Breakout session: Co-design and Co-production

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Supporting better quality health and social care for everyone in Scotland
This session will:

- Demonstrate why co-design and co-production are vital to a quality management system.
- Explore how collaborative and participatory approaches can provide the insights and inputs needed to ensure all areas of a QMS framework are focused on what really matters, enabling public services to have an equal focus on both ‘doing the right thing’ and ‘doing the thing right’.
QMS framework: Co-design and co-production

Processes and culture that support individuals, families and communities to become equal partners in all aspects of quality planning, improvement and control.

Processes and culture that ensures staff at all levels have the knowledge, skills and time to engage in the work of quality planning, improvement and control at a level commensurate with their role.
Participation ladder

- Co-producing
- Co-designing
- Engaging
- Consulting
- Informing
- Educating
- Coercing

*Adapted from Arnstein’s participation ladder, 1969*
Co-design and co-production
What’s the difference?

The difference between co-design and co-production is that co-design addresses the problem collaboratively and a solution is identified, whereas co-production collaboratively embeds the solution into reality.

McDougall, 2012
Why co-design and co-produce?

User Experience

Poor Design
People-led design approaches are being used across the public sector

In the ihub we are utilising:

- Scottish Approach to Service Design (SAtSD)
- Experience Based Co-design (EBCD)
- Care experience Improvement Model (CEIM), and other design-led approaches
User experience leading design

Ohio state university walkways
Focusing on collaborative relationships and user experience helps us deliver person-centred care


• **Cost effectiveness** *(Olsson et al; 2009, Picker, 2016)*

• **Improved adherence to treatment and medication regimes** *(Haynes et al 2008; NICE, 2009)*

• **Increased trust in clinicians** *(Keating et al 2002)*

• **Improved patient experience and satisfaction** *(Raleigh et al 2009)*

• **Improved staff experience** *(Raleigh et al 2009; The King’s Fund, 2012).*
Practical examples from Scotland
Co-designing Antenatal Education - Need for change

“Attendance at antenatal classes was variable and we wanted to explore why this was happening and to design an improved experience for both women and midwives.”

Lead midwife
The Experience Based Co-design process steps

1. Observation at antenatal classes
2. Interviews with staff
3. Interviews with women
4. Creation of a film of people’s experiences (staff and women)
5. Events to identify and agree improvement priorities separately
6. Co-design event to agree improvement priorities and improvement ideas to work on
7. Women and staff work together to prototype and test ideas that tackle the improvement priorities
<table>
<thead>
<tr>
<th>Midwives thought</th>
<th>Women said</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who already had a baby thought they didn’t need antenatal classes because they had done it before or had other children to look after</td>
<td>We are required to sign up to all classes and it would be more helpful if we could just attend those sessions that we want to refresh on, but it’s not clear in the class information what’s happening at each class.</td>
</tr>
<tr>
<td>Women would prefer to use social media and online platforms to get their information about pregnancy and birth these days</td>
<td>We find the classes help us with things we cant get online and allow us to speak to and learn from other women. We still want classes but would like more online content too.</td>
</tr>
<tr>
<td>Women have good information about classes and have easy access by phone to book on</td>
<td>The information has been photocopied so many times it is difficult to read. The phone line for booking classes isn’t always manned so it’s sometimes hard to book on.</td>
</tr>
<tr>
<td>The same educational content is delivered across all 3 community sites as content is mandated by government</td>
<td>We are not getting the same content in all parts of the region and each midwife delivers it differently</td>
</tr>
</tbody>
</table>
Developing and prioritising improvement ideas and prototyping together
How this relates to QMS and the Framework

High-level Quality Management System Framework (working draft 2)
Quality Planning
How might we meaningfully involve people in quality planning?

Processes and culture that support individuals, families and communities to become equal partners in all aspects of quality planning, improvement and control.

Quality Planning

Understand needs and assets from the customer/population perspective and the gaps with what you provide.
What methods or techniques could you use?

Quality Planning

- Staff and public stakeholder mapping
- Integrated Systems mapping
- Person-centred observation
- Journey mapping - service user focus
- Discovery interviews/conversations (understand experiences of current state)
- Workshops / listening events
- Service user panels / reference groups
- Focus groups

What else?
Quality Improvement
How might we meaningfully involve people in quality improvement?

Processes and culture that support individuals, families and communities to become equal partners in all aspects of quality planning, improvement and control.

Quality Improvement

Individuals, families and communities to become equal partners in all aspects
What methods or techniques could you use?

**Quality Improvement**

- Co-design events - participatory decision making approaches
- Discovery interviews/conversations
- Service user/patient/staff qualitative stories
- Participatory journey mapping/gap analysis
- Patient and family advisory councils
- Public/Carer representatives
- Volunteers/Lay advisors

*What else?*
Quality control
How might we meaningfully involve people in quality control?

Processes and culture that support individuals, families and communities to become equal partners in all aspects of quality planning, improvement and control.

Quality control

Embed mechanisms into teams/services so they can detect variation from agreed standards/desired quality
What methods or techniques could you use?

Quality control

- Impact stories *(at key milestones)*
- Surveys *(monitoring experiences over time)*
- Patient and family advisory councils

*What else?*


Experience Base Co-design toolkit: [https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/](https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/)

This is Service Design Doing: [https://www.thisisservicedesignndoing.com/methods](https://www.thisisservicedesignndoing.com/methods)


Ihub: [https://ihub.scot/about-us/](https://ihub.scot/about-us/)
Thank you

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