Resource sheet: design thinking and coproduction

".. be open to collaboration. Other people and other people's ideas are often better than your own. Find a group of people who challenge and inspire you. Spend a lot of time with them. It will change your life"

Amy Poehler

Where do design thinking and coproduction fit with ELC?

Experience led commissioning is built on and harnesses design thinking within health system management and contract design to ensure that service contracts and key performance indicators are built upon a deep understanding of what matters to people (people and families who use services and the caregivers who provide them). Within ELC, what matters to people who use service and those who deliver them are equally valued and recognised.

Harnessing design thinking enables a robust, person-centred process that support innovative, sustainable solutions.

Coproduction is at the heart of and underpins delivery of the ELC process.

What is design thinking?

Design thinking supports health system leaders to "think around the problem" and create better ways of expressing value within contracting processes and targets or key performance indicators (KPIs).

The elements of design thinking align with best practice in person centred health system transformation[1]. More information about this best practice is provided in the resource sheet

Design thinking has three elements:

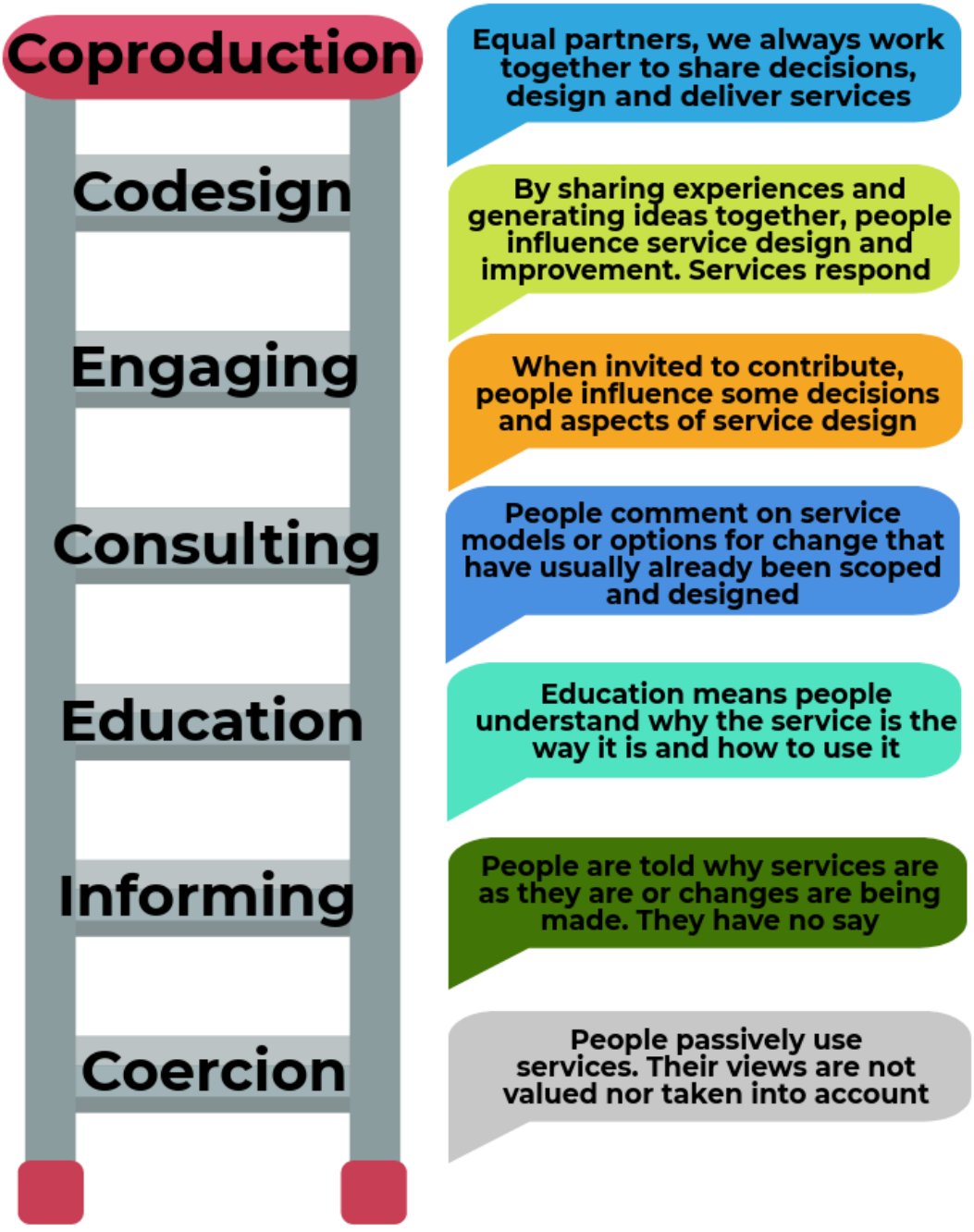
- **Empathy:** design thinkers seek to deeply understand the ender user perspective by developing empathy for them and standing in their shoes when they design solutions. Within the ELC process, we define the end users as people and families who use services and the staff who deliver them. The discovery phase of ELC creates the deep understanding and insights that provide empathy that contextualises the design of contracts, targets and KPIs.

- **Collective idea generation:** the principle of collective idea generation is central to design thinking. Design thinkers recognise that involving people with a range of experiences and perspectives leads to a richer harvest of ideas and solutions. Often in health and care systems, decision about the design of contracts, targets and KPIs are made by a relatively small group of people who often have very similar backgrounds and ideas. Intentionally embracing collective idea generation shifts the power and responsibility for system management from the few to the many. This also gives end users of the health and care system greater power and influence, thus democratising health system accountability, shifting the power balance towards diffused leadership of change and improvement. Within the ELC process, collective idea generation happens during the Dream and Design stages at group events.

- **Prototyping and improving:** design thinkers recognise, accept, and embrace the need to prototype, learn and improve. They expect that the first iteration of any design will be partly right and in need of ongoing adjustment and improvement. They go with their best guess and build on experience gained from implementation. The principle of prototyping and improving is less common in health and care systems. Often risk averse, iterative improvement is seen as challenging for both service providers and system managers. Contract, target and KPI frameworks often focus more on easy to measure outputs rather than outcomes for this reason, and often, the contracts, targets and KPIs systems design lead to unintended and often negative consequences and system or provider behaviours. ELC changes the mindset and introduces the principle of system leaders being open to prototype, learn and improve the design of system levers so that service providers are focused on continuous person-centred improvement and remain agile and responsive to what matters most. As what matters to people changes over time, prototyping and improving is an essential element of person centred, values-based health and care systems.

[1] Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: a realist review. *Milbank* Q. 2012 Sep; 90(3):421-56. doi: 10.1111/j.1468-0009.2012.00670.x. PMID: 22985277; PMCID: PMC3479379.

The ladder of participation



The concept of a ladder of participation builds on Sherry Arnstein's seminal paper published in 1969[2]. Her "Ladder of Citizen Participation" is one of the most

[2] Arnstein, S. A ladder of citizen participation. *Journal of the American Planning Association*. 1969. 35(4): 216–224.

widely referenced and influential models in the field of democratic public participation. For those who want to understand foundational theories of public engagement and participation, and the ways in which empowered public institutions and officials deny power to citizens, Arnstein's seminal article is essential reading.

In Arnstein's formulation, citizen participation equals citizen power and if citizen participation is to be considered genuine, it requires the redistribution of power. Without authentic reallocation of power, for example, in the form of money or decision-making authority, it is not authentic and "allows the powerholders to claim that all sides were considered but makes it possible for only some of those sides to benefit. It maintains the status quo."

Arnstein's model has been built on over the years. The ladder of participation described is an adaptation, promoted by The National Co-Production Advisory Group (NCAG) and Think Local, Act Personal (TLAP)[3].

NCAG is a team of people who use services, carers, and their families. TLAP is a national partnership of over 50 organisations who work together with people who use services, carers, and family members to transform health and care through personalisation and community-based support.

The ladder of participation describes a series of steps towards co-production in health and social care and aims to help organisations to understand the various stages of evolution that health and care systems go through at strategic level before full co-production within the context of commissioning, contracting and target setting is achieved.

The table below provides examples of the different levels of participation:

Level of participation	**Example**
Coproduction	An ELC programme to redesign the contract for primary care services that is implemented in partnership with local people and providers
Codesign	A co design session, within an ELC programme where people who use service, their families, staff who deliver primary care, social care, and specialist services, health service managers, the voluntary sector (non-governmental organisations) and others who can bring a different perspective come together to design a service. Their service design is adopted

[3] https://www.thinklocalactpersonal.org.uk/_assets/COPRODUCTION/Ladder-of-coproduction.pdf

	within a contract that is determined by system leaders
Engagement	People who use services are invited to come to a "Town Hall" event and have their say in the design of services. System leaders get a report of the discussions. This is distributed and may be fed into contract discussions if the ideas resonate with those who review it
Consultation	System leaders come up with several ideas about changes to the design of primary care services. They prepare a consultation paper and make it available in the public domain so that people affected can read it. They provide an email for people to submit comments. Feedback is collated and presented as a report that may inform contract discussions if the ideas resonate with system leader
Educating	System leaders present their chosen ideas to people and explain why they have made the decisions they have made and why primary care services are changing. People have no say or influence in the decision
Informing	System leader come up with idea about changes to primary care delivery, decide the changes that they want to happen and communicate to affected people what changes are being made and when the changes will happen. People have no say or influence in the decision
Coercion	People are not told what is happening. The primary care services changes and they must passively accept the change. People have no say or influence in the decision

All levels of participation may have their place – even coercion. For instance, in life threatening emergency situations, coercion may be the only option. However, best practice in change management and quality improvement shows that the greater the level of participation, the better.

The ELC process operates at the levels of co design and co-production. Organisations that adopt and embed ELC will accelerate their progress up the ladder of participation.

What is coproduction?

Coproduction is the ultimate expression of participation.

When coproduction is embedded into strategic health system management and provider delivery, it nudges a health and care system where people are equal partners in co-creating the health and care system and the services people use.

> "Co-production is a way of working that involves people who use health and care services, carers, and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development, and evaluation.
>
> Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions, and to maintain a person-centred perspective. Co-production is part of a range of approaches that includes citizen involvement, participation, engagement, and consultation."[4]

In England, NHS organisations have a legal duty to ensure that people are appropriately involved in planning, proposals and decisions regarding NHS services and are governed by both statutory guidance to work in partnership with people and communities. NHS guidance issued in 2022 *Improving experience of care: a shared commitment for those working in health and care systems*[5] commits NHS organisations at all levels to undertake planning at all levels built on 3 key principles, which closely mirror the ELC approach:

1. Co-production as the default for improvement
2. Using insight and feedback
3. Improving experience of care being at the centre of all change programmes.

Guidance recognises co-production as a significant culture shift, underpinned by positive relationships built on mutual respect and understanding, and that that system values and behaviours need to align to ensure co-production becomes part of the way a health and care system works as follows:

1. Everyone needs to own, understand, and support co-production as the way we run our health and care system
2. There is a culture of openness and honesty; a "no blame" culture
3. Everyone is committed to sharing power and decisions with citizens and people

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[4] https://www.england.nhs.uk/always-events/co-production/

[5] https://www.england.nhs.uk/publication/improving-experience-of-care-a-shared-commitment-for-those-working-in-health-and-care-systems/

4. Everyone communicates clearly in plain English (simple jargon free language)
5. There is a culture of people being valued and respected.

This video summarises the co-production mind set and journey:
https://youtu.be/OpoWdyxAvYo?si=3LPnIXB3-p82aNld

Co-production is also recognised as the default amongst leading thinkers on health system improvement

Listen to Don Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI) describes in this conversation with We Coproduce:
https://www.youtube.com/watch?v=iqUv2_Il4cI

Whilst it still has a long way to go, the NHS in England is currently working nationally and local towards demonstrating that all NHS organisations:

- Always start from what matters most to people who use and work in services
- Work with people who have relevant lived experience (patients, service users, unpaid carers, and people in paid lived experience roles) and with staff, in everything they do to directly connect with multiple and diverse voices
- Build equal and reciprocal partnerships with people who have relevant lived experience, and staff, including with those from.

ELC demands a coproduction mindset as the default at system management level. The 8-role model, described in the Resource Sheet: person centred organisational development, supports organisations to sustain coproduction with communities ovr time.