Co-production: what it is and how it can ensure inclusive practice for service users and staff.

MAKEY, Laura Michelle, WALSH, Claire Louise and SALIH, Ifrah

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Why you should read this article:

To identify that co-production is developing in health and social care services, education and research

To be aware of the benefits and challenges of co-production

To recognise that with careful design and organisation, co-production can become an essential part of leading and managing groups of people and organisations

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Laura Michelle Makey, Claire Louise Walsh, Ifrah Salih

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Correspondence
l.makey@shu.ac.uk; 0114 2255701

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Key points

1. Co-production with service users and professionals is an essential approach to furthering equality diversity and inclusion in health and social care. 2. Co-production is more than an approach or process, but a philosophical commitment to understanding the experiences of others so that services can be improved. 3. Co-production has foundations in healthcare and is rapidly evolving in research and healthcare education.

Abstract

Co-production is a process adopted in health, social care, research, policy development and education that aims to bring together the skills and experiences of service users and professionals. It has a range of advantages, such as enabling users of a service to have a voice and to equalise power among service users, professionals and leaders. It is a process that is continually developing and often referred to in contemporary health and social care policy. When designed well, co-production can create a variety of advantages for service users, professionals and the wider community. This article demonstrates that co-production can be an effective framework to improve experiences for service users and healthcare staff. It is an empowering process that can happen in varying degrees and can be a key part of nurse managers' practice. This article explores how co-production can be successfully used in a range of healthcare and education environments. Ideas about how nurse managers can use co-production to address diversity and inclusion in services are explored.

Author details

Laura Michelle Makey, senior lecturer, College of Health, Wellbeing and Life Sciences, Sheffield Hallam University, Sheffield, England; Claire Louise Walsh, head of academic development and inclusivity, Sheffield Hallam University, Sheffield, England; Ifrah Salih, senior lecturer in academic development and inclusivity, Sheffield Hallam University, Sheffield, England

Keywords

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Co-production is a process that aims to bring together the skills and experiences of service users and professionals. Its goal is to ensure social justice and to equalise power among service users, professionals and leaders. It functions by giving service users a voice so that their experiences can be improved (Social Care Institute for Excellence 2013). It is part of the statutory requirement of the Care Act 2014. Local authorities have a responsibility to engage actively with service users, carers and relatives to co-produce services.

The term co-production was first developed by Edgar Cahn, a civil rights lawyer and co-founder of a law school in the US (Cahn 2004). Following a cardiac incident, he reflected on the unjust experiences of people who had fewer choices and resources and less money. He decided to analyse local services and suggested approaches to reorganise them to ensure that they valued the service users, staff and communities they served. He believed that groups of service users have a valuable and untapped knowledge that could act to enhance a service. Without this knowledge, services are at risk of being ineffective because they do not fully understand the service user's needs and, consequently, staff are at risk of burnout. Examples include when staff see repeated patient admissions and the patients seem unwilling or unable to change their lifestyles to improve their health. Cahn found consistent issues among a range of services, such as the police struggling to develop safer neighbourhoods and substance misuse detox programmes struggling to keep a person free of drugs and alcohol. It became clear to Cahn that there was a constant theme and he determined that there must be an issue with the production of the services. Hence, he developed the concept of 'co-production' to foster new ways of working. In this process, the bringing together of groups of people from community groups, service users, relatives and professionals acts as a method of creating parity and equality of power.

Since then, co-production has evolved significantly and over time the definitions have changed. Other terms used are co-design, co-creation, co-planning, service user involvement and patient and public involvement to name a few. Co-production in healthcare is seen to ensure innovation and improvement of services, although it can be met with limitations such as issues with responsibility and a resistant healthcare culture (Batalden et al 2015). Others discuss co-production as having many positive outcomes, however, they suggest there is scope for more evidence-based methods to measure effectiveness (Durose et al 2017). Despite some of its complexities, a culture of co-production in healthcare is positively encouraged and is adopted in the NHS Five Year Forward View (NHS England 2014). Co-production is now a vital framework in health and social care leadership, commissioning and policy development.

How and when does co-production happen?

In health and social care, co-production happens in different forms, such as individual, group or collective strategies.

Individual co-production activities are now part of the more commonly recognised term 'shared decision-making'. For example, a nurse practitioner may identify a patient who is struggling to adhere to a medication regimen and will devise a co-produced plan of how the patient can be supported.

Group co-production is a process where professionals organise group sessions with patients, relatives or service users. An example is a support group for people diagnosed with viral hepatitis. The group, which is led by professionals and dedicated service users, offers a regular meeting that aims to share real-life experiences and offer information and support from people living with viral hepatitis (Hepatitis B Foundation 2022). In clinical research, group co-production activities have many functions. The Health Research Authority has regional committees of experts and lay members that review and provide ethical opinions for NHS research (Health Research Authority 2021). Similarly, models of group co-production are encouraged in research by the National Institute for Health Research (NIHR) (2019). Patient and public involvement groups meet regularly to evaluate potential and ongoing research projects.

Collective co-production is a term used when from more than one organisation connect to create outcomes, such as policy guidance and standards. In the creation and writing of National Institute for Health and Care Excellence (NICE) guidance for example, members of the public are actively involved by either being in a committee or reviewing guidelines before publication. This is a method to ensure that specialists and the public co-produce the guidance that will be used widely by health and social care practitioners and

commissioners. Stakeholders are also encouraged to contact NICE if they believe the guidance needs updating to ensure ongoing quality improvements are driven by the public (NICE 2014).

These are some of the many examples of how co-production is now an accepted approach to reconfiguring service delivery and policy improvement.

Co-production core values

Co-production must have certain core values and they are equality, inclusivity, developing and maintaining engagement and reciprocity. Equality is important and must be navigated carefully, such as ensuring that service users who agree to be co-producers feel enabled to speak. Differences of opinion can happen and can be challenging for group members, however, they must not be a reason to discontinue the activities (Oliver et al 2019). It is thought that managing challenges should be part of the design stages. For example, facilitators should make plans to equalise any power relationship between members (Herrera et al 2010). Historically in co-production, marginalised groups have been unintentionally excluded. People less likely to take part in co-production are from ethnic minority backgrounds, LGBTQ communities or individuals, people who communicate differently, people with limited capacity and/or people with dementia (Herrera et al 2010). Methods to ensure inclusivity and accessibility are in their infancy. Suggestions include embracing diversity, such as asking key community members to be part of and recruit to co-production groups. Meetings should be accessible to a diversity of people and meeting documentation should be carefully considered, such as whether it is a readable text size and available in appropriate formats and languages. One research group developing a mental capacity assessment tool found the use of artifacts such as pictures and images a useful method to co-create a series of patient-facing resources. Service users commented how they felt enabled in the process due to their contributions being highly visible (Cooke et al 2017).

Maintaining engagement and reciprocity may be challenging to fully achieve. Issues may occur if members or professionals are unwilling to take on board other members' views (Mockford et al 2012). It is advised that members are encouraged to reflect on any preconceptions or biases that they may bring to the process (NIHR 2018). Recommendations to encourage and maintain engagement include chairs of the group being led by a member of the community rather than a professional in the field. Similarly, there should be opportunities for personal growth and an emphasis on supporting individuals to contribute to the co-production activities. Members of the co-production group need to be willing to accept and trust each other to ensure reciprocity. Likewise, the contributions of each of the members should be acknowledged and members should feel they personally benefit from being in the group, such as increasing confidence or gaining experience that may help access courses or work experience (NIHR 2018). Understanding the intricacies of managing a co-production activity requires training and consultation with people who have experience as co-producers. Organisations such as NICE offer a range of training and masterclasses to voluntary organisations and the community sector in understanding how co-production activities can be effectively project managed (NICE 2022).

The evidence behind co-production

A systematic review analysing the effect of patient and public involvement in healthcare found that many forms of co-production activities take place in the UK (Mockford et al 2012). In the review, many of the studies reported co-production to be an innovative and successful means of improving a service. For example, service users have co-produced training packages for staff as part of their continuing professional development. Co-production has been reported as a helpful way to navigate challenging issues in healthcare. For example, research looking at diagnostic error showed co-production to be an effective tool in educating patients about why errors occur. This activity was found to increase trust between patients and professionals (Jo and Nabatchi 2018).

Potential barriers to recruitment and maintaining engagement have been reported in empirical evidence. For example, in the recruitment of co-production members, research showed that staff limited recruitment strategies and tended to ask a narrow selection of patients (El Enany et al 2013). In this instance, research showed a divide was created between patients. Those who were not involved would dislike members who were included in the co-production activities. Although this may only happen in a close community network, this research shows the importance of paying close attention to the recruitment processes. Some have criticised current co-production models as being high in elitism and tokenism. They suggest co-production design should use models that work hard to concentrate and address potential recruitment and membership issues (Ocloo and Matthews 2016).

Others suggest professional and public roles should be blurred to ensure authentic collaboration in healthcare research design (Cooke et al 2017). An example is when co-producers actively involve community leaders in the design and ongoing running of the project. A systematic review found active involvement of key community members created a greater sense of ownership that

contributed to the project's success. This can be particularly helpful for inclusivity and ensuring populations less likely to be involved are included (Bonevski et al 2014). By including members of the community in the design, co-production activities are open to creativity that will enhance the overall running of the project.

A pilot study suggested that a major step in the co-production process is to learn from previous experience. In this way, co-production partners from previous projects are invited to the group to share the good and the not so good aspects of their co-production experiences (Lam et al 2017). This activity can act to encourage the group to plan and discuss any potential pitfalls and create a commonly agreed map of what the co-production team hopes to achieve. Therefore, with the help and sharing of other co-production experiences, the process can improve future projects and continually evolve.

Measuring the success of co-production

It is challenging to fully measure the overall benefits of co-production. In a project that evaluated the co-production and implementation of the new Scottish social security system, it was suggested that the 'ecosystem perspective' was a way to understand the nature and complexity of measuring effectiveness (Strokosch and Osborne 2020). In this theory, services are 'living systems' that are supported or constrained by many entities such as service users, policymakers, managers, activists, resources and technologies within the service. It is accepted that services are complex due to the interconnectivity between many layers of human interactions that occur on a daily, monthly or yearly basis. Therefore, effectively capturing the effectiveness of a co-production activity can be challenging and 'snapshot' evaluations may not be a true reflection of the project success. This is due to the ever-changing nature of external influencers such as political and contextual issues (Strokosch and Osborne 2020). For this reason, leaders of co-production activities may choose a variety of outcomes and time points to measure the effectiveness of the project.

Co-production in education

Co-production in higher education has strong foundations. The Office for Students has co-produced a charter for mental health (Office for Students 2019). Other examples are the development of a new curriculum where students were active members in the writing of learning materials (Evans et al 2015). In a healthcare nursing curriculum a group of service users with learning disabilities and their relatives are actively involved in the creation and delivery of educational sessions. Informal feedback suggests this has created important and meaningful outcomes for students and service users, such as increasing service users' confidence and enhancing students' communication skills.

Another co-production activity has successfully involved students as co-researchers (Vignette 1). This activity enabled students to gain practical experience in the research process, such as to recruit and interview research participants. This process has been positive in developing relationships and the research skills of the student and staff members. Other activities in higher education and healthcare organisations include addressing prominent issues for diverse groups. For example, academics have developed co-production approaches to address gaps in student and staff experiences, such as for people from ethnic minority backgrounds or LGBTQ groups. One innovation in nursing, midwifery and allied health education is the development of a monthly online meeting. In this activity, groups of students and staff meet online to discuss aspects about student and staff placement experiences, decolonising the curriculum and evaluating assessment criteria to ensure they are inclusive. In this co-production activity, students and academics take on board the core co-production values of ensuring accessibility and reciprocity by creating a platform to hear voices and empower people. The group has successfully achieved many outcomes, such as developing training resources for staff, presenting at a range of conferences and making links with students across other universities to co-create a conference (Vignette 2). Such activities are a grassroots movement aiming to equalise power relationships, address inclusivity and extend to healthcare environments so that co-production activities are familiar to students and future healthcare professionals. Research has evaluated student perceptions of co-production and found the main outcomes are an increased understanding of other people's roles and understanding their challenges (Garcia et al 2018). It is argued that the aims of co-production should be less about changing and more about enabling individuals and groups of people by increasing knowledge and empowering those involved (Palumbo and Manna 2018).

Vignette 1

Interprofessional education (IPE) is a critical approach for preparing students to enter the health workforce. IPE is a key part of a redesign of healthcare systems to promote interprofessional teamwork, enhance the quality of patient care and improve health outcomes. In response, an undergraduate preregistration integrated care curriculum was designed. The purpose of the project was to evaluate the current curriculum and collate student perspectives of IPE and collaborative learning experiences. To ensure authenticity

of data, part of the research design bid was to apply for funding to recruit and pay student researchers to be part of the research team. They acted as co-producers of the evaluation and were an essential part of the data collection and analysis. The research team has been effective in recruiting and facilitating four focus groups because of the many ideas the students had about recruitment strategies. The student researchers and staff members have gained many skills, such as experience in understanding the research process, recruitment and data collection. The process has been successful and the student researchers plan to present at professional conferences. Overall, people have gathered and produced research. The team was an excellent example of how co-production can be an important part of research design and exemplifies how people with a range of skills can work together effectively.

Vignette 2

The importance of diversity in the workforce is linked to effective patient care improving planning and provision of services. It is argued that without co-production activities, commissioners are at risk of falling short of provision for the most disadvantaged and deprived groups, including people from African and Asian ethnic minorities. To address this, the NHS and care workforce, leaders and commissioners of services must be reflective of the populations they seek to serve. Currently, a project is taking place between healthcare students and staff from Sheffield Hallam University and the University of Sheffield who have collaborated with local trusts and voluntary organisations to co-design an annual conference. The initial conference aimed to identify and raise awareness of the health inequalities faced by people from ethnic minority backgrounds, including maternal deaths, the effect of the coronavirus disease 2019 and mental health. This is a project that is driven by the interests of students from ethnic minority backgrounds and aims to improve experiences in the workplace by learning from, with and about one another. Students, academics and healthcare staff from local hospital trusts are invited to the conference. The conference took place in 2021 and received positive feedback. The second conference is hosted in 2022 and includes presenters nationally who are sharing initiatives that raise awareness of health inequalities in people from ethnic minority backgrounds and strategies to tackle racism in healthcare education. The conference is available nationally to all healthcare staff, students and educators.

Conclusion

Co-production is advancing in health and social care services, research and higher education. It is a process that aims to gather knowledge and make shared changes in a service or educational course. It must include core values to be successful, such as equality and accessibility. Careful considerations must be made about inclusivity and methods to fully engage partners. The evidence supports the view that co-production can have positive outcomes and often results in improved understanding between professionals, service users and students. Without careful and inclusive recruitment and retention strategies, only a narrow range of views will be heard. Engagement of key community members is important to ensure recruitment and retention throughout the project. Creativity to improve retention and outcome quality is an important aspect to consider. Discussions with experienced co-producers can help to navigate and steer projects. In higher education institutions, many co-production activities are ongoing, and examples are provided that are effective methods to engage healthcare students in gaining research experience in an academic team and developing a platform for people from ethnic minority backgrounds or LGBTQ groups to have a voice. This activity is helping to empower and equip individuals who are the future workforce and leaders in healthcare. Overall, co-production can be a positive process and with careful design and organisation can become an essential part of leading and managing groups of people and organisations.

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