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ORIGINAL PAPER

Coproduction in Practice: Participatory Action Research to Develop a Model of Community Aged Care

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Abstract Coproduction has become synonymous with innovative approaches to public service delivery in European Union countries as well as in Australia. Coproduction has the potential to bring together individuals, communities, and organisations in a process to collaboratively develop new models and services which improve public services. Yet, Australian policy makers and practitioners who would like to deploy coproduction within the context of older adult social care can only draw on a handful of papers and reports that could guide implementation. This paper fills this gap by reporting on the implementation of a multi-stakeholder coproduction approach to the development of a consumer directed care model for older people with complex health issues. The paper describes and critically highlights methodological challenges encountered during the 12 month-long participatory action research phase of a larger project involving older people with complex care needs, their carers, and government and non-government stakeholders. The paper outlines key considerations regarding (1) the involvement of older people with complex needs, (2) collaboration with industry partners, (3) engagement of government representatives, and (4) reflects on implementing participatory research projects within a context of outsourcing and interlinked supply chains. While not all challenges encountered could be resolved, the coproduction approach was successful in bringing together a wide range of stakeholders with competing agendas in an iterative process geared to resolve a plethora of concerns raised by older people, carers and services providers. This paper provides an example for others seeking to use coproduction and participatory methods to provide person-centred care services for older people.

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Introduction

Coproduction has become synonymous with innovative approaches to public service delivery in Australia and European Union countries (Hunter and Ritchie 2007; Loeffler et al. 2008; Needham 2008; Alford 2009; Dunston et al. 2009). Recent trends show a shift away from the private sector-inspired managerial forms of policy development of the 1980s and 1990s (Alford 1998; Bovaird 2006), and the return to more participatory approaches to public policy making popularised in the United States of America (USA) during the 1970s (Sharp 1980; Whitaker 1980; Parks et al. 1981). This shift is premised on the insight that the involvement of consumers in the design and implementation process of public services has the potential to (1) improve the quality and responsiveness of public services (Leadbeater 2007), (2) increase effectiveness of services and reduce public spending (Gershon 2004), and (3) strengthen and invigorate citizenship, social capital, and democracy (Vamstad 2004).

Historically 'coproduction' is rooted in a vast body of thought that aims to empower ordinary citizens by involving them in decisions that directly affect their lives. More recent initiatives featuring participatory forms of program development and governance are rooted in the demands of social movements during the 1960s and 1970s that popularised participatory ideals (Ottmann 2009). In the delivery of health services, participatory ideals became enshrined in Sherry Arnstein's ladder of citizenship participation (in A Ladder of Citizen Participation, 1969) and during the 1970s in the Alma Ata Declaration. However, whereas Arnstein envisaged a participatory culture in which health service users would play a key role in the decision-making process affecting their care, most subsequent attempts to institutionalise participatory ideals in health services in North America, Europe, and Australia defaulted to relatively low levels of citizen participation (Entwistle et al. 1998; Johnson and Silburn 2000; Abelson and Forest 2002; Church et al. 2002; Morone and Kilbreth 2003; Nathan 2004). Indeed, today many large health service providers feature consumer reference groups and other mechanisms of citizenship involvement, but few of these institutions are 'participatory' when held against Arnstein's ladder.

According to proponents, 'coproduction' has the capacity to renew Arnstein's vision of more inclusive and empowering health and social care (Dunston et al. 2009). The concept of 'coproduction' harbours a number of meanings that need to be differentiated. In the US, the concept of 'Coproduction' emerged during the 1970s (Ostrom 1973), a time of growing public sector budget deficits and declining trust in governments. At that time the term largely referred to the joint provision of public services and the stimulation of social engagement (Whitaker 1980). During the 1990s, 'coproduction' increasingly acquired a connotation of 'empowerment' with ordinary citizens admitted into the decision-making sphere and being involved in the policy-making aspects of public service delivery (Alford 1998; Cooper and Kathi 2005; Dunston et al. 2009). In this transformative sense, 'coproduction' is more than generating social capital. It is about individuals, communities, and organisations developing the skills, knowledge, and ability to work together to develop new models and services drawing on their own experience and expertise with the aim to negotiate improvements in public services (Needham 2008; McIntyre-Mills 2010). This conceptualisation of 'coproduction' is used and developed in this paper.

'Coproduction' methods are seldom clearly articulated beyond a set of basic principles (see, for instance, NDTi 2010). Moreover, these principles share a lot of common ground with action research approaches (Cooper and Kathi 2005; Cockburn 2007; NDTi 2010). Indeed, accounts of how coproduction actually works in practice have been few (Bovaird and Loeffler 2007). Australian policy makers and practitioners who would like to deploy coproduction within the context of older adult social care have access to few reports to guide them through model development and implementation (Alford 1993, 1998, 2002; Considine 2002; Considine and Lewis 2003; Casey and Dalton 2006; Dunston et al. 2009; Needham and Carr 2009). This UK focused literature discusses the inclusion of older people in fairly broad terms. Practitioners of transformative 'coproduction' tend to employ cyclic 'plan, act, observe, reflect, refine' iterations informed by user attitudes and experience, an approach that has much in common with action research. In fact 'coproduction' can be conceptualised as a call to collective program and policy making geared to bring together key stakeholders and decisions-makers under the aegis that such collective approaches have better outcomes for service users than unilateral, government-prescribed ones. In as much, transformative 'coproduction' appears to be a form of action research based on an often elusive method. Much of the literature on coproduction describes the basic principles of the approach in terms of an organic growth of skills and capacities that eventually give rise to successful problem solving (see, for instance, Needham 2008; McIntyre-Mills 2010). Vestiges of such romanticised collective processes can also be found in more theoretically inclined descriptions of collaborative inquiries of the action research family where Habermas' ideal speech acts and, by extension, communicative action (Habermas 1981) are used to explain what happens in action research phases (Kakabadse et al. 2007). Experienced action researchers would argue that most participatory processes that lead to focused outcomes are rarely organic or ideal. Rather they must be carefully managed, take into account systemic issues, and must be able to balance power differentials and competing agendas (Galuppo et al. 2010). Although power imbalances, authority, and confrontations are common in action research and are among the hardest to manage, they rarely form the focal point of academic publications (Pettigrew 2003; Oyum 2007). Power imbalances are particularly common and significant in multi-organisational partnerships where they spell important ethical questions for the researchers (Pettigrew 2003; Goduscheit et al. 2008). Yet the fact that power is still being ignored as a major factor in academic contributions focusing on inter-organizational relationships (see, for instance, Angeli Ghisi and Pinheiro Martinelli 2006) raises the question whether action research has been emptied of its social critical content and turned into a process improvement tool (Maguire 2002).

Within a context of de-centralisation and outsourcing where organisations/government departments subcontract chains of inter-connected yet competing entities that subcontracted each other to provide goods and services, differentials of power and authority play an important role. Accounts of an 'organic meeting of minds' often cast in simplistic dyadic relationships obscure the fact that group and inter-organisational dynamics can be very complex. Indeed they can be dysfunctional to a point where appeals to Habermasian ideal speech acts will yield rather unimpressive results.

This paper suggests that researchers and policy makers interested in harnessing collective approaches to problem solving in a multi-agency setting involving a range of stakeholders with different capacities will need to manage power dynamics and build the capacity of politically weaker stakeholders. Also, a robust, well-structured method that draws on research-based evidence may be of assistance.

This paper reports on the development and implementation of a model of social care for community dwelling older people that employs a coproduction approach grounded in co-operative inquiry, a practice that belongs to the family of action research (Reason and Bradbury 2001). The paper provides lessons for others interested in using these methods to provide person-centred care services for older people.

Project Background

The research formed the first phase of a larger project designed to develop, implement, and evaluate a consumer-directed care model for older people with complex care needs in Melbourne, Australia. The project was hosted by two mid-sized community care agencies that brokered home care, plus a small agency that provided both case management and home care services. This paper reports on the development phase (phase 1) of the project which involved older people, carers, service providers, and government representatives in drafting a self-directed aged care service model that was later termed the People at Centre Stage (PACS) model.

In Australia, home-based aged care for people with more complex needs is financed by federal government and tendered to a host of organisations which, in turn, generally subcontract services to a wide range of providers including local government. Hence, to achieve more flexibility in the provision of aged care, the whole community aged care sector had to be involved.

Aims

This paper will describe and critically reflect on key events that shaped a 12 month-long action research-inspired 'coproduction' process which involved older people with complex care needs, carers, government and industry stakeholders. The paper highlights obstacles and the potential of a collaborative approach to design a program and outlines the lessons learnt.

Description of Project Methods

The method underpinning the model development was chosen collaboratively with representatives of all stakeholder organisations. From the outset, representatives agreed that the project needed to involve the entire spectrum of stakeholders that included older people with complex care needs, carers, aged care broker organisations, aged care service providers (home care, community nursing, and health), older people's advocacy organisations, aged care industry peak bodies, aged care assessment organisations, as well as local, state, and federal government representatives. Importantly, older people using the services and their carers were central to the project and were involved directly in its development.

We agreed on a Co-operative Inquiry (CI) framework because it met most of the above-mentioned expectations and provided problem solving capacity. We extended the method by weaving research-derived evidence (aggregate practical knowledge) into the process. Reason (2002) describes the CI process as four inter-dependent phases. Phase one includes the formation of a working group, agreement on a focal point, and an initial exchange of ideas, stories, and ideals. An initial propositional frame of reference is established. During phase two the co-researchers begin to record group interactions, carefully recording how the group moves from the initial proposition by bringing into play everyday life

experiences. During phase three, all co-researchers are thoroughly familiar with the topic under discussion and are able to reflect on proposals fully engaging their experience. During this phase participants views rooted in their lived experience solidify. This may lend strength and depth to the initial proposition or lead to conceptual shifts. Phase four is essentially a reflection phase during which participants deliberate on the initial proposal in light of their experience and develop a counter proposal (Reason 2002). We used the research evidence to inform the initial propositional frame of reference. We applied this method to three working groups over a 12 month period. What is more, we attached a triangulation point to the research cycles to validate the findings. The basic research functions are presented diagrammatically in Fig. 1.

In Step one the literature was reviewed (Ottmann et al. 2009) providing a solid research evidence base. Six focus groups were undertaken in Step two to obtain feedback from a sample of 62 older people and carers. Step three involved the formation and running of three working groups: a service User and Carer Group (UCG), a service Provider Group (PG), and an Advisory Group (AG) comprised of industry and government representatives. Findings from the literature review and the focus groups guided the agenda and discussions in these three working groups. The aim of the UCG was to identify major gaps and shortcomings in the way care services were provided and collaborate with the researchers in developing a flexible model of community aged care designed to meet the needs and preferences of older people. The aims of the PG and the AG were to identify model implementation issues and consider solutions to systemic and legislative barriers.

The service User and Carer Group (UCG) met on 15 occasions. It was composed of eight older people with complex care needs aged 59–88 years, and six carers aged 35–75 years. The group included older people of Slavic origin, first generation Italian and Sri Lankan immigrants, and people of Anglo-Saxon descent. The group included middle

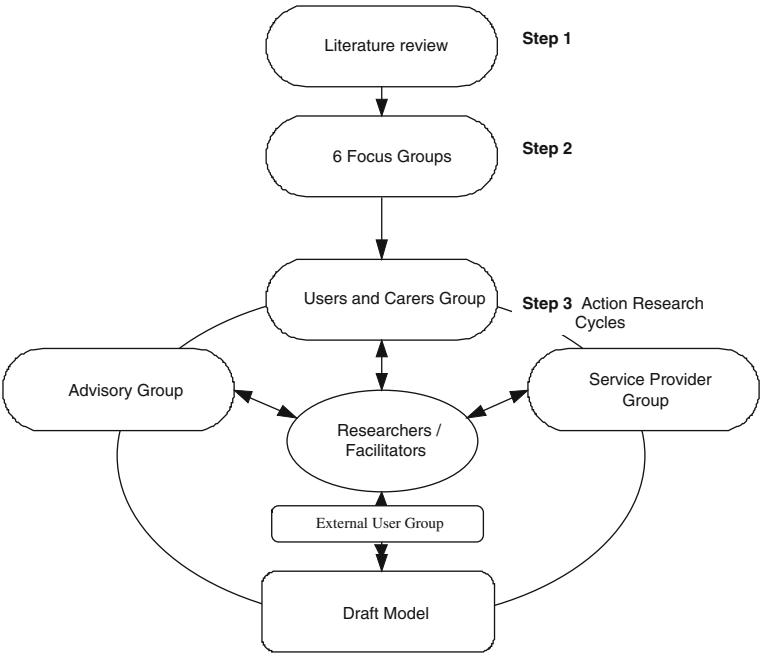

Fig. 1 Overview phase one

class professionals and participants from a lower socio-economic background. Seven service users and five carers attended meetings regularly. Initially approached by case managers who were employed by two of the home care organisations, prospective UCG members were then contacted by the research team to explain the project and obtain their informed consent. Criteria for inclusion into the group included the ability to attend face-to-face meetings, to converse in the English language and/or to have access to a carer able to interpret, and an interest in self-directed care.

The service Provider Group (PG) met on eight occasions. It was initially made up of ten participants representing local government aged care branches, private sector and not-for-profit homecare providers, a community nursing agency, and a representative of the state's aged care assessment team. However, the composition of this group changed over the 12 months as discussed below.

The Advisory Group (AG) met on three occasions. It was composed of 14 participants representing industry peak bodies, advocacy organisations, as well as local government and state government representatives. Federal government representatives were invited but declined to attend any meetings due to a perceived conflict of interest.

PG and AG working group members were recruited via invitation letter and self-selected into the group. All relevant aged care organisations in the region were given a brief outline of the project and were invited to an introductory meeting. Selection criteria included direct involvement in the regional aged care sector, an interest in self-directed care modalities, and an ability to make a significant time commitment. Inclusion criteria were relevance of services provided to the project, geographic location and a commitment to self-directed care.

Over the course of the year, problems associated with service provision and associated systems issues identified by the UCG were presented to the other two working groups to consider solutions. The outcomes of these discussions were then presented back to the UCG by the research team for their comment and appraisal. The UCG met on 15 occasions, these being monthly meetings plus additional meetings as required. The other two working groups met when their input was required by the UCG and the researchers. The information obtained from these meetings informed the development of a draft service model. The UCG commented on and suggested improvements to this initial draft model.

Ethics Approvals

Ethics approval was obtained from Deakin University as well as participating organisations.

Data Collection

Data were collected between January 2009 and January 2010. Data were captured from multiple sources and included the literature review, focus groups, feedback from social care professionals and managers (expert or practitioner opinions recorded during meetings), a review of internal documents and a project audit trail. Moreover, the transcripts of tape recordings from the three working groups comprised important data.

Data Analysis

All data recorded plus participant observation notes and internal documents were thematically analysed. A hybrid approach of inductive and deductive coding and theme development integrating data- and theory-driven codes was used to interpret raw data

(Fereday and Muir-Cochrane 2006). Whereas theoretical insights provided a point of departure for the coding process, data derived codes remained key reference points over the course of the data analysis as they re-shaped and, on occasions, replaced theory-derived codes.

Implementation Issues

The 'coproduction' approach employed in this project created opportunities for different stakeholders to discuss systemic and cultural obstacles to more flexible service delivery. However, the approach also generated a number of important challenges summarised in the form of 'lessons learnt' presented in Table 1.

The following discusses each 'lesson' and adjustments to generate successful outcomes.

Table 1 Lessons learnt

1. When co-producing with frail older people it is important to:
   a. Build trust. It may take time for older people to feel secure enough to speak their minds;
   b. Make appropriate arrangements so that frail older people can participate in meetings and discussions;
   c. Clearly and repeatedly outline the context of a discussion (e.g. explain how this discussion feeds directly into the project decision-making process);
   d. Fill knowledge gaps;
   e. Use practical examples when explaining concepts and processes;
   f. Test out whether 'role playing' exercises are acceptable to participants;
   g. Provide advocacy support
2. When co-producing with service providers it is important to:
   a. Carefully select group participants in order to avoid overly competitive behaviour and mutual 'policing'. This may involve the
      i. Splitting of the supply chain into discrete logistic units;
      ii. Avoid representatives from agencies who predominately represent the interests of legislators
   b. Employ an experienced group mediator with substantial knowledge of the sector
3. When co-producing with government stakeholders it is important to:
   a. Establish whether government partners endorse and share the principles of co-production;
   b. Ascertain whether the project has attracted decision makers who are relevant to the project and have the authority to make decisions;
   c. Confirm that stakeholders have the necessary time at their disposal to participate in lengthy negotiations and discussions
4. When co-producing with agencies that are to implement a project it is important to:
   a. To develop risk analysis-based contingency plans accepted by all major stakeholders that outline how the project is to progress when a major obstacle is faced
   b. Ensure senior executives and/or board members are aware of the project's requirements to guard against disruption if the manager supporting the project leaves
   c. Delineate a clear change management strategy. This may involve the
      i. Establishment of a clear project management plan,
      ii. Nomination of a team leader 'champion' responsible for the implementation of the project,
      iii. Definition of clear accountability structures and communications channels, and
      iv. Development of a sense of responsibility and ownership of the project

Coproducing with Frail Older People

Service User and Carer Group (UCG) members reported a plethora of serious illnesses and/or disabilities (stroke, cancer, arthritis, mild cognitive impairments) that limited their mobility and, according to the participants, their cognitive capacity. Yet, all group members participated in deliberations and provided valuable feedback. Measures employed to facilitate this are described below. Moreover, the majority of the group's participants were committed to the project and invested a great deal of time and effort to ensure positive outcomes.

Trust Building

It took approximately 3 months (three meetings) for group participants to build sufficient trust to express their views and opinions. During the earlier meetings participants appeared to test whether their participation would have negative repercussions on their relationship with their case manager or fellow group members. Aware that two members of the research team employed by a university were co-located with the agency that provided their home care, they only highlighted positive aspects of their care. After reassurances from the researchers that all information was confidential and would not affect their relationships with their case managers, participants became increasingly vocal and expressed their views. Lack of confidence and entitlement were associated with lack of trust. It took several sessions to build sufficient trust to address these issues. The researchers facilitated this process by providing information and facilitating peer discussion. Once reassured and feeling comfortable with fellow group participants, UCG members embraced the participatory nature of the project.

UCG members identified gaps and weaknesses in the provision of aged care services and guided the development of the service model from a consumer perspective. They co-determined meeting agendas and undertook research tasks such as reviewing tools and documents to ensure their appropriateness for older people (see also Zurakowski et al. 2006; Hanoch et al. 2007).

Consumer Advocacy

Insights provided by members of the UCG shaped the project and provided the basis for most discussions with the other two working groups. To ensure this outcome, however, researchers were forced to take on the role of consumer advocate with other stakeholders. It became clear early on that without our advocacy stance, the needs and preferences of the consumer group would be overrun by administrative and/or operational issues.

Accessibility of Venues

During collaboration with the UCG, the researchers faced a number of key issues that had to be addressed in order to maximise the outcome of this working group. Restricted mobility and health problems were major barriers to group members' active participation. These barriers were overcome by reimbursing group members for transport and personal carer costs incurred, telephone links to meetings and briefing members in writing about the outcomes of previous sessions if unable to attend.

Clearly Articulated Contextual Information

It was apparent from the earliest meetings that useful discussions and successful outcomes were dependent upon the context and purpose of the meeting and the UCG role needed to be clearly explained at the beginning of each meeting. Participants needed to be reminded how the issues and debates fitted into the wider task of developing a community aged care service model in order to remain focussed on the topic of discussion. This requirement is not unique to discussions involving older people (Needham 2008).

Plugging Knowledge Gaps

When co-producing with service users, including older people, knowledge gaps will represent an obstacle (NDTi 2010). Hence, group facilitators have to conduct a gap analysis to identify gaps that need to be addressed. In our case, the provision of information about the functioning and financing of the Australian community aged care system proved to be crucial. In addition, participants required a user-friendly introduction to self-directed care models as implemented around the world. In order to provide such subject-specific information, the researchers experimented with various adult learning styles (Truluck and Courtenay 1999; Zurakowski et al. 2006; Hanoch et al. 2007). We discovered a gap in the research literature regarding older adults' preferred learning/communication styles (Zurakowski et al. 2006). Given the growing number of ageing 'baby boomers' who are likely to make demands on educational resources within a health and social care context, older adults' preferred learning styles merit more research. In our study, we found that practical applied examples based on the principles of experiential learning worked best to communicate such information.

Practical Examples and Abstract Concepts

The provision of theoretical and abstract background information was at times challenging. Participants found practical examples of how proposals and concepts apply to them were helpful. Based on principles of reflective and experiential learning, activities allowing participants to 'see' and, in a limited sense, experience key features of the proposed program proved useful (see, for instance, Moon 2004).

The relevance of the topic under discussion was related to participants' engagement. When topics were directly relevant, for example planning ahead and end of life decision making, participants' interest and focus increased. Nevertheless, participants were willing to engage in more mundane and laborious tasks such as the reviewing of information pamphlets. All were motivated to participate in the project by a desire to contribute to a greater good and give something back to society (see also, Alford 2002).

Test Acceptability of Role Play

Attempts to use role-play, where participants assumed the role of another older person in order to test research tools to be employed during the evaluation of the project, were unsuccessful. Group members found it difficult to slip into the character of another person and, as a result, became confused and frustrated.

It is important to highlight that social interaction was an important aspect of the UCG meetings (see, also Alford 2002). Group members welcomed the opportunity to meet like-minded people and to exchange views and experiences. As a result, meetings were never tightly structured and sufficient time was allocated for humour and informal conversations.

Coproducing with Service Providers

Selection of Participants

Initially, the service provider group (PG) presented significant challenges that undermined its role to find solutions to the requests made by the UCG. This was largely due to the mix of representatives brought together in the group. The PG included brokers and representatives of subcontracted agencies who competed with each other for market share. Managers were keen to highlight that their agency was more efficient and more client-centred than a competitor. Initial discussions were often hampered by these competitive relationships. Moreover, the group included a member of a service who saw their role as one of a government representative. Rather than seeking flexible solutions to problems, this representative reasserted the need to comply with federal legislation and guidelines that, according to other members of the group, were barriers to service development. In combination, these two factors often resulted in defensive 'sparring' and in remarks challenging the group coordinator who had only limited knowledge of the industry. Over the three meetings it was apparent that the group was unable to engage in productive and collaborative problem solving. Again, this example highlights the difficulties associated with 'conflict of interest' within the coproduction process and the need for careful consideration of strong advocacy processes.

The following steps proved effective in improving the functionality of the group:

- First, the group was divided into two subgroups and an experienced practitioner was engaged as an advisor.
- Second, representatives of broker organisations (organisations that coordinate services but subcontract others to provide direct care) were removed to change the group dynamics and remove tensions that issued from including brokers and sub-contracted agencies (agencies subcontracted by broker organisations) together. Participants representing broker organizations were invited to attend separate Implementation Management Meetings.
- Third, the 'government representative' was re-assigned to the AG.
- A fourth strategy was focusing meetings more tightly to fit with the time constraints of busy middle managers.

These strategies proved most valuable. Service provider representatives felt increasingly able to freely discuss their agency's practice and identify common ground on which a more flexible service delivery model could be negotiated. The changes brought about an 'in principle support' for the project that facilitated the definition of processes and guidelines as well as templates of contracts that could be used to operationalise a more flexible service model.

Coproducing with Government Stakeholders

A further challenge to 'coproduction' underpinning the project emanated from the Advisory Group (AG). Similar to the service Provider Group (PG), AG members were asked to find solutions to systemic and legislative barriers identified during the model development process. Key government decision makers announced that they would not to be involved in the coproduction process. They did not share the ideals of coproduction and were concerned that their participation could undermine their position in the wider government policy processes. It was often difficult to determine which of the branches of a decentralised government department was responsible for decisions that needed to be made.

Consequently, it was difficult to invite the appropriate senior government representatives to participate.

Due to demands on their time, government executives with authority to make decisions often sent junior colleagues to the meetings who had limited ability to contribute to the problem solving process. As a result, the group became a dissemination forum regarding project progress and limited problem solving occurred. The more important decisions affecting the project, such as the creation of a funding base for the program by administratively combining a range of different funding streams (pooled funding), took place without 'coproduction' stakeholders. Accordingly, fundamental administrative processes underpinning community aged care were 'off limits' to the 'coproduction' stakeholders and not negotiable. Due to the reluctance of government representatives to directly engage in a discussion about bureaucratic constraints to greater program flexibility and user focus, the project team engaged an experienced lobbyist to liaise with more senior bureaucrats at the national level. The contracting of a lobbyist did not form part of the original 'coproduction' methodology as the lobbyist essentially acted outside the negotiation loops built around the key stakeholders. The official government reply to the project team's list of requests submitted by this person was largely unresponsive and allowed only a small fraction of the flexibility that was initially requested. As a result, several key project features such as a pooled funding base had to be altered.

Coproducing with Implementing Agencies

Develop Contingency Plans Embraced by Key Stakeholders

Government refusal to relax administrative guidelines resulted in expected productivity gains not eventuating. As a result, the agencies implementing the PACS model questioned the project's financial viability and their commitment. The project's implementation was threatened thereby undermining the potential benefits for consumers and carers. Negotiations between the researchers and implementing agencies became difficult.

The research team sought to mitigate these challenges in two ways. Firstly, the team lobbied the tier of government responsible for funding guidelines for more flexibility. Government representatives retorted that the barriers to a more flexible service model were the result of service providers' 'conservative' interpretation of guidelines and policies effectively limiting the number and type of support services aged care packages could be spent on. Service providers responded that ambiguous guidelines and auditing processes forced them to adopt a more conservative stance, thus essentially limiting service options for clients. The opportunity to create a greater alignment between all stakeholders' expectations using a collaborative approach was missed because the key players declined to engage in an ongoing discussion. This communication breakdown led to a retreat to predefined positions and blame shifting between parties.

The research team attempted to convince service providers to implement the project with limited government support and to absorb any additional costs that this might generate. However, the departure of senior managers supporting the project in two of the three implementing agencies undermined the outcome of these discussions.

Ensure Continuity of Management Support

In the absence of clear senior management support for the project in the initiating agency, negotiations stalled. After some months, negotiations recommenced with the newly

appointed senior managers who provided unequivocal support for the project. They allocated organisational finances to implement the model for trial and evaluation. Without the willingness of the partner organisations to take some potential financial risks associated with implementing the PACS model the outcome of the project would have been jeopardised. The goodwill of partner organisations counteracted the inflexibilities of senior government bureaucrats. Subsequently, the model's implementation advanced rapidly and smoothly. The development of a clear *change management* strategy by the implementing agencies assisted this outcome greatly.

The following management factors at the agency level contributed to this positive outcome:

- Clear change management plans and accountability structures.
- Nomination of a team leader responsible for the implementation of the PACS model. This role was essential to successful implementation by liaising between middle management and the operational level.
- Clearly defined management structures and communication channels.
- A sense of ownership of the project fostered within the organisations.

Discussion

'Coproduction' is a proposition that, if endorsed by key stakeholders, harbours the potential to bring together actors, within and across institutional boundaries, to engage in a collaborative problem solving process. When this process harbours transformational objectives, it is likely to involve a re-alignment of relationships and the power that underpins them. The concept of 'coproduction' is not a method as such. Rather, the term encapsulates an approach to a problem. It is an epistemological device that, if charged with moral and political authority can unite actors with competing agendas to bring about systemic change. To be successfully implemented, 'coproduction' needs to be grounded in a robust, systemically consistent method that is capable of effectively balancing power differentials arising during collaborative processes.

The 'coproduction' approach underpinning this project generated a climate of cooperation that enabled a wide range of agencies involved in the provision of community aged care to engage in an iterative problem solving process addressing a plethora of concerns raised by older people, carers and service providers. Throughout the process the voices of older people and carers influenced most major decisions. Furthermore, the approach facilitated a genuinely collaborative spirit which, in conjunction with an abundance of collective professional expertise, enabled project participants to remove many operational barriers. These ranged from inter-agency communication to accountability issues that seemed insurmountable at the outset. What is more, the Co-operative Inquiry method used to operationalise 'coproduction' amplified the voice of consumers and gave it more weight in the negotiation processes that underpinned the development of the PACS model. UCG participants gained confidence and know-how over the course of their involvement in the group which enabled them to express their needs and preferences more clearly.

However, it is important to point out that significant challenges were encountered with the 'coproduction' approach and not all were resolved. The most difficult challenge was our inability to sufficiently involve key government stakeholders which were needed to resolve key issues at the core of inflexible community aged care administration in Australia. This forced the researchers to design the new model within existing, arguably

cumbersome, administrative structures, which substantially limited the model's flexibility. Governmental stakeholders were reluctant to commit to the 'coproduction' process and remained at its periphery. Government representatives preferred high-level stakeholder consultation in the form of a ministerial working group involving peak organisations, consumer representatives, and service provider agencies. Although the researchers were represented in this forum, this approach did not resolve the inflexibility identified by the coproduction process stemming from systemic and legislative barriers. The likely failure of relatively low-level coproduction approaches, in our case an approach that involved only a small sector of the community, to resolve core problems of national priority has been highlighted elsewhere (Casey and Dalton 2006; Needham 2008). This clearly signalled the limits of the coproduction approach underpinning the project.

Another issue that proved difficult in the Co-operative Inquiry process was the power differential between the competing stakeholder groups. Some voices within the 'coproduction' process held distinctly more power and were more able to influence outcomes. As a result, some voices within the collaborative process needed to be strengthened (Ottmann and Laragy 2010). Consumers' voices were weaker and were easily overcome by administrative and operational 'imperatives'. Interestingly, consumer advocacy organisations involved in the project largely failed to amplify the voices of consumers. This intrinsic power imbalance is a problematic feature at the core of participatory processes in general and the 'coproduction' process in particular (see, for instance, Pettigrew 2003; Chung and Lounsbury 2006; Oyum 2007; Goduscheit et al. 2008; Galuppo et al. 2010). Hence, it is extremely important for proponents of collaborative problem solving approaches, particularly within an inter-organizational context involving service users whose collective voice is fragile, to monitor the various stakeholder voices and amplify them if required. It is important to note that researchers may not be in the best position to take on this advocacy role.

Conclusion

Contextual issues arising around coproduction approaches are shaped by administrative, societal and political factors. While there are limitations to the transferability of learnings regarding the implementation of coproduction approaches, this paper identifies systemic factors that can be considered in a variety of contexts. The paper described and critically reflected on key events encountered while employing a collaborative approach to the development of a community aged care model. It highlighted key obstacles and provides an overview of the conflict mediation and advocacy processes required to bring the development phase of this project to a successful conclusion. The paper distinguishes a number of key issues that are likely to emerge in a decentralised, out-sourced services environment, issues that are often overlooked in the academic literature. The account identifies power differentials in this public services supply chain suggesting that service users have often the weakest stakeholder requiring advocacy and capacity building. Moreover, the paper describes core tensions in the negotiation process, such as competition between research participants in a multi-agency setting and the difficulty of engaging key government decision makers in negotiations. The principles of 'coproduction' generated sufficient goodwill among community aged care providers to participate in a 12 month-long iterative process addressing a wide range of care issues raised by older people and carers. However, the approach was unable to involve in the process government representatives with a level of authority to lower stifling administrative hurdles. Moreover, the

paper demonstrates that methodologies such as the Co-operative Inquiry may need to be adjusted in order to manage multitudes of agendas and conflicting interests when dealing with a service sector rather than an individual service provider. In as much, the paper outlines the strength and limitations of 'coproduction' and the Co-operative Inquiry employed to operationalise the concept. In an environment in which most production processes and service delivery systems involve networks of discrete, subcontracted entities, issues of power and authority should not be overlooked.

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