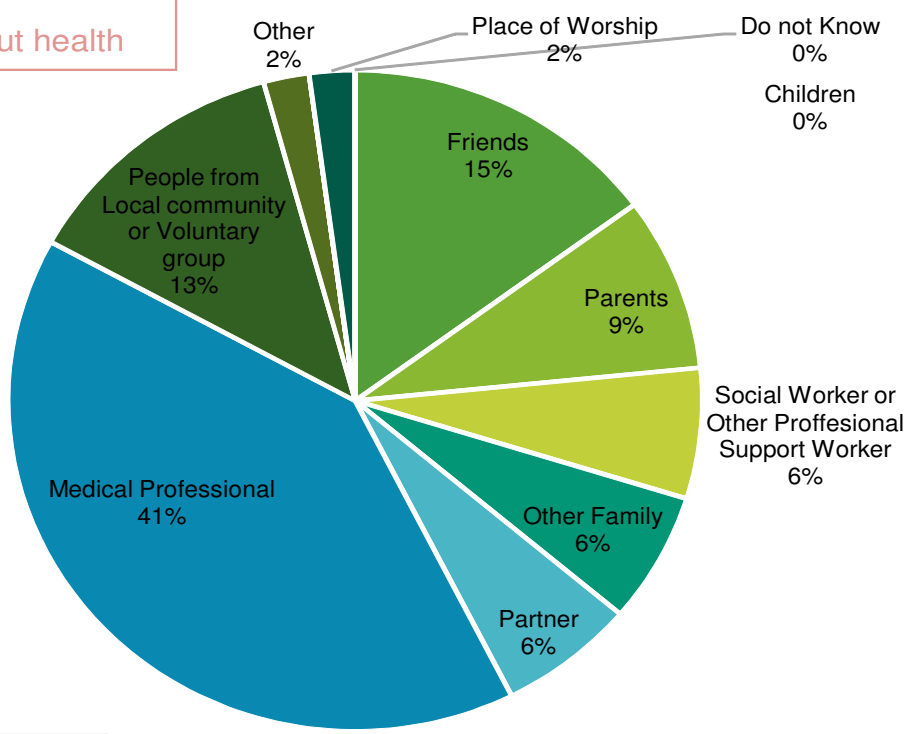


Chart: 1

Respondents were asked to express their attitudes towards the use of health services if they were run in community organizations, results indicated that 84% of individuals would use the services within the community groups and 14% may use the services or recommend them to a friend (see chart 2). Developing on this question, respondents were also asked how they would feel about the services. 88% of the respondents felt positive towards the services in meeting their needs, specifically in terms of being treated with respect, feeling listed to and providing reliable information. Findings also suggested that respondents felt staff within community groups would be aware of stigma in the community. However, whilst 72% of respondents felt they would be more likely to use these services than the GP, a far greater number of strongly disagreed or disagreed with this than in other questions (see chart 3). This indicates that respondents still feel services such as GPs play a fundamental role in health care. It can be concluded that whilst the potential of running health services in the community is positively regarded by the respondents, the statutory health services remain an important part of delivering health care services. This further substantiates the need to ensure that community based initiatives are balanced with services delivered by statutory agencies. Furthermore, it indicates that health services delivered by medical professionals should be co-designed to better meet the needs of the communities.

Seeking help when concerned about health



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Potential use of health services at community groups

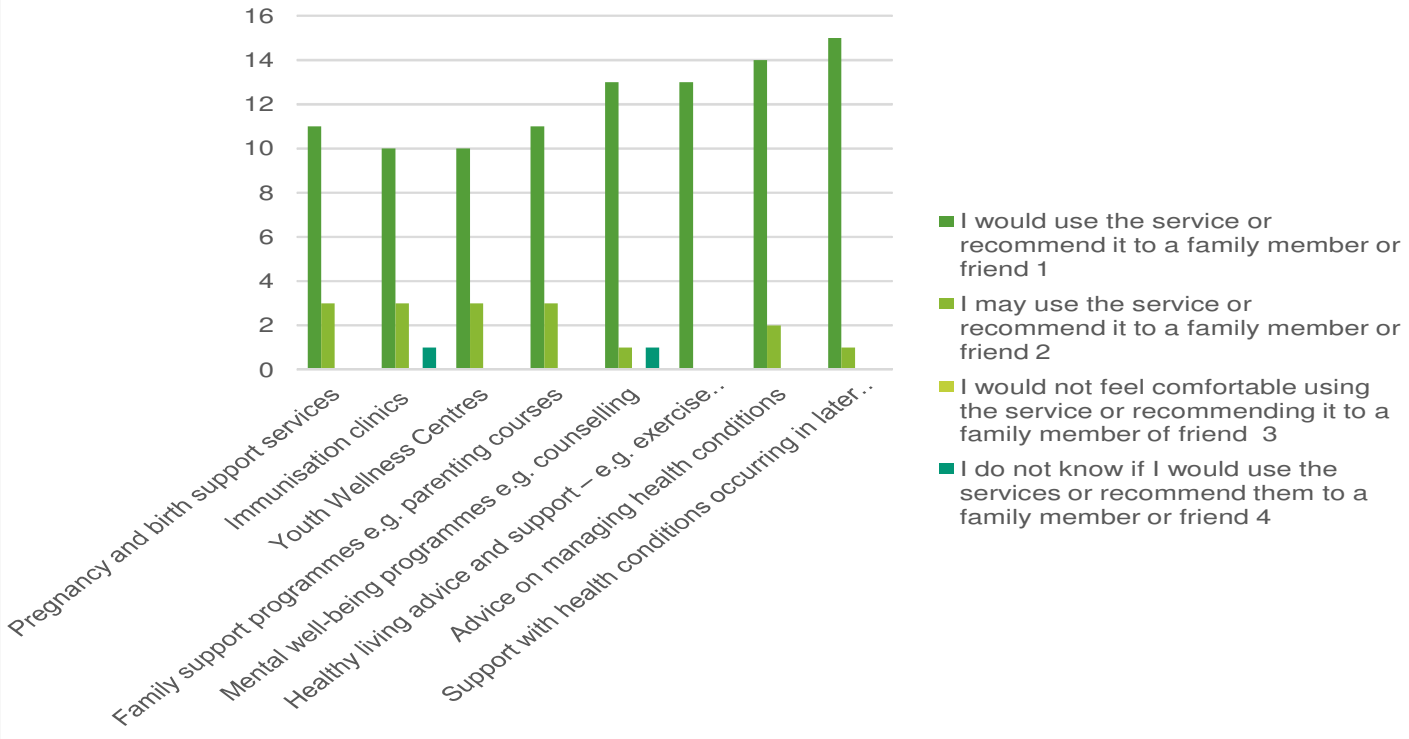


Chart: 2

Feelings towards health services if delivered at community sites

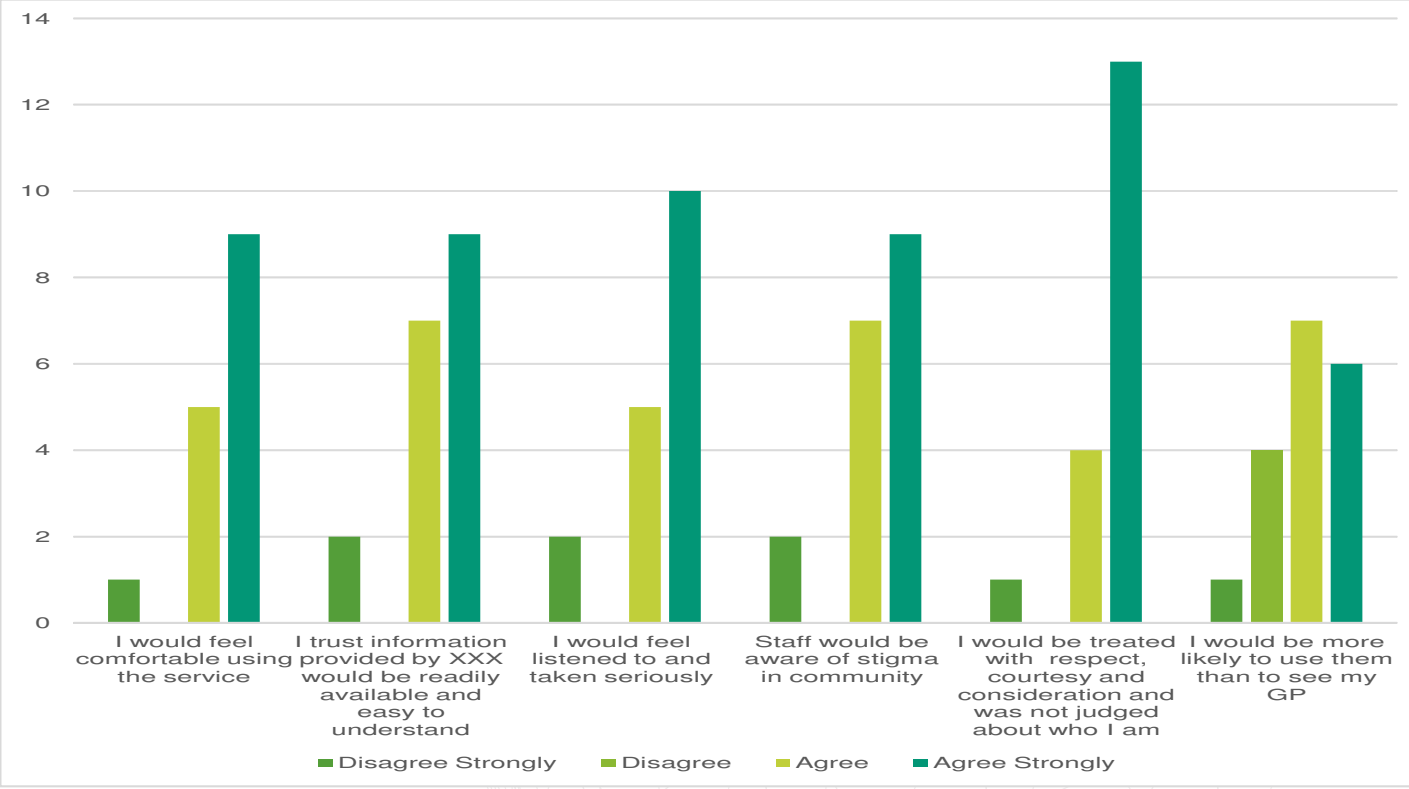


Chart: 3

Satisfaction with Coproduced Initiatives

The remainder of the findings in this section focus on participants who had taken part in coproduced initiatives, including healthy cooking and exercise programmess, parenting courses and IAPT. Respondents were asked about their experiences of using the services in relation to levels of comfort, treatment in relation to feeling respected and accessing the right information (see chart 4). 86% of the respondents expressed satisfaction with the services by stating they either agreed or strongly agreed with the outcomes used to define satisfaction. All participants felt that staff in the services were aware of stigma, given this poses a significant risk to deterring individuals from seeking support at the earliest stages, this highlights the importance of early intervention initiatives being delivered at community sites.

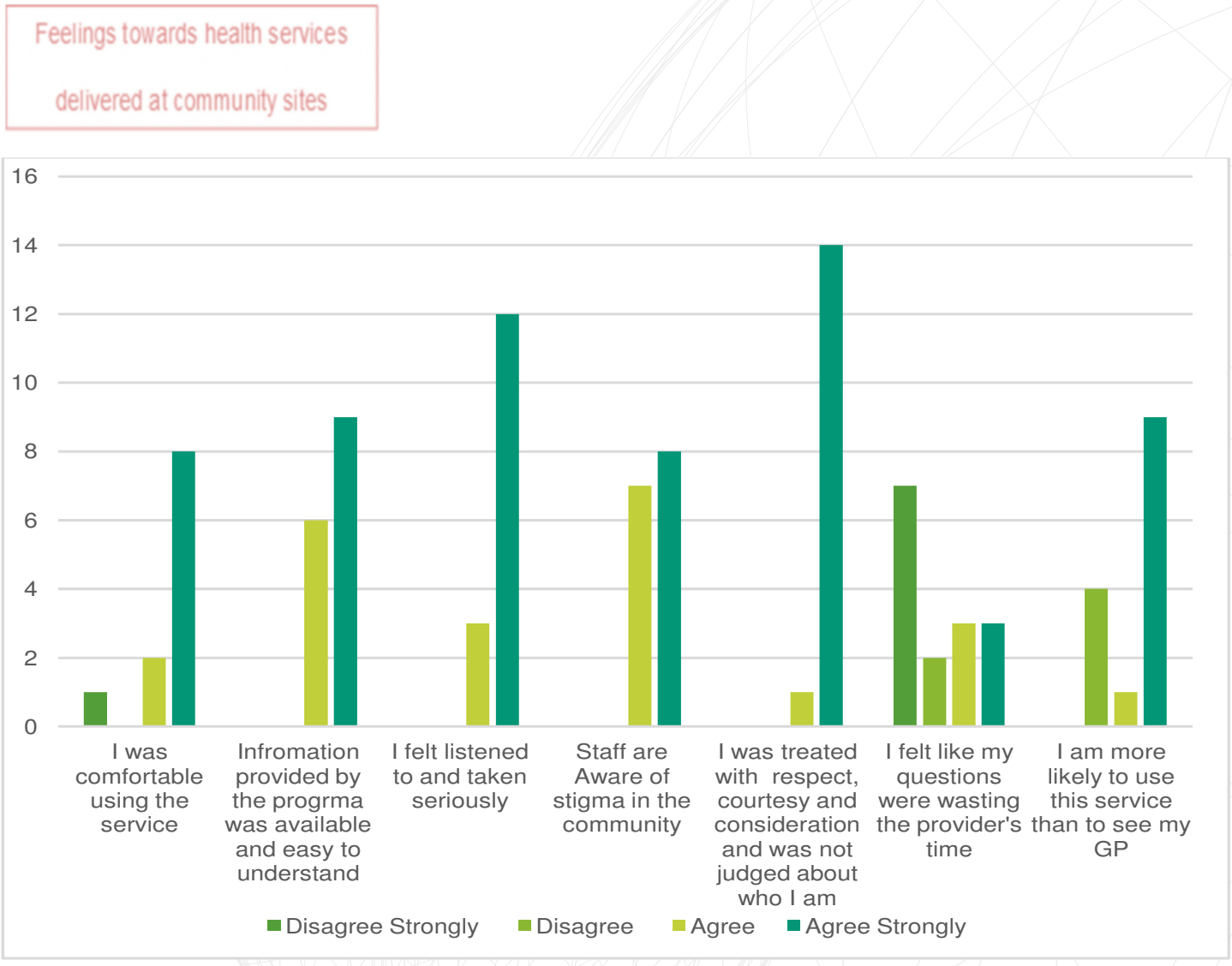


Chart: 4

Qualitative feedback

A space was provided for qualitative comments if respondents wanted to make any additions about their experiences. Overall, respondents expressed satisfaction with services. The comments suggested that the social aspect of community based health services was important for them and encouraged involvement. Furthermore, one respondent expressed that the environment was non-threatening, which further encouraged participation.

> *'The information was clear and easy to understand. The environment was non-threatening so we were at ease to participate.'*

The nature of the staff was another important factor that arose in the majority of comments. In one comment, the importance of ongoing relationships was important and this is a significant benefit of embedding services within social systems, relationships have longevity, which in turn have outcomes for development of social networks and therefore better health outcomes.

> *'…The openness and willingness of the facilitators to keep relationship even when the programme finished.'*

Some respondents also implied shifts in their individual behaviors as results of the programs. For example, they expressed an improvement in their approaches to parenting which in turn has created a non-violent household. One respondent stated that they had gained significant knowledge in mental health and a number of practical strategies to deal with any personal challenges. Finally, one respondent stated that the healthy eating programs had provided her with information, which led to shifts in her individual behavior – she had now started to read food labels.

In conclusion, the collection of individual health outcomes data is a known problematic area, specifically when services are coproduced. However, measuring health outcomes will be fundamental if there is to be shift of financial resources from the statutory agencies to community groups. A systematic approach to collecting individual health data will need to be implemented in order to sustain the work that WCEN are already delivering or intend to deliver. From the limited data collected in this survey, it may be concluded that the potential to run services within community sites is positively regarded by individuals; however, this does not substitute for statutory service health care provision. Data analysis also suggested that participants were satisfied with the experiences at coproduced initiatives already in existence. Analysis suggested that community sites play a key role in addressing stigma associated to particular health care services. Based on the findings from this data, it is suggested that services within the community sites should be used to complement existing statutory services and/or focus on early intervention initiatives.

Barriers to Change

In the previous sections, a summary of the four key shifts were explored; these included shifts in identities, ideas, practices and individuals, this section will now discuss some of the barriers to systems change. These include; risk adversity, professional values and redistribution of financial resources. These ideas are separated for the purpose of this discussion. However, there are direct and indirect links between them, making these barriers difficult to negotiate in practice.

The persistence of professional views and values, which can impede coproduction process, requires a continuation of organizational learning and senior-level endorsement to transformative coproduction practices. Furthermore, the safe spaces, such as the conferences, will continue to play a key role in shifting professional views to conceptualize coproduction as a transformative process that shifts the focus from the individual to the collective.

Risk Adversity

During the focus group with statutory agencies it was evident that coproduction may become locked at certain levels due to institutional risk adversity. The greatest risk was not associated to clinical-safety but instead financial risk; it was a common view in the interviews that coproduction is considered a risky venture due to the lack of scientific evidence base for individual health outcomes. Conversely, it was highlighted in the focus group with statutory agencies that other government initiatives such as the 'health trainers', with relatively weak evidence bases, were still commissioned and scaled up across the country. This highlights that whilst risk is an issue for statutory agencies there may be other dynamics that play a role, such as the reluctance for statutory agencies to shift power to the communities.

Risk was also linked to a lack of governance and formal processes of accountability. It was made clear in the majority of interviews with statutory agencies that WCEN need to formalize processes of accountability to minimize this risk.

> *…this is what we've done, this is how we work and it's getting them to understand that they've got to work in that governance, in a framework that has some accountabilities, it has clear lines of delegation, it has clear lines of accountability around what happens, so for me that's the big thing that we need to get going… - statutory agency interview.*

This quote, amongst other evidence from interviews, suggests that WCEN can address this barrier with capacity building across the community organisations and the implementation of systems of accountability. Some of these steps will be outlined in the recommendations section.

Professional views of coproduction

Despite the significant work that has been carried out in Wandsworth, there will still be individuals within institutions who have a different conceptualization of coproduction and this will continue to pose barriers to the work. This barrier is even more difficult to challenge, when the institutions themselves define coproduction in alternative ways. So for example, in one interview a senior manager discussed the process they had used to define what successful coproduction is as part of their strategy development:

> *'…Yes, it's a range, so we've been, we've discussed it as a board, we've discussed it with senior managers, we've discussed it with some stakeholders and we've discussed it with service users, but we will go back and test it with service users ultimately because the definition of how we've succeeded needs to be one that our service users have significantly had input into, not one that we as, we as senior managers sit down and think oh, we think it's that…'*

This conceptualization of coproduction is limited to the individual level and only requires nominal participation from the community. This approach maintains the divides and boundaries between statutory agencies and community, and further demarcates the imbalance of power between them. This view surfaces in a number of other ways and it raises concerns about professional perspectives of coproduction and their potential to hinder a mutually beneficial coproduction process.

The redistribution of financial resources

Whilst there had been some evidence of shifting of financial resources, according to interviews with statutory agencies still remained on a less formalized level than other financial exchanges – there was minimal evidence that the redistribution of resources was an institutional practice and instead relied upon the cooperation of key decision makers. Furthermore, there was no evidence to suggest that the specific health services that were being provided by individuals in community groups, e.g. IAPT and Family Therapy, were being paid for their labor.

However, the equivalent role within the statutory services were salaried roles. There was also an ongoing discussion regarding the supervision of the qualified family therapists in the Pastors Network, however, it appeared that the possibility to shift this systemic change was prolonged due to a lack of institutionalized practices of shifting finances from the statutory agencies to WCEN.

In order to shift the power associated with financial resources, the process of shifting finances would need to be formalized at an institutional level.With that said, a more reassuring approach was offered by two members of statutory agencies, where they acknowledge that the health services provided by WCEN coproduced initiatives should be funded.

> *'I think you can't just expect people to do it and go into that void without some encouragement, some structures, some formalisation about some things, some resources as well to do it.'*
>
> *'Yes, no, no, no, I do, I think it's, I think at the end of the day the community can do things cheaper than we could be commissioning them and it's only fair that if they are doing things that we are currently paying for, that we commission them. We can't just expect them to do it, do us a favour continually without funding them.'*

It may be argued that only when these views materialise and there is economic redistribution, between the statutory agencies and WCEN, that transformative power will be evident. The development of governance and accountability (discussed in the previous section) will remove some of the potential barriers to institutionalising practices of shifting financial resources.

The outcomes highlighted from this stage of the model makes clear that WCEN have transformed and reconfigured identities, relations, power and values amongst its community groups and the statutory agencies. However, what is also noted is some of the key barriers to change that emerged from the data; risk adversity, professional views and the redistribution of financial resources. Whilst all barriers require continued efforts on behalf of WCEN there is potential for change as WCEN move into their next phase of development. The future of the network will be discussed in the following chapter.

Future of the Network

Participants were provided with the opportunity to identify opportunities and challenges in relation to the expansion of the network and its co-production activities. Analysis identified three global themes around this issue: Opportunities, risks and limitations, and ensuring sustainable change. Each are discussed in turn below.

Opportunities

Statutory and community partners were united in the acknowledgement of the strengths provided by having a diverse range of partners and actors within the network. This was identified as a route to increasing opportunities for engagement in communities. Specifically, the presence of strong community partners, who remained anchored to geographical locations was seen as a key route to riding out phases of political transition that impacted on statutory bodies. For example:

> *At any point in time systems change, priorities change. But this doesn't have to be that limiting, if we work with communities. Local communities stand the test of time, regardless of wider system changes, they are always there. – Senior manager – statutory body*

The diversity of partners creates further opportunities in the network, such as the ability to mitigate some of the risks related to expanding community participation in the delivery of care, which has been identified in literature as a barrier to successful coproduction (Palumbo (2016). Participants from statutory partners suggested that the network created the opportunity for multiple statutory agencies to share in risks linked to new programmes. This is an important aspect of encouraging statutory partners in taking 'leaps of faith' in the absence of appropriate evidence around new ways of practice. As one senior executive within the formal health sector noted:

> *"We (our organisation) are not very good at being brave, but over time there has been a growing recognition of the need to assess risk and know that some risk is worth backing....but the investments need to be wider than just one organisation, so that if things go wrong we can all take some of that responsibility, and own that. With the increased participation of the local council in [the network], it's starting to happen, but not quite there yet" - Senior Management, Statutory Organisation*

New opportunities were also noted around the ability to expand on current successes of the network. Coproduction around mental health services was identified as the strongest area of work done by WCEN thus far in terms of actual service delivery, and as such, the clearest opportunity for future growth by multiple statutory partners:

> *The things that we've done about family therapy and about training people within the local community with tools and techniques and not just like a day training, this was 20 weeks and they get a qualification at the end of it, this was really something and I've then seen it in action in terms of how they're using it and actually, this is a model of which we need to do more of and so I've been encouraging that. – Senior management Mental health Trust*

A willingness to expand on this work was linked to emerging evidence supporting not only the value of the process of coproduction within the family therapy program, but also its ability to transfer as a training model to a new community – with the Muslim family care network.

"Family therapy or CVD are huge areas for development – we have some evidence showing that the training works, and can be translated to other spaces. – Senior management

However, despite this enthusiasm, participants from both the statutory and community partners were adamant that certain factors posed serious risk to expanding these ideas and sustaining positive changes established thus far. These are presented as risks and limitations currently facing the network described in the following section.

Risks

'Don't run before you can walk'

Having demonstrated some significant changes to the systems in Wandsworth, a temptation may be to 'run before you can walk'. However, the next phase requires careful consideration and reflection. The next stage of work for WCEN will require both strategic and detailed approaches to the work ahead. This work will require planning and input from all community groups. This phase of work will require the development of existing assets as a primary focus and the secondary focus should be on developing new relationships, initiatives and ideas.

This notion of 'running before you walk' may also be encouraged by the statutory agencies. In several interviews there was a reoccurring theme suggesting WCEN engaging with alternative groups as they have already developed relationships with the current members. However, this suggestion presents risks; it may be tempting to proceed with engaging others but systemic change requires time, and engagement with other groups maybe to the detriment of the strength of the network as it is. For example, in an interview, it was implied that the work WCEN do must be 'easy' now as it is already successful, but the evidence from the evaluation agrees there are areas of success, but there needs to be greater focus on maintaining, sustaining and evidencing that the model is successful before spreading the 'net too far'.

'so there's been lots of work done around black pastors and other areas, but they're more a sub-set of for instance hard to reach groups, but actually rather than just focusing on that, because it's been successful and maybe it's easy now, actually how do we say right, that's doing quite well, but what else, who else do we need to target, what else do we need to do, refugee groups or whatever' – statutory organisations interview- senior management

'Running' into this next phase of work will pose huge risk to the sustainability for the organization and undermine its accomplishments to date.

Resilience to change

Practices in the statutory agencies shift and change constantly (for example a shift from tendering to outcomes-based commissioning). The ongoing change means WCEN need to ensure they are resilient. There is a great risk to sustainability when there is a reliance on individual figures to carry the coproduction agenda or continue to support the work WCEN do. In this regard, the secondary focus identified in the previous discussion, becomes paramount - building capacity and building alliances as modes of strengthening resilience.

Loosing Organisational Identity

As it stands WCEN situates its approach and activities in a critical framework, this has been fundamental for the systemic changes that has occurred so far. As a move towards becoming more accountable and systematic with monitoring and evaluation, with a view to demonstrating the ability to becoming a potential public service provider (one of the recommendations of this report) there needs to be great caution taken in regards to mission drift, professionalization and isomorphism. Research since the 1990's has indicated that the voluntary and community sector has been greatly impacted by its increased role as a contracted service provider. There has been evidence of mission drift, increased business-like practices, a loss of its campaigning and advocacy role and lastly a shift to operating in ways that replicate the work of local government as opposed to one, which addresses and tackles social injustices (See MacMillan, 2010 for detailed discussion). For WCEN, the risk maybe somewhat mitigated by the strong infrastructure that has been developed by the network in phase 0 of the coproduction process; an infrastructure that has social justice as one of its central pillars. However, this risk still remains paramount as contracting is increasingly more stringent and punitive. One aspect of mitigating this risk can be to ensure that values, aims, objectives and visions for the organization are set out in coming stages of WCEN development. They can therefore, be used to shape funding applications, to ensure work is closely aligned and to ensure the organization is held accountable to its core values by a board of trustees, other key stakeholders and members.

Instrumental Participation

The increasing interest in coproduction has largely come around because of public spending cutbacks. The link between cost-saving and coproduction is a significant risk, as it only requires instrumental participation from the community. Instrumental participation is characterized by means to achieve a particular goal, and in context of public expenditure saving, this would refer to cost-efficiency. In one interview, it was expressed that the stance of some key figures in statutory agencies was merely to save money.

> *'…I said it's not like the council or any of the statutory partners have suddenly grown a heart, it's because they truly, it's true, but they've suddenly realised that the community can do a lot of work themselves, far cheaper than if we were to commission it, so that's the sort of reality of it, that in practice that's the way forward…'*

Whilst cost efficiency is one argument for coproduction (Ostrom, 1996), it cannot be the only basis as the cost-benefits of coproduction can take years to emerge. Therefore, by focusing on cost-efficiency as rationale is more likely to lead to an imbalanced redistribution of responsibility to the communities with devolved responsibility from statutory agencies. This potential risk needs to be mitigated by WCEN by continuing to build a network based on values such as solidarity and equality; in doing this it will promote transformative participation and minimize the likelihood of being drawn into tokenistic or instrumental forms of participation.

Sustaining Change

In addition to the risks to expansion identified above, further factors were identified in order to sustain gains made thus far. Firstly both statutory and community partners highlighted that it was not sustainable to continue to rely on the work of one or two key individuals to maintain the network. Specifically, an overreliance on the WCEN director was noted as an unsustainable practice for the future. As noted by one community organisation member:

> *one of the things I think of often is around again we need to have a succession plan around, who will be participating in things - because I won't do it forever… and there needs to be other people who'd be able to step forward…. we need to think around how to make that happen and it's not good enough when just one person opts into things that I'm the person whose name is put forward... it's not sustainable – Community Organisation member, Female*

Current structures in the network rely on key individuals to carry the load of the majority of work, whether that be within WCEN, its community group members of key figure heads from the statutory agencies. This suggests the need for a focus on distributive leadership – this will be further discussed in the recommendations.

The second danger with the reliance on individuals was linked to the processes of buy in from statutory partners. While this is also a strength of the model, there are concerns linked to establishing programmes supported by key individuals who then move on, at times in the middle of a project. As noted by one organisation on their partnerships with police organisations in early stages of their participation in the network:

> *One of the challenges, is, it's influenced by the policy makers, what they want, so if you're priority then there are people who look for you and they will come to you, if you're not priority for that time, they'll cut that relationship.... then in a couple of years you become a priority again and then they try to link again....we've been running this organisation within Wandsworth Council for the past 10 years and within these 10 years we've seen so many changes, so many people coming, so many people leaving – each time you have to start again - Community organisation member, Male*

Finally, it was suggested that in order to sustain change, there was a dire need to even out the capacity across the community network sites. Despite the involvement of a very wide range of groups, it was clear from site visits that not all groups are created equally. Two of the four community sites visited were sustained by the inputs of two key individuals who were responsible for running programmes, management of finances, and general systems management – in addition to the added engagement on various groups through WCEN. This was confirmed in the accounts of many community organisation members, for example:

> *The network is broad and the network can come together and like sizeable, but actually in terms of capacity it's really tiny and also the network is very varied, so you can slice it at one point and what you see is very different if you sliced it differently and I think that sometimes is problematic and I think sometimes it's problematic also for [the director], because I think sometimes he looks out on the network and he thinks oh well, we have so many different people and we have so much capacity and we can do that, and while there is a commitment and intention, there is very little capacity .....*

Recommendations

Findings from this evaluation highlight a series of significant changes established through WCENs work on coproduction. More importantly, they highlight a strong foundation from which to build and expand and an opportunity to enable community organisations to take more truly active roles in the health economy, in ways that avoid typical challenges created by volunteerism (Burgess 2014) and the use of communities as 'handmaidens' of health services (Campbell 2003; Campbell & Burgess, 2012).

However, in order for these positive changes to be maintained and new opportunities to be capitalised on, in ways that are successful we present a series of recommendations to be considered. As suggested in figure 5 below, recommendations for future practice are geared towards establishing sustainability, not only within WCEN itself, but also across the community organisation sites. Through this proposed line of work, it is hoped that communities and organisations like WCEN can be become less reliant on external funding priorities, and more protected from the constant shifts in wider health agendas.

Current priorities in health systems management and financing highlighted in the NHS five-year forward view highlight an approach to community participation through the development of Multispecialty community providers (NHS, 2014). Such entities seek to expand definitions of leadership in primary care to include a wider range of practitioners, of which 'community based professionals' are considered. Over the past few years, WCEN has begun the work to establish certain individuals within the network to be positioned at such levels – in particular, this is seen in projects on family therapy and IAPT. However, due to the uneven nature of the network, not all sites have the capacity to participate to the level required to capitalise on this opportunities, particularly in areas of bidding and management of contracts, delivery of care, and more importantly monitoring and evaluation of services, which is a particular gap in the current work of the network.

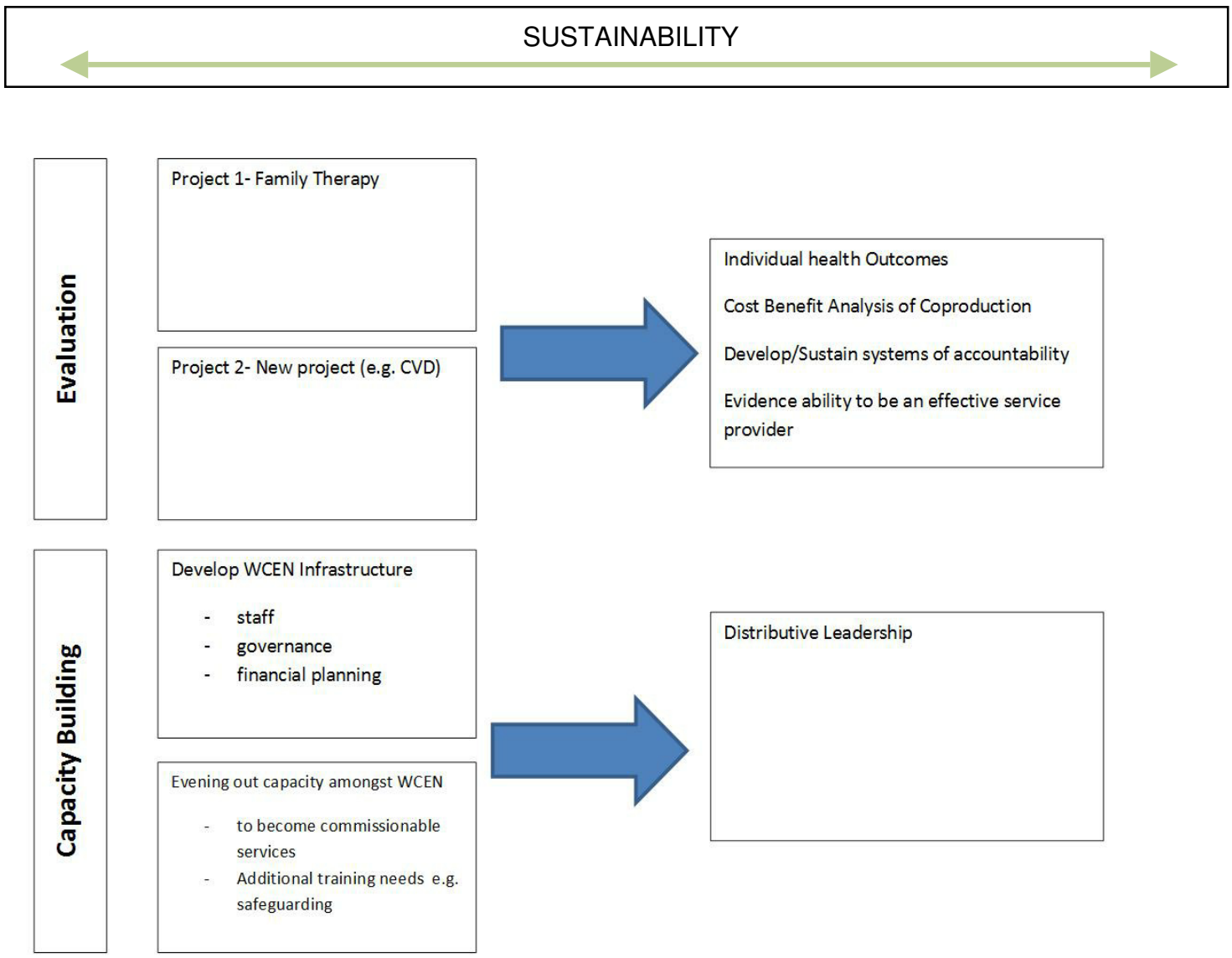


Figure 5: Recommendations

As such, our recommendations are as follows:

1. **Streamlining focus**

We suggest that over the next five years WCEN should not aim to develop a wide range of new activities, but instead focus on developing and supporting sustainability around existing areas of strength: coproduced mental health services and lifestyle or CVD conditions. In doing so, this would ensure sufficient attention to the complex arenas to be navigated around enabling network organisations to be able to deliver specific programmes in one or two key areas, which can be monitored and evaluated effectively. If new programme areas were to be developed (i.e. new health focuses, or engagement with new community groups into coproduction processes), it is imperative that WCEN maintain ample space for phase 0 to occur and support any new ventures, as this phase has been critical to successes seen thus far. If any new sites begin the development of the coproduction cycle, we also advise longitudinal evaluation of this process at key stages of development in order to provide a stronger evidence base for its coproduction work.

2. **Developing mechanisms of accountability to specific outcomes – in particular health improvement and patient outcomes**

For WCEN and its community level partners to participate in new opportunities such as the Multispecialty community provider framework, the network will need to be able to produce 'hard' forms of evidence in relation to the delivery of care, in particular evidence related to improved service user outcomes. Given the absence of this to date, we suggest that WCEN consider over the next five years, financing the delivery of TWO service delivery programmes, run by community sites, which are monitored and evaluated along the course of the intervention. Any evaluation processes should be linked to statutory sector outcome measures, so that they can speak to the evidence needs of commissioners.
Beyond this, we suggest that these programmes be linked to network groups with the highest level of capacity at present, in particular the family therapy programme. Furthermore, as part of this new programme, we suggest attention to avoiding the burnout of key volunteers who deliver services, and as such consider the establishment of formal paid roles linked to service delivery.

3. **Evening out capacity across sites: distributing leadership**

Our third and final recommendation seeks to redress the issues around leadership and uneven capacity. Firstly, capacity could be increased through the provision of training that enables organisations to participate in the wider health economy in more formal ways. In doing so, community groups will be better insulated against shifting priorities of the wider health economy, as they will have the baseline skills needed to deliver services in formalised settings, and be more responsive to priority shifts as they arise. For example, training in areas such as applications for funding and commissioning contracts, budget management, and navigating the health sector discourse, would help to ensure that the work of community groups would be sustainable even in the absence of WCEN.

Beyond this, there is a need to increase support to the sites from WCEN, which would only be achieved through increasing capacity of the WCEN hub itself. The overreliance on the skills, personal attributes and commitment of a single individual has been the networks' biggest strength and also presents its biggest risk. The network must increase its capacity at an organisational level ideally through the creation of a new posts. Suggestions for this include monitoring and evaluation of programmes, community network training and support, and budget management. Finally, within community organisations themselves, there is also overreliance on key individuals, who often have multiple responsibilities in various domains of their life. As such, there is a need to ensure that community organisations are supported in developing further staff level capacities within each organisation – for example, bringing new individuals in as part of project expansion, and training and mentoring for these individuals about the processes involved in participating within the network and coproduction more broadly.

Conclusions

Findings from this evaluation highlight that the WCEN model to coproduction is theoretically innovative and promotes wider systems change. It has managed to create safe spaces that lead to the empowerment of communities and individuals facing multiple disadvantage. In the current context of wider shifts in health systems priorities, WCEN has an unique opportunity to develop and embed these changes in the wider health system. The task remains to ensure that these changes are sustained and communities are able to work as true partners with health sectors in responding to their health related needs.

References

Abercrombie, R. Harries, E. and Wharton, R. (2015). Systems Change: A guide to what it is and how to do it. New Philanthropy Capital: London.

Batalden, M., Batalden, P., Margolis, P., Seid, M., Armstrong, G., Opipari-Arrigan, L., & Hartung, H. (2015). Coproduction of healthcare service. BMJ quality & safety, bmjqs-2015.

Becher, E. H., & Wieling, E. (2015). The intersections of culture and power in clinician and interpreter relationships: A qualitative study. Cultural Diversity and Ethnic Minority Psychology, 21(3), 450.

Bovaird, T., & Loeffler, E. (2012) We're all in this together: User and community co-production of public outcomes. Discussion Paper, Institution of Local Government Studies, Third sector research Centre, University of Birmingham.

Bovaird, T, Van Ryzin,G., Elke Loeffler, and Parrado, S. (2015) "Activating citizens to participate in collective co-production of public services." Journal of Social Policy 44, no. 01: 1-23.

Bovaird, T. (2007) Beyond engagement and participation: user and community coproduction of public services. Public Administrative Review 67, 846-60

Brudney, J.L. and England, R.E. (1983). Toward a definition of the coproduction concept. Public Administration Review, 43(1)59-65

Burgess, R.A. (2014). Burgess, R. A. (2014). 'It Depends on Them'–Exploring Order and Disjuncture in Responding to the Local Needs of AIDS Affected Communities in the Kingdom of Swaziland. *Journal of Development Studies*, *50*(4), 467-480.

Burgess, R. A. (2015). Supporting mental health in South African HIV-affected communities: primary health care professionals' understandings and responses. Health policy and planning, 30(7), 917-927.

Campbell, C., & Burgess, R. (2012). The role of communities in advancing the goals of the Movement for Global Mental Health. Transcultural Psychiatry, 49(3-4), 379-395.

Campbell, C., & Cornish, F. (2010). Towards a "fourth generation" of approaches to HIV/AIDS management: Creating contexts for effective community mobilisation. AIDS Care, 22(S2), 1569–1579 Campbell, C. (2014). Community mobilisation in the 21st century: Updating our theory of social change?. Journal of health psychology, 19(1), 46-59.

Cramm, J. M., & Nieboer, A. P. (2016). The changing nature of chronic care and coproduction of care between primary care professionals and patients with COPD and their informal caregivers. International journal of chronic obstructive pulmonary disease, 11, 175.

Cornish, F., Campbell, C., Shukla, A., & Banerji, R. (2012). From brothel to boardroom: Prospects for community leadership of HIV interventions in the context of global funding practices. Health & place, 18(3), 468-474.

Cornish, F., Montenegro, C., van Reisen, K., Zaka, F., & Sevitt, J. (2014). Trust the process: Community health psychology after Occupy. Journal of health psychology, 19(1), 60-71.

Durose, C., Mangan, C., Needham, C., Rees, J. (2014). Evaluating co-production: pragmatic approaches to building the evidence base. Paper presented at Political Studies Association Conference, April 2014.

Freire, P. (1973). Education for Critical Consciousness (introd. de D. Goulet: ed. y tr. por Myra Bergman Ramos) Nueva York: EUA Continuum

Foucault, M. (1988). Madness and civilization: A history of insanity in the age of reason: Vintage.

Rifkin, S. B. (2014). Examining the links between community participation and health outcomes: a review of the literature. Health policy and planning, 29 (suppl 2), ii98-ii106

Laverack, G. (2013). Individualism or activism for health in hard times?.Journal of Public Health, 21(4), 385.

Laverack, G (2007). Health promotion practice: building empowered communities. New York: Mcgraw Hill

Leone, R. P., Walker, C. A., Curry, L. C., & Agee, E. J. (2012). Application of a marketing concept to patient-centred care: Co-producing health with heart failure patients. Online Journal of Issues in Nursing, 17(2)

Loeffler, E., Power, G., Bovaird T., Hine-Huges, F. (eds). (2013). Co-production of health and wellbieng in Scotland. Birmingham, UK: Governance international. Accessed online at: http://www.govint.org/fileadmin/user_upload/publications/CoProduction_of_Health_and_Wellbeing_in_Scotland.pdf

Macmillan, R., 2010. The third sector delivering public services: an evidence review. Centre for third Sector research: London

Mishler, E. G. (1984). The discourse of medicine: dialectics of medical interviews. Norwood, New Jersey: Ablex Pub. Corp.

National Health Service (NHS) (2014). Five-year forward view. Accessed online: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Ostrom, E., 1996. Crossing the great divide: coproduction, synergy, and development. *World development*, *24*(6), pp.1073-1087.

Palumbo, R. (2016). Contextualizing co-production of health care: a systematic literature review. International Journal of Public Sector Management, 29(1), 72-90.

Public Health England (2015). A guide to community-centered approaches for health and wellbeing. Full report PHE publications gateway number: 2014711 Accessed online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing__full_report_.pdf

utnam, R. D. (2000). Bowling alone: the collapse and revival of American community. New York: Simon & Schuster

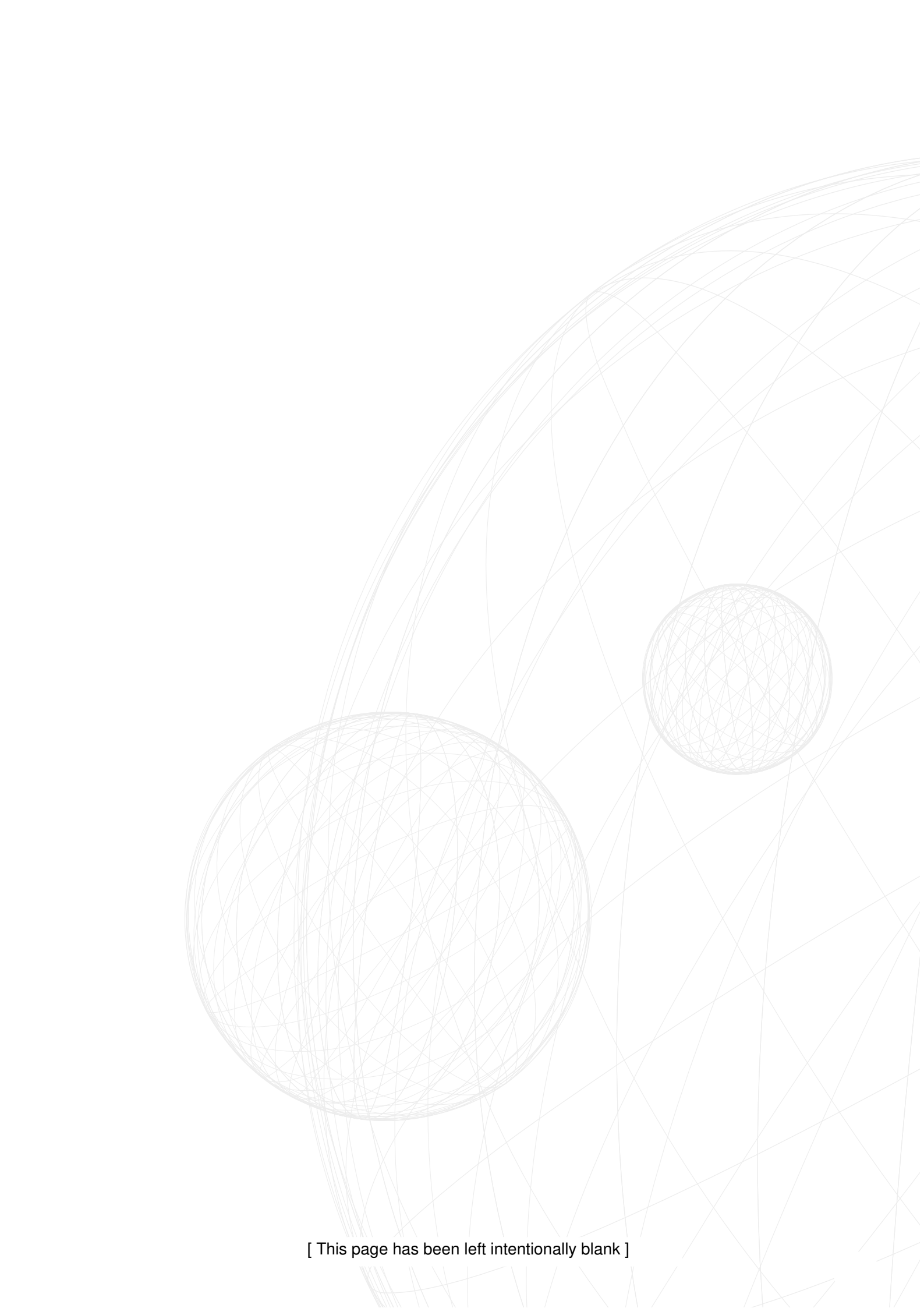
Sharma, S., Conduit, J., & Hill, S. R. (2014). Organisational capabilities for customer participation in health care service innovation. Australasian Marketing Journal (AMJ), 22(3), 179-188.

Vanneste, B. S. (2015). From interpersonal to interorganisationnal trust: The role of indirect reciprocity. Journal of Trust Research, 1-30.

Vaughan, C. (2011). Dialogue, critical consciousness, and praxis, In: D.Hook, B. Franks & M. Bauer (Eds). The Social Psychology of Communication. Basingstoke: Palgrave Macmillan

White, S. C. (1996). Depoliticising development: the uses and abuses of participation. Development in practice, 6(1), 6-15.

Woolcock, M. (1998). Social capital and economic development: Toward a theoretical synthesis and policy framework. Theory and society, 27(2), 151-208.



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Appendices

Appendix 1- Research Plan

Wandsworth Community Empowerment Network Evaluation: Timeline

	Sep	Oct	Nov	Dec	Jan	Feb
Planning						
Stage 1: Network Workshop						
Stage 2: Multi sited Ethnography						
Stage 2: Observations						
Stage 2: Survey						
Stage 3: Statutory Agencies Workshop						
Stage 4: Development Theoretical Framework						
Final Evaluation						

Appendix 2 – Interview Schedule – Community group Interview

Phase 2: Multi Site Ethnography (Semi –structured Interviews schedule)

Introduction

Warm up questions – role/background

Network

How would you describe the network?

- What does the network do?
- What does it stand for?
- What are the principles and values of the network?

What is unique about the network?

How does the network differ from other existing networks in the borough?

Benefits and challenges

What are the benefits of being a part of the network for your individual organisation and for the communities you work with?

What challenges do you (as an individual organisation) coming up against being a part of the network?

What typically happens when you are faced with challenges?

How are tensions within the network handled?

How would things be for your organisation without the network?

Development/Changes

How did you become involved in the network? What is your involvement?

How long have you been involve in the network? What has sustained your commitment/involvement to the network?

What changes have there been to the network over time?

- What led to those changes? Any particular driving force?

What significant milestones have there been for the network?

What is your vision for the network in 5 years' time?

Impact

What impacts have there been as a result of being a part of the network?
- For individual (being interviewed)
- For organisation
- For communities they serve

How have relationships between you organisation and statutory agencies changed as a result of being in the network?

What does a successful network look like?

How do you know when a successful network in in place?

Is there anything that blocks/prevents success?

Leadership

Do you need a leader in a coproduction model/network? If yes, what key functions do they serve?

Functions/Knowledge/Processes

How does knowledge move from you- leaders to the community?

How did you decide which coproduced services should be held in your organisation?

How do the services you run at your organisation benefit the communities you work with?

Appendix 3 – Interview Schedule – Statutory Agencies Interviews

Phase 3: Semi –structured Interviews with Statutory Partners

Introduction

Warm up questions – role/background

Development/Changes

How did you become involved in the network? What is your involvement?

How long have you been involve in the network? What has sustained your commitment/involvement to the network?

What changes have there been to the network over time?
- What led to those changes? Any particular driving force?

What significant milestones have there been for the network?
What is your vision for working in partnership with the network in 5 years' time?

Network

How would you describe the network?
- What does the network do?
- What does it stand for?
- What are the principles and values of the network?

What is unique about the network?

How does the network differ from other existing networks in the borough?

Benefits and challenges

What are the benefits of being involved with the network for your individual organisation and for the communities you work with?

What challenges do you (as an individual organisation) coming up against when working with the network?

What typically happens when you are faced with challenges?

How are tensions within the network handled?

How would things be for your organisation without the network?

Impact

What impacts have there been as a result of being involved in the network?
- For individual (being interviewed)
- For organisation
- For communities they serve

How have relationships between your organisation and community groups changed as a result of being in the network?

What does a successful network look like?

How do you know when a successful network in in place?

Is there anything that blocks/prevents success?

Service Delivery

Does the network support your organisational goals/aims/targets?

Do you envisage working together with the network to deliver services to the community?

What may be some of the limitations/challenges of doing this?

Afterword

For over 16 years, WCEN has been on the frontline of public policy programmes, witnessing their impact on our communities. In 2001 we were part of the Governments National Strategy for Neighbourhood Renewal and a central part of the Wandsworth Local Strategic Partnership (LSP). The aim then (as it is now) was to enable local people, particularly those living or working in areas of multiple deprivation, as they are better placed to know what would work for them, to be at the centre of decision making processes, to work in a “joined up” way with our LSP partners to help “bend the mainstream”, so that public resources are being directed towards meeting the greatest needs. Whilst the intentions were right and correct, the speed at which Whitehall required implementation, lacking understanding on the time and processes required for empowerment and development, meant that communities continued to remain as passive recipients of top-down interventions and meddling.

The Neighbourhood Renewal programme was abandoned by 2005, and what followed was a return to short-term programmes, controlled and driven from the centre, and major reorganisation of our public institutions - the NHS shifting from Primary Care Groups to Primary Care Trusts to Clinical Commissioning Groups to the current sub-regional mergers; Public Health moving out of the NHS and into Local Authorities; and Local Authorities themselves who will experience upto 70% reduction in their capacity across this decade.

With this constant shifting and reorganising of public policy objectives and infrastructure, with endless amounts of new directives and programmes continuing to come down the pipeline, community empowerment has fallen further down the agenda to the point where we now have fragmented, disjointed communities, existing in isolated pockets of exclusion, not living or working together, or with our public agencies in any meaningful way. At worst, as the recent Casey Review into opportunity and integration noted, reflecting on the division between many communities, that where they “live separately, with fewer interactions between people from different backgrounds, mistrust, anxiety and prejudice grow”. A recent report from The Red Cross said that our health services are facing a “humanitarian crises” by virtue of their inability to manage demand. The Joseph Rowntree Foundation have called the levels of poverty in the UK as “shameful” with increasing numbers of people falling into hardship and crisis.

In Wandsworth, many of those who were around the Local Strategic Partnership table in the early ‘00s, are still working together today, but with the benefit and insights that have emerged from almost two decades of change and flux, with the index of deprivation in the areas in which we have worked remaining relatively the same, and in some cases, much worst. Why? This question triggered a coming together of people from across our mainstream agencies and communities, all equally frustrated at the lack of progress that we have been able to make, to try to find ways to unlock leadership and capabilities across a genuinely whole system- not just public agencies, but other centres of influence and association like churches, mosques, temples, community groups and social networks- to find smarter and better ways to meet our shared objectives - to improve lives, close the gaps in inequalities and to make a difference. Those who stepped-up understood and appreciated both the system levers and limitations that can affect change, as well as the capabilities that lay dormant across our communities, and which when working in synergy have the greatest transformational possibilities. They got the necessity of working across traditional lines, the need to build new kinds of relationships and alliances, and the importance of creating an environment within which new ideas and ways of working could be nurtured and grown.

This set in chain a series of processes from the development of a linked programme of conferences and workshops to create “safe spaces” for the sharing of information and knowledge across multiple systems and diverse networks, the establishment of a High-Level Coproduction Reference Group that sort to provide a “heat shield” to enable new relationships to be built and ideas to flourish and the testing and modelling of new ways of working (sketched out in the Case Studies in this report)

A key lesson that emerged was that developing these new ways is a slow and deliberate process. It is the opposite of public policy processes that are very good on describing the WHAT, but lacking in the HOW, demanding things to be done in prescribed and time-limited ways. The reality of system change is that it requires daily practice in small and systematic ways day-in day-out, to a point where all involved learn these new ways, and then these are shared with others, and then we slowly build and grow again. Person by person. Group by group. Service by service.

In Wandsworth, after a steep climb, we have now reached base camp! This evaluation has enabled us to bring to the surface the deliberate and necessary processes of “bridging” and “bonding” that enables knowledge and information to flow and relationships to be built, to get to a place where partnership and genuine collaboration becomes possible. Some of the new processes and languages that are being developed in other sectors- in technologies like Uber, Air BnB, Facebook for example – are better able to describe the work that we have underway, from the ideas of creating “platforms” that have “two-sided networks” to the understanding that “value” can be generated outside traditional structures and unlocking this is the key to growth and productivity.

The next stage of this work is to develop a Governance and Assurance Framework – a platform- so that both sides of the network- mainstream services and community networks- are able to operate within a partnership that is able to serve, and unlock the capabilities, of both sides. On the one hand the management of risk and governance requirements for the spending of public resources, the setting of key performance indicators that are able to measure value and return-on investment, and on the other the environment in which community networks are able to deploy their strengths and assets to generate public value.

By developing these processes in the deliberate and systemic ways that we have learnt, we are much more likely to be able to generate network effects that multiply user involvement, speed up the rate of adoption and create beneficial whole system effects.

As the latest policy cycles come around- addressing similar challenges to those presented to the Neighbourhood Renewal programme 16 years ago, but this time wearing the clothes of Early Action, New Care Models, Sustainability and Transformational Plans (STPs) and Social Prescribing...., we are now better placed to meet them half way, not as passive recipients of them, but as active coproducers. Over the next period, bringing these ideas and practices together into a measurable system for community led early intervention and prevention is the leadership and mission goals of our community.

Thank You to Dr Rochelle Burgess and Natasha Choudary for their skill and expertise in marshalling and evaluating the evidence from our practice and providing the guidance and support for our next steps; our funding partners The Lankelly Chase Foundation for their advice and support and opportunities to provide reflective space in which we are able to learn from and contextual our work ; the Coproduction Reference Group- Wandsworth Council, Wandsworth CCG, Wandsworth Public Health and SWLSTG who shared in the cost of this evaluation and contributed substantially in enabling the many colleagues across our sectors and systems to participate freely and openly in sharing learning and practice. We could not have reached the settling points that we have without their leadership and support.

Our community networks and partners, friends one and all, are the foundation stone on which we are building. Their years of volunteering, their passion and commitment for change, their ideas and their labour is the inspiration that helps drive our work. Within their own communities and groups they are "being the change that they want to see"; role-modelling what the leadership for social reconstruction looks like. Their voices are heard throughout this report; they are in the DNA of the new systems that we are seeking to build.

Short films, photo galleries, reports and evaluations of all the work that we undertake is available on our website www.wcen.co.uk and our other social media. We will continue to share our work through these forums and through our regular conferences and workshops. We aim to formally report back on the next stages described here towards the end of 2018.

In the meantime, we invite you to take-a-look, question, challenge, share and join-in; our collective thoughts, ideas and actions will make us all better and stronger, for ourselves, and for each other.

Malik Gul
Director
Wandsworth Community Empowerment Network